EXPERIENCES OF PREGNANT UNMARRIED ADOLESCENTS IN MASERU

by

TJOETSO VERONICA LEHANA

a dissertation submitted in accordance with the requirements for the

Masters Societatis Scientiae (M.Soc.Sc. Nursing)

in the
Faculty of Health Sciences
School of Nursing

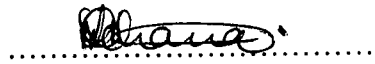
at the

University of the Orange Free State

SUPERVISOR: Dr. Lily van Rhyn

NOVEMBER 2000

I declare that the dissertation submitted for the degree, Magister Societatis Scientiae in Nursing to the University of the Orange Free State is my own independent work and has not previously been submitted for a degree to another university.



T.V. LEHANA

THIS RESEARCH IS DEDICATED TO:

My mother, 'me' 'M'aleboto Lesoma. I am here today because of your unquantifiable efforts to enhance my success in life. It is now time for you to rejoice and to glorify God. We have both made it.

My family (The Trio) Lefela, Molebo and ntate Habofanoe. You inspired me to climb the academic ladder. I am almost at the top, but the climbing is getting tough daily. However, I will ultimately reach the top, with your encouragement, support and the meaning in life you give me.

My late father, ntate Mahlomola Lesoma. You once told me that you were proud of me. Today I would like to say, "I am proud of myself".

My late sister, Mrs. Salang 'M'aleronti Lekorotsoana. You used to tell me that you were not learned, but you were more educated than I was. This time you would not compare yourself with me anymore.

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to the following:

- The Lesotho Government for sponsoring this adventure.
- Participants in this research, for their openness and co-operation.
- My colleagues at the clinics where this study was conducted, for their support.
- Nursing Officer Nthabiseng Lebaka for your willingness and enthusiasm in conducting focus group interviews.
- Dr. Annali Fichardt for analysing the data. You have never turned me down when I needed help.
- Ms. Elzabé Gleeson, for the timeless, neat clean typing. Your patience is unimaginable.
- Ms. Catherine Bitzer, for language editing and translation.
- Numerous people, not mentioned by name, who in some way have contributed to this study.
- Dr. Lily van Rhyn, for your clear and firm guidance and exceptional visionary ability in what often felt like overwhelming chaos. I feel priviledged to have had this experience under your guidance.

- Finally, to God for enabling me to finish this study. One of the greatest challenges I have yet faced.

INDEX

Page

Page

Page

LIST OF FIGURES

LIST OF TABLES

Page

CHAPTER 1

Introduction and problem statement

1.1 INTRODUCTION

1.1.1 Background

1.1.1.1 Geography

The kingdom of Lesotho is a small landlocked country, completely surrounded by the Republic of South Africa (RSA). It occupies a land area of 30,355 square kilometers and has a projected population of 2.1 million in the year 2000 (Bureau of Statistics, 1996). It lies between latitudes 28° and 31° south and between longitudes 27° and 30° east (Ministry of Health and Social Welfare [MOHSW], 1993:21). Its highlands and mountains cover three quarters of the country and rise to nearly 3,500 metres above sea level in the Drakensberg range. The remaining one quarter is the lowlands. Maseru, the capital, lies in this region. The topography of Lesotho presents difficult terrain in terms of accessibility and leaves very limited cultivable land.

Climatic conditions vary sharply throughout the year. Temperatures range from –8 to 32° Celsius in the lowlands, and are generally lower in the highlands. Severely cold winters, heavy snowfall especially in the mountains, and hail storms throughout the country limit further accessibility to services. This can result in life threatening situations, and sometimes fatality. Summer months are

hot and the rainy season is often variable (United Nations Population Fund [UNFPA], 1996:9).

1.1.1.2 Administrative context

Lesotho is divided into 10 administrative districts (see Figure 1.1, p.3). Each district is headed by a district secretary, and is subdivided into wards and villages. The traditional chieftainship system is still recognised as relevant and important to the process of governance. Ward councils are chaired by local hereditary chiefs (UNFPA, 1996:1, 9).

Besides the districts, Lesotho is further subdivided into four geographical regions namely:

- the mountain region covering 58% of the country and lying to the east;
- the lowlands region covering 17% of the country and lying to the west;
- the foothills region covering 15% of the country and lying between the mountains and the lowlands region; and
- the Senqu River Valley covering 10% of the country and stretching along the Senqu River between the Southern mountain region (MOHSW, 1993:21) (see Figure 1.2, p.4).

Unlike most African countries, Lesotho has a homogeneous society in terms of ethnicity (only Basotho with an insignificant number of the Xhosas and Ndebele). Thus it is insulated from the typical interethnic rivalries and conflicts that have beset other countries. However, similar to other developing countries, Lesotho has a pro-natalist culture that is supportive of large families. The society is partrilineal and patriarchal (UNFPA, 1996:13)

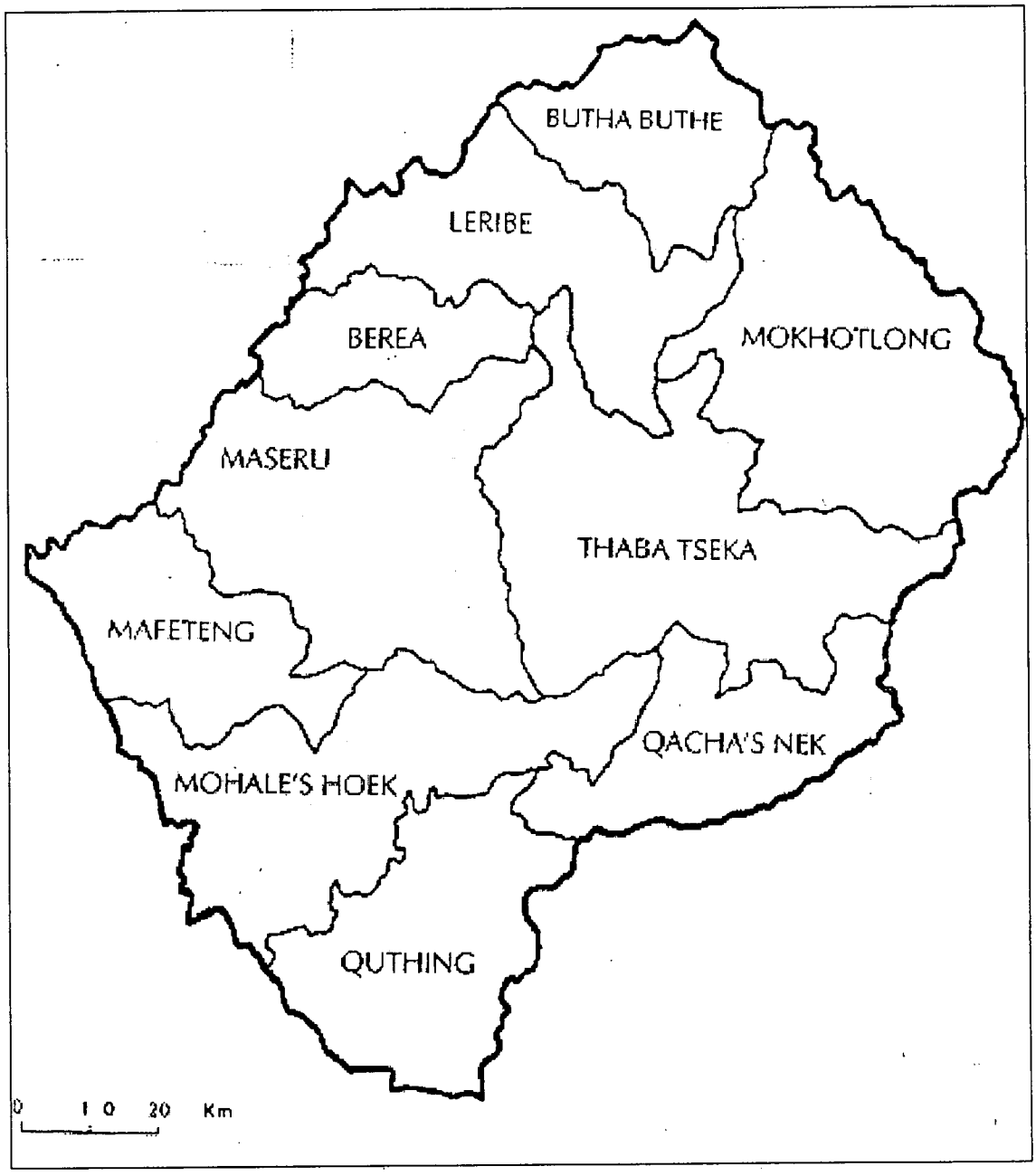


FIGURE 1.1: Ten districts of Lesotho

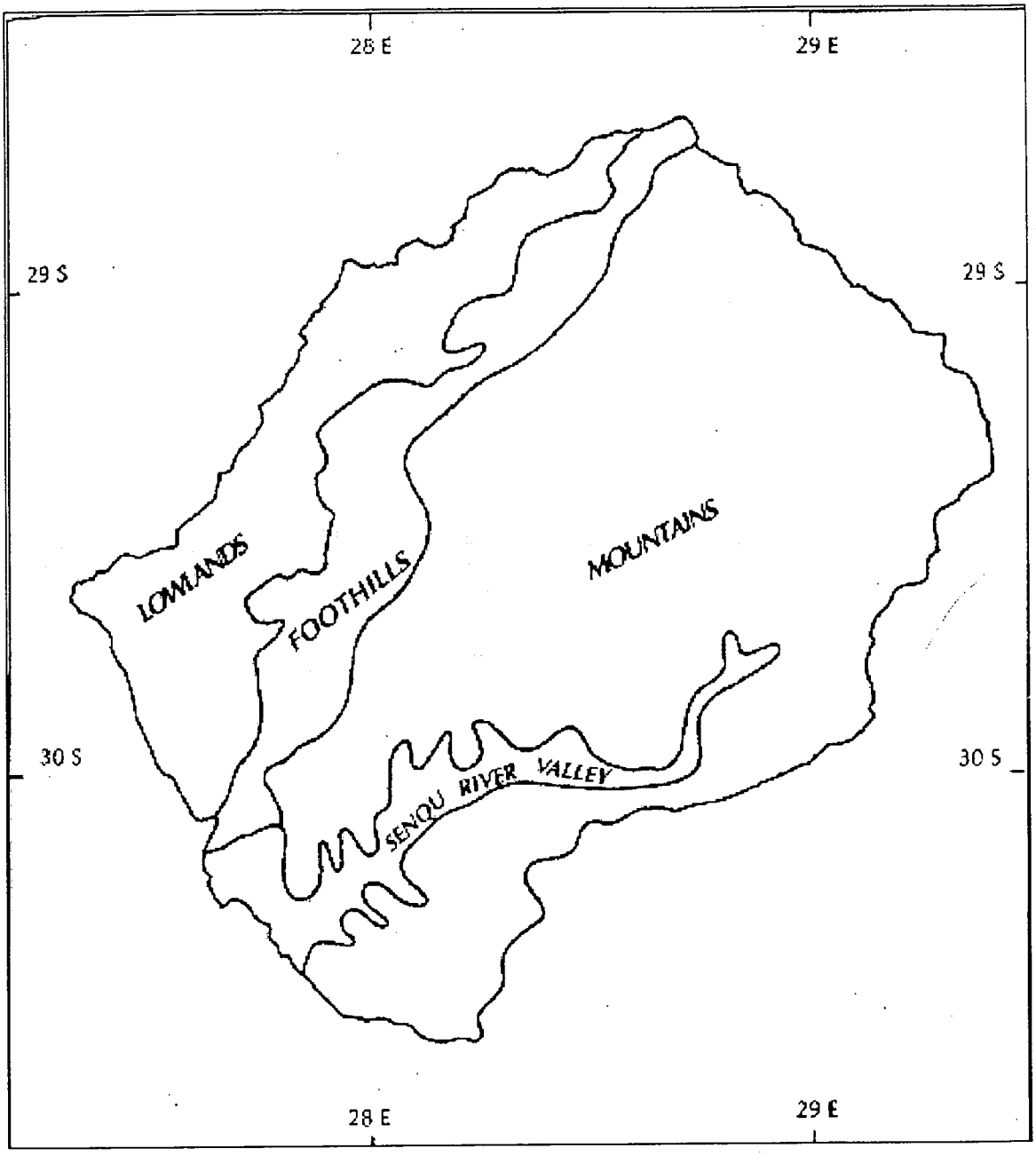


FIGURE 1.2: Lesotho geographical regions

1.1.1.3 Economy

Lesotho is strongly linked to the economy of the RSA, which makes it vulnerable to external economic forces. There is, however, the Lesotho Highlands Water Project in the Thaba-Tseka district, which aims to sell water to the RSA and to generate electricity for Lesotho. Although economic gains are accruing from this project, the social and health impact should be closely watched (UNFPA, 1996:1).

1.1.1.4 Health system

1.1.1.4.1 Delivery of health services

The Ministry of Health and Social Welfare (MOHSW) has primary responsibility for the development of policies, strategies and programs for health care in Lesotho. The key institutions for the delivery of health care services are Health Service Areas (HSAs), Health centres (HCs) and Community Health Workers (both village Health Workers and Traditional Birth Attendants), which fall under either government or Christian Health Association of Lesotho (CHAL). HSA hospitals are a key element of the health infrastructure. They do not only provide clinical care, but also support the development of primary health care within the HSA, and supervise all of the HSA clinics, regardless of ownership. There are 19 HSAs. The 19th is served by the Flying Doctor Service (Ministry of Economic Planning, 1997:182).

1.1.1.4.2 Reproductive health

The early indulgence of young people (10-24 years) in sexual activity in Lesotho has increased the rate of teenage marriages and teenage pregnancies. According to the existing MOHSW policy, family planning (FP) is to be provided as an integral part of all maternal and child health (MCH) services from the Natioinal referral hospital (Queen Elizabeth II), to the lowest level clinic. There is no parental consent required in the provision of FP services. Lesotho Planned Parenthood Association (LPPA) provides FP and information on family life. Family life education is also included in in-school and out-of-school programs (for example, media) (UNFPA, 1996:5).

1.1.1.5 Migration and urbanisation

Limited employment opportunities compel Basotho to become migrants, especially to the RSA, to work in the Gold and Coal Mines. However, with the political and economic changes that occurred in RSA, Basotho are increasingly retrenched from the mines. This further compounds the existing unemployment situation and limits the financial remittance to families. Internal migration from rural to urban areas is more common among women seeking higher education and employment opportunities. Out of the 16.8% of the total urban population in 1996, 7.4% reside in Maseru alone (Bureau of statistics, 1996:census; UNFPA, 1996:11-12).

1.1.1.6 Study area

Maseru, the capital of Lesotho, lies in the western lowlands of the country where the temperatures are relatively warmer and favourable for both human habitation and agriculture. Rainfall, though seasonal falling mainly in summer

and autumn, is adequate for cropping and providing a reliable source of domestic water supply. Maseru has a rural area which is mainly characterised by farming, and an urban area which has a high concentration of job opportunities, infrastructural and other socio-economic services. These factors result in the influx of population to Maseru, especially its urban area (Ministry of Interior, 1990:4-5). However, the urban migration of adolescents may have adverse effects on their life and development, especially as many of them may not be enrolled in school nor fully employed due to poverty, high unemployment rate and others (Ministry of Health and Social Welfare in collaboration with World Health Organisatioin and United Nations Population Fund [MOHSW/WHO/ UNFPA], 1994:3). The Maseru district has 44 clinics that offer prenatal services (Bureau of statistics, 1998:5). The data for this study were collected from 10 randomly selected clinics in the Maseru district and they belong to four health service areas.

1.1.2 Introduction to the problem

Unmarried adolescent mothers are at risk of adverse psychological and behavioral problems that can affect the mother's life, as well as the infant's health and development (Lesser, Anderson & Koniak-Griffin, 1998:7).

Talking about sex before marriage is a taboo in Lesotho. This tends to determine the extent to which adolescents (13 to 19 years of age) can be taught about sexuality (Ministry of Health and Social Welfare Lesotho in collaboration with the World Health Organisation (MOHSW/WHO, 1997:9). There is also a lack of community involvement and commitment in teaching the youth about family life (which encompasses: physical, psychological and social developments that occur during adolescence and how to deal with the changes that occur as a result of these developments; sexually transmitted diseases including HIV/AIDS;

pregnancy and how to prevent them). The reasons for this lack of commitment are: some parents say that they do not feel comfortable discussing the topic with their children, as premarital sexual relations are still considered a taboo in Lesotho. Some parents feel that they are not capable of teaching their children about the subject as they lack training (MOHSW, 1993:95) and knowledge about these matters. According to Moore and Rosenthal (1993:145) many adolescents are sexually active at an early age and fail to use adequate or any measures to avoid conception. When sexual activity begins, most adolescents lack accurate knowledge about reproduction and sexuality. They also lack access to reproductive health services, including contraception (World Health Organisation [WHO], 1998: 98.4). Based on the Mafeteng study conducted by the Ministry of Health and Social Welfare Lesotho (1993), adolescents do not use contraceptives, because they are afraid or ashamed of being seen at the family planning services. They are also afraid of discussing contraception if they go to the clinic or private surgery. This is because premarital sexual relation is still considered a taboo in Lesotho.

Health personnel in most health care services in Lesotho are not trained on providing adolescent fertility management services. Because adolescents do not want to be seen or known to be using contraceptives, their preference is to have such services available at school where they are not presently available. This would enable adolescents to use fertility management services, including family planning, freely without any fears (MOHSW/WHO/UNFPA, 1994:24). However, they become sexually active at an early age, with the mean age at first sexual intercourse of 17.5 years (MOHSW, 1993:58).

In Lesotho, like in many developing countries, there is an alarming increase in adolescent pregnancy. The epidemiological profile of adolescents in Lesotho shows high incidence of adolescent pregnancy (as a proportion of first pregnancies among antenatal clients) of 52.1% (MOHSW/WHO, 1997:V). According to MOHSW (1993:58-59), more than 50% of mothers attending antenatal clinics at that time (single and married) had their first pregnancy at the age of 19 and below.

1.2 PROBLEM STATEMENT

Pregnancy outside marriage is regarded as antisocial and carries a stigma in Lesotho. This is evidenced by the discrimination against the mother-to-be by family members. The male partner usually denies parentage of the child; her peers are discouraged from associating with her, and at times even friends reject her. The adolescent mother-to-be does not belong either to a group of peers or of mothers (MOHSW/WHO/UNFPA, 1994:27). This rejection puts unmarried adolescent mothers at risk of developing adverse psychological and behavioral problems that could affect their lives, as well as the infant's health and development (Lesser *et al.*, 1998:7). These psychological problems may include:

- Psychological distress that could lead to suicide or illegal* abortion which may have fatal complications;

- Isolation of the adolescent mother due to lack of partner's support and failure to establish, or poor establishment of close relationships with peers of both sexes . Many young boys may also be uninterested in dating the adolescent mother (Moore & Rosenthal, 1993 :157).

---

* Illegal abortion: the law in Lesotho does not permit voluntary abortion.

The children are at risk of parental neglect, child abuse, abandonment, and other forms of parental mistreatment. These are attributed to adolescent mothers' immaturity, lack of parenting skills and inadequate financial resources. Studies show that adolescent mothers are less responsive to their infants and engage in more physical and less verbal interaction. This parenting style is said to impede optimal cognitive development in children (Lesser *et al.*, 1998:7; Moore & Rosenthal, 1993:160). Hayes (1987) as cited in Moore and Rosenthal (1993:160) concludes that *"having an adolescent mother negatively affects a child's development and the effects do not decrease over time."*

According to Moore and Rosenthal (1993: 158), research shows that pregnant adolescents drop out of school earlier and are less likely to go to college or university. Some high schools, especially those belonging to religious denominations, are hostile and non-accepting environments for pregnant adolescents, which provides little incentive for them to return after the baby's birth. This interruption in schooling or termination of education may have long-term economic implications for the adolescent mother-to-be (Lesser *et al.*, 1998:7; MOHSW/WHO/UNFPA, 1994: 24; Moore & Rosenthal 1993: 158).

As described above, it is clear that pregnancy can have different implications for unmarried adolescents, and that they may have different experiences. An exploration of the experiences of pregnant unmarried adolescents has not been done in Lesotho. It is therefore important to explore these, in order to modify the nursing care provided to pregnant adolescents and to be able to implement appropriate strategies that will help pregnant adolescents to become healthy mothers with healthy infants.

1.3 PURPOSE OF THE STUDY

The purpose of this study was two-fold:

- to explore and describe the experiences of pregnant unmarried adolescents in relation to their first pregnancy in the Maseru district in Lesotho and

- based on the above to develop appropriate guidelines for an educational and counseling program for pregnant adolescents, if necessary.

1.4 DEFINITION OF CONCEPTS

1.4.1 ***Adolescent:*** According to WHO (1998:98.4) an adolescent is a young person who is between 10 and 19 years of age. Kaplan and Sadock (1998:42) define an adolescent as a young person who is between 11 and 20 years of age, and Morse (1991:213) defines an adolescent as a young person who is between 13 and 18 years of age.

For the purpose of this study an adolescent refers to a young person between 13 and 19 years of age.

1.4.2 ***Viable pregnancy:*** In this study pregnancy refers to the state of having a developing fetus within the body with the gestational age of twenty-eight weeks and over. This gestational age is selected because unmarried pregnant adolescents tend to start attending antenatal clinics late. The reason is that they hide the pregnancy; also that before 28 weeks, they can still have an abortion and the pregnancy can go unrecognised.

1.4.3 ***Unmarried:*** Refers to an adolescent who is not married in court, church or through a Sesotho traditional marriage in which there is a signed agreement (in the presence of the chief*) between the families of the two people who are getting married.

1.5 RESEARCH DESIGN

Since the purpose of this study was to explore and describe the experiences of pregnancy as lived by pregnant unmarried adolescents in Maseru, the most appropriate design was a qualitative, descriptive, exploratory and contextual design. A phenomenological approach was used.

1.5.1 Research context

This research was confined to pregnant unmarried adolescents in the Maseru district in Lesotho, who attended the antenatal clinics.

1.6 RESEARCH TECHNIQUE

This research was conducted in two phases.

1.6.1 Phase one: Individual phenomenological interviews

The researcher conducted phenomenological interviews with each research subject. The central question of the interview was: ***"Can you tell me more about your experiences with this pregnancy from the time you realised that you were pregnant until now?"*** *(A ko nqoqele haholoanyane ka*

---

* Chief: a person who in accordance with tradition has authority over a group of Basotho in Lesotho.

mathata le manolo ao u fetileng ho oona ka bokhachane bona, ho tloha mohla u elelloang hore u mokhachane ho fihlela ha joale).

Phenomenological interviews were chosen because, according to Burns and grove (1997:355), they provide in-depth information about the phenomenon. They are flexible, therefore they allow the researcher to grasp more fully the subject's experience than would be possible with a more rigidly structured interview.

1.6.1.1 Population and sampling

The population in this study was pregnant adolescents in the Maseru district in Lesotho. The inclusion criteria were that they:

- be able to speak and understand Sesotho;
- be between 13 and 19 years of age;
- be pregnant for the first time with the gestational age of twenty-eight (28) weeks and above (according to Neagle's rule and McDonald's method of measurement) (see motivation, p.11);
- be unmarried (see definition, p.12);
- be from the district of Maseru; and
- express a willingness to participate in research.

1.6.1.2 Sampling technique

Sampling frame of all clinics that offer antenatal care in the Maseru district was made. Eight clinics were selected from this frame, using the simple random sampling method. One of the advantages of the simple random sampling method is the selection with replacement, which provides equal opportunity for each clinic to be selected (Burns & Grove, 1997:298). The researcher selected eight

clinics to avoid getting only positive or only negative experiences from the subjects who attended the same clinic.

Then convenience (accidental) sampling was used to find subjects who met the sampling criteria from the selected clinics. The most accessible way to find subjects in this study was when they attended the antenatal clinics. It was difficult to identify them in the community, as premarital adolescent pregnancy is still regarded as antisocial in Lesotho.

1.6.1.3 Pilot study

Seidman (1991:29) defines the verb *"pilot"* as to guide along strange paths or through dangerous places.

A pilot study was done in two clinics in the Maseru district in Lesotho during the first and second weeks of June 2000. Phenomenological interviews were conducted with four subjects from both clinics, who met the sampling criteria and had signed the informed consent form. They were attending the antenatal clinic on the day of the interview. These two clinics and four subjects were excluded from the main study and focus groups.

The pilot study was undertaken to test the research question. The techniques that would be used to enhance rigor and trustworthiness of the results were evaluated. The researcher gained experience with the subjects, setting and interviewing technique (Burns & Grove, 1997:52). Seidman (1991:30) urges all the interviewing researchers to undertake a pilot venture in which they try out their interviewing design with a small number of participants. In this way they will learn whether their research structure is appropriate for the study they envision. It will also assist them to come to grips with some of the practical

aspects of establishing access, making contacts and conducting the interview. The pilot can also alert researchers to elements of their own interview techniques that support the objectives of the study and to those that detract from those objectives.

Through the pilot study, it was identified that the research question was not clear. It read *"can you tell me more about your pregnancy"* and it was modified to read *"can you tell me more about your experiences with this pregnancy from the time you realised that you were pregnant until now"*. It was also identified that the second question which read *"have you got suggestions to change the situation?"* was also not clear and did not give the researcher much information in relation to the purpose of the study. It was therefore omitted after the pilot study.

1.6.1.4 Data collection

Phenomenological interviews were conducted with two subjects in each of the eight clinics. The researcher interviewed two subjects per each of the eight clinics to make sure that there was representation from all selected clinics. The interviews which were conducted in the clinics were conducted in Sesotho, because Sesotho is the official language in Lesotho. They were tape-recorded per subject's consent and transcribed in English as soon as possible. Field notes were also taken.

1.6.2 Phase two: Focus group interviews

Two focus group interviews were facilitated by a psychiatric nurse. Data obtained was used to confirm and verify individual phenomenological interviews' data. Population and the inclusion criteria were the same as in the individual phenomenological interviews.

1.6.2.1 Sampling technique

The simple random sampling method was used to select two clinics. These two clinics were not the ones used in the pilot study or in conducting individual phenomenological interviews. Convenience (accidental) sampling method was used to obtain group members.

1.6.2.3 Data collection

Two focus group interviews were facilitated by a psychiatric nurse in two clinics in the Maseru district. The same question as for the individual interviews was asked and field notes were taken.

1.7 DATA ANALYSIS

The transcribed interviews (for both individual and focus groups) and field notes were analysed using Tesch's (1990) method of analysis.

1.8 MEASURES TO ENSURE TRUSTWORTHINESS OF THE RESULTS

Guba's (1981) model of assessing trustworthiness, as presented in Krefting (1991: 214-222) and Lincoln and Guba (1985:290-331), was used to ensure trustworthiness of the results in both individual and focus group interviews. This model identifies four criteria for assessing trustworthiness in qualitative research as: credibility, transferebility, dependability and confirmability.

1.9 ETHICAL CONSIDERATIONS

The researcher maintained the ethical standards appropriate to this study (see complete description in Chapter 2).

1.10 CONCLUSION

In this chapter, the introduction and problem statement were discussed. In the following chapter, the research methodology will be fully discussed.

Summary of the study chapters:

Chapter 1: Introduction and problem statement

Chapter 2: Research methodology

Chapter 3: Data presentation and literature control

Chapter 4: Discussion, conclusion, study limitations and recommendations

CHAPTER 2

Research methodology

2.1 INTRODUCTION

The introduction and problem statement were formulated in Chapter 1. The quality of research findings is directly dependent on the methodological procedures followed in the study. Therefore a complete account of the way in which this research has been planned, structured and executed will be given in this chapter.

2.2 RESEARCH DESIGN

Burns and Grove (1997:225) and Uys and Basson (1991:38) define research design as the structural framework or blueprint of the study. This framework guides the researcher in the planning and implementation of the study, while achieving optimal control over the factors that could influence the study.

In this study, a qualitative, descriptive, exploratory and contextual design was used to explore and describe the experiences of pregnancy as lived by pregnant unmarried adolescents in Maseru.

2.2.1 Qualitative design

A qualitative design is an approach in research that concentrates on the qualities of the human experience. It concentrates on the qualitative aspects rather than the quantitative and measurable aspects of human behaviour (Polit & Hungler, 1991:25; Uys & Basson, 1991:51). The focus of qualitative

research is complex and broad. Its intent is to understand the response of the whole human being, not just specific parts or behaviours. In qualitative research each subject is viewed as a holistic individual, therefore two subjects describing the same lived experience are not expected to generate duplicate data (Hopkinson, 1999:203). All people are viewed as equals: the thief's perspective is just as important as the judge's. Human experience is a complex phenomenon with a holistic meaning. Within this holistic framework, qualitative research attempts to discover the depth and complexity of the experience (Burns & Grove, 1997:28-30; Uys & Basson, 1991:51).

The focus of this research was on the experiences of pregnant unmarried adolescents. The insight into these experiences will be utilised for the improvement of nursing care services that are rendered to pregnant adolescents.

In qualitative research, the researcher must be actively involved. According to Beck (1996:99), Burns and Grove (1997:29) qualitative research is subjective and it assumes that subjectivity is essential for the understanding of human experiences. The researcher had an active role in this study as she conducted the interviews and used her communication skills (such as probing, reflecting, validating and summarising) in order to discover the depth and complexity of those experiences.

2.2.2 The strengths of qualitative research

Qualitative research derives its strengths primarily from its: inductive approach; focus on specific situations or people; emphasis on words rather than on numbers; and the ability to gain greater understanding of an experience. Qualitative research meets the above requirements while maintaining the context of the everyday lived experience where meaning resides (Maxwell, 1996:17; Robertson-Malt, 1999:290).

2.2.3 Descriptive research

According to Burns and Grove (1997:30, 250) a descriptive research provides an accurate portrayal or account of characteristics of a particular individual, situation or group. Its purpose is to provide a picture of situations as they naturally happen. Uys and Basson (1991:51) state that the purpose of qualitative research is to describe, explain, predict and control. Therefore a qualitative researcher aims to describe as accurately as possible the experience as it is lived by the individual concerned. It also attempts to describe the meanings that this experience has for the individual who participates in it, rather than indulging in attempts to explain it within a pre-given framework. The researcher remains true to the facts as they are happening (Beck, 1996:99; Burns & Grove, 1997:31; Hopkinson, 1999:203; Kruger, 1988:143; Leininger, 1985:82; Morse, 1991:51).

This study was descriptive, because it sought to understand the events, situations and actions that pregnant unmarried adolescents were involved with. An understanding of the accounts that they gave of their lives and experiences was also aimed for. The pregnant unmarried adolescents were allowed to give a narrative description of their experiences in their own perspective. The perspective of the subjects on their lived experiences of pregnancy was not simply their account of those experiences; it was part of the reality that the researcher was trying to understand (Maxwell, 1996:17). Through the analysis of the descriptions, the nature of the experience of pregnancy by pregnant unmarried adolescents was revealed. An understanding of the meaning of such experience for the subject was gained (Parse, Coyne & Smith, 1985:16).

2.2.4 Exploratory studies

Exploratory studies investigate an unknown field, with the purpose of gaining new insights into the domain phenomenon (Uys & Basson, 1991:38). The focus of this study was to explore the experiences of pregnant unmarried adolescents of their first pregnancy. The aim was to gain insight into their experiences. This insight would help in changing or improving the nursing services rendered to pregnant adolescents and also in developing a counseling and educational program for pregnant adolescents if need be.

2.2.5 Contextual design

One of the purposes of qualitative research is to understand the particular context within which the participants act, and the influence that this context has on their actions. It does not attempt to control the context of the research, but rather attempts to capture it entirely (Polit & Hungler, 1991:25). Qualitative researchers study a relatively small number of individuals or situations. The data collection method used aims to preserve the spontaneity of the subjects' lived experiences and the individuality of each of these in the analyses. Thus, they are able to understand how events, actions and meanings are shaped by the unique circumstances in which these occur (Hopkinson, 1999:203; Maxwell, 1996:17, 19; Robertson-Malt, 1999:290).

This study was contextual because it considered the particular context (the area of Maseru, the Sesotho culture and the societal norms) within which the pregnant unmarried adolescents experienced their first pregnancy and the influence that this context had on their lives. Seidman (1991:10) maintains that people's behaviour becomes meaningful and understandable when placed in the context of their lives and the lives of those around them. Without context, there is little possibility of exploring the meaning of the experience.

2.3 POPULATION AND SAMPLING

Population: Refers to all elements that meet certain criteria for inclusion in a given universe. It is also known as the target population (Burns & Grove, 1997:58).

Sample: Is a subset of the population that is selected for a particular study and the elements of a sample are the subjects (Burns & Grove, 1997:58; Uys & Basson, 1991:87).

Sampling criteria: Lists the characteristics essential for membership in the target population. The researcher needs to provide logical reasons for the characteristics selected. However, the researcher must be careful not to make the sampling criteria too narrow and restrictive as it will reduce the sample size or make obtaining a sample difficult. The criteria should also not be too broad as this could make interpretation of the results difficult (Burns & Grove, 1997:294).

The population in this study was pregnant adolescents in the Maseru district in Lesotho. The inclusion criteria into the sample was that they should:

- be able to speak and understand Sesotho;
- be between 13 and 19 years of age (see definition of adolescent, p.11);
- be pregnant for the first time with the gestational age of 28 weeks and above (according to Neagle's rule and McDonald's method of measurement) (see motivation, p.11);
- be unmarried (see definition, p.12);
- be from the district of Maseru; and
- express a willingness to participate in research.

Kruger (1988:150) maintains that subjects in phenomenological research should: *"have had experience with the phenomenon under investigation; be verbally fluent and able to communicate their feelings, thoughts and perceptions in relation to the researched phenomenon; have the same home language with the researcher to avoid possible loss of subtle semantic nuances owing to the need to translate from one language to the other; and should express their willingness to be open to the researcher".* Phenomenology as a methodology supports and guides inquirers in their attempts to gain depth and scope in understanding human experience through encouraging particular attention to the nature and meaning of the language used to describe the experience. According to Leonard (1989:43) as cited by Robertson-Malt (1999:292): *"language sets up the world; makes things show up for us ... a vocabulary, or the kinds of metaphors that one uses can name things into being and change the sensibility of age ... Language creates the possibility for particular ways of feelings and of relating that makes sense within a culture".*

Sampling: Is defined by Burns and Grove (1997:294) and Uys and Basson (1991:87) as the process whereby the sample is drawn from the population. It involves selecting a group of people, events, behaviours or other elements with which to conduct a study.

Advantages of sampling

- Smaller units of the population can be studied if the population is too large.

- Sampling saves time and energy and it is cost-effective.

- With smaller units, the Hawthorne and other effects can be better controlled.

- If sampling is carried out correctly, the data can be of more value (Uys & Basson, 1991:89).

The number of subjects in qualitative research is often limited, because of the quantity and richness of data obtained and the extent to which the phenomenon is explored in the interview (Jacobson, 1994:96). According to Parse *et al.* (1985:17) the sample is considered adequate when saturation of data is reached. Saturation is characterised by the emergence of repeating themes. In this study saturation was reached when no more new experiences of pregnancy were being revealed by the subjects (pregnant unmarried adolescents) and the themes were being repeated after interviewing 16 subjects.

The sampling methods used in this study will be described together with the research technique.

2.4 RESEARCH TECHNIQUE

This study was conducted in two phases.

2.4.1 Phase I: Individual phenomenological interviews

Uys and Basson (1991:58) define an interview as:

- the personal conversation through which research information is obtained;
- a conversation with a purpose; or
- a technique in which the researcher poses a series of verbal questions for the respondents in a face-to-face situation.

The main purpose of the research interview is to obtain information about the human being, his opinions, attitudes, values, experiences and his perceptions towards his environment (Uys & Basson, 1991:59). In this research the purpose of the interview was to obtain information about the experiences of pregnancy as lived by pregnant unmarried adolescents in Maseru.

The researcher conducted phenomenological interviews with each research subject until saturation of data was reached. Sixteen (16) interviews were conducted. The researcher used her communication skills (such as probing, reflecting, validating and summarising) to get more information about the experiences from each subject. Berg (1995:32) states that *"in an unstructured interview, interviewers must develop, adapt and generate questions and follow-up probes appropriate to the given situation and the central purpose of the investigation".*

Probe: Is a neutral verbal or non-verbal way of encouraging the client to answer, or to clarify, or to extend an answer; it is a way of helping clients to identify and explore experiences, behaviours and feelings (Arthur, 1999:659; Powney & Watts, 1987:138). According to Berg (1995:39) the central purpose of a probe is to elicit more information about whatever the respondent has already said in response to a question. The interviewer can make use of a number of verbal and non-verbal techniques to elicit more information from the client, such as:

- eye contact, especially an inquiring glance;
- *"could you tell me more about that please"* (use of open-ended question);
- an expectant silence;
- repeating back the client's own words (reflection);
- *"mmm..."* (verbal cues that researcher is listening);
- *"I am not quite sure if I understand what you mean"* (validation) (Burns & Grove, 1997:355; Powney & Watts, 1987:138).

However, Burns and Grove (1997:355) and Powney and Watts (1987:139) also warn interviewers and researchers not to use probes to harass clients but to give them sufficient time and opportunity to answer fully. If not used carefully, probes may lead clients in a particular line of answering. Probes may also reduce consistency in presentation between interviews, unless used in the same way in each interview.

Advantages of unstructured interviews

Unstructured phenomenological interviews were used in this study, because according to Burns and Grove (1997:355), they provide in-depth information about the phenomenon. Questions can be rephrased for clarity and interpersonal skills can be used to facilitate co-operation and to elicit more information. They can also be used for people who cannot read or write. During the interview, non-verbal messages can be observed and interpreted. People speak for themselves therefore all the data collected is first hand (Winchester, 1996:125). As a method of inquiry, phenomenological interviewing is most consistent with people's ability to make meaning through language. It is deeply satisfying to researchers who are interested in others' stories, because at the heart of a phenomenological interview is an interest in other individuals' stories, because they are valuable. Since the researcher's goal was to understand the experiences and the meaning pregnant unmarried adolescents made of their experiences, interviewing provided a sufficient avenue of inquiry which other more rigid methodological techniques would not provide (Kruger, 1988:152; Seidman, 1991:4, 7).

Phenomenological interview is, however, not without disadvantages. Its major disadvantages according to Burns and Grove (1997:355) and Jacobson (1994:96) include the fact that they require much more time than questionnaires and scales. Thus they are more costly. Because of the time and costs, the quantity and richness of data obtained, and the extent to

which the phenomenon is explored, the sample size is usually limited. Subject and interviewer bias is a major threat to the validity of findings, as well as the researcher's inconsistency in data collection from one subject to another.

The quality of data collected depends on the skills of the interviewer. Certainly interviewing skills matter if the researcher wants to avoid unnecessary loss of important information. Powney and Watts (1987:37) stress that *"no amount of sophisticated scale – building or statistical analysis can rescue a research project in which conceptualisation and instrumentation have been built on poorly conducted exploratory interview".* To acquire skills, the researcher took a course on interpersonal skills before undertaking this research.

2.4.1.1 Sampling technique

Sampling frame of the clinics that offer antenatal services in the Maseru district was made and eight clinics were selected from this list using the simple random sampling method. Each name on the list was written on a small piece of paper, the papers were folded twice, put into a hat and mixed well. Names were selected by picking one piece of paper randomly from the hat, writing down the selected name and replacing the piece of paper into the hat before picking the next one. This was done until the names of eight clinics were selected, ignoring the names that had already been selected (Burns & Grove, 1997:298; Uys & Basson, 1991:89-90). One of the advantages of this simple random sampling method is selection with replacement, which according to Burns and Grove (1997:298) provides exactly equal opportunities for each clinic to be selected. The researcher selected eight clinics to avoid getting only positive or only negative experiences from the subjects who attended the same clinic.

Then convenience (accidental) sampling was used to obtain subjects who met the sampling criteria from the selected clinics. The first two subjects who met the sampling criteria and were attending the antenatal clinic on the day of the interview were selected in each clinic (Burns & Grove, 1997:303; Uys & Basson, 1991:93). Convenience samples provide a means to conduct studies on topics that could not be examined using probability sampling. It also provides a means to acquire information in unexplored areas. Burns and Grove (1997:303) recommend that convenience samples should be used for exploratory studies but not for confirmatory studies. The great advantage of convenience sampling is its accessibility. The most accessible way to find subjects in this study was at the time when they attended the antenatal clinic, because it was difficult for the researcher to identify them in the community. Premarital adolescent pregnancy is still regarded as anti-social in Lesotho. Pregnant unmarried adolescents therefore hide the pregnancy. Since the purpose of this study was to explore and describe the experiences of pregnant unmarried adolescents with their first pregnancy, convenience sampling was the best way to research this unexplored area in Lesotho.

2.4.1.2 Data collection

Data collection is the process by which the researcher acquires subjects and collects the information needed to answer the research problem (Massey, 1995:79). Data collection did not commence until the researcher received the approval from the Ethics Committee of the Faculty of Health Sciences of the University of the Orange Free State, Director of Health Services, Ministry of Health in Lesotho and the Director, Christian Health Association in Lesotho (CHAL).

In accordance with the phenomenological method, the researcher, prior to data collection, did suspend all that was known about the experiences of pregnant unmarried adolescents in Lesotho through the process of phenomenological reduction or bracketing. By bracketing, the researcher attempted to control judgement that might be based on values, motivations and pre-conceptions, thus helping to eliminate bias (Beck, 1996:99; Cutcliffe, 1999:106; Jacobson, 1994:96; Polit & Hungler, 1991:328). This means that the phenomenological researcher should not pre-judge any particular phenomenon nor see it through any given perspective merely because previous knowledge about the phenomenon exists (Kruger, 1988:144).

The first two subjects who met the sampling criteria and attended the antenatal clinic on the day of the interview, and had signed or had their parent/guardian sign the informed consent form, were interviewed in each of the eight selected clinics in Maseru. Data were collected through phenomenological in-depth interviews which were conducted at the clinic, in a quiet room free from the everyday distractions of noise from telephone, other clients and staff. Burns and Grove (1997:355), Hopkinson (1999:206) and Jacobson (1994:96) stress that the site selected for the interview should be quiet, allow privacy for the interaction and provide a pleasant environment.

The researcher interviewed two subjects per each of the eight clinics to make sure that there was representation from all selected clinics. Saturation of data was reached with 16 interviews.

Permission was sought from each subject to tape-record the conversation in order to ensure accurate transcriptions. The researcher explained the rationale for audio-taping to each subject. Each subject was told that the tapes would not be made available to anyone except to the researcher. The interviews, which lasted for 45 to 60 minutes, were begun with the researcher introducing herself and asking subjects about their biographical data. This was to comfort and help subjects relax and also to help subjects to become

accustomed to the tape-recorder (Cutcliffe, 1999:107-108; Fichardt, Van Wyk & Weich, 1994:17; Hopkinson, 1999:206; Jacobson, 1994:96). Self-consciousness on the part of the subject about the tape-recorder was reduced by the use of a pocket model tape-recorder which was placed outside the subject's field of vision. Fichardt *et al.* (1994:18) are of the opinion that the disadvantages of a tape-recorder can be overshadowed by maintaining continued eye contact with the client. Continued eye contact also, according to them, improves communication with the subject. Therefore the researcher maintained continued eye contact with the subjects throughout the interview.

The researcher believes that to work most reliably with the words of the subjects, the spoken words should be transformed into a written text, to study. Therefore the primary method of creating text from interviews is to tape-record the interviews and to transcribe them verbatim, because each word a subject speaks reflects his or her consciousness (Seidman, 1991:87).

The other advantages of tape-recording as outlined by Seidman (1991:87) are:

- By preserving the words of the subject the researchers have the original data. If something is not clear in the transcript, the researchers can return to the source and check for accuracy.

- Later if they are accused of mishandling their interview material, they can go back to the original sources to demonstrate their accountability to the data.

- Tape-recording also benefits the participants. They can feel assured that there is a record of what they have said to which they have access. Therefore they have more confidence that their words will be treated responsibly.

- Interviewers can also use the tapes to study their own interviewing technique to improve upon it.

The names of the subjects or their next of kin were not used in the interview. Instead numbers were used as references to ensure anonymity (that is subject M1/M2 ... until all subjects had been identified).

The interview revolved around the central question, which was ***"Can you tell me more about your experiences with this pregnancy, from the time you realised that you were pregnant until now"*** *(A k'o nqoqele haholoanyane ka mathata le manolo ao o fetileng ho oona ka bokhachane bona, ho tloha mohla u elelloang hore u mokhachane ho fihlela hajoale).* Pregnant unmarried adolescents were allowed to give a narrative description of their experiences with their first pregnancy in their own perspective. Both positive and negative experiences were described. The perspective of the subjects on their lived experiences of pregnancy was not simply their account of those experiences, it was part of the reality that the researcher was trying to understand (Maxwell, 1996:17). They also described the feelings that were associated with those experiences and the context in which the experiences occurred. These descriptions were allowed because the aim of a phenomenological study, according to Burns and Grove (1997:31), Kruger (1988:143), Leininger (1985:82) and Morse (1991:56), is to describe human experiences as they are lived by a person and also to describe the meanings that these experiences have for the individual who participates in them. Sufficient time was allowed for each subject to provide a complete description until no more new experiences were being revealed.

The researcher remained responsible for making sure that the interview focused on or around the central question. The researcher used communication techniques to elicit more information or to clarify the responses without interrupting or harassing the subjects. Burns and Grove (1997:355) and Powney and Watts (1987:139) maintain that probes should

be used to give subjects sufficient time and opportunity to answer fully; not to harass them or to lead them to a particular line of answering. It must also be mentioned that the central question raised emotions for some subjects. The researcher managed those emotions effectively, but some of the respondents were referred for further management. The researcher was also attentive to non-verbal cues from the subjects. She therefore used field notes as a system for remembering the observations she made, and most importantly for retrieving and analysing them (Wilson, 1989:434).

Schatzman and Straus's (1982) model, as presented in Wilson (1989:434), offers three types of field notes:

- **Observational notes:** are descriptions of events experienced through watching and listening. They contain the who, what, where and how of a situation and contain as little interpretation as possible.

- **Theoretical notes:** are purposeful attempts to derive meaning from the observational notes. Here the field researcher interprets, infers, conjectures and hypothesises to build his/her analytic scheme.

- **Methodological notes:** are instructions to oneself, critiques of one's tactics, and reminders about methodological approaches that might be fruitful.

Wilson (1989:435) adds the fourth type as:

- **Personal notes:** are notes about one's own reactions and reflections, experiences. Wilson (1989:436) maintains that field work relies on the investigator's ability to "take the role of the other" and be introspective.

During the interview, the researcher observed the non-verbal communication of each subject and the circumstances surrounding the interview. She jotted a word, phrase or cue down and then recorded them as full notes immediately after the subject left the interview room.

This was to provide the details, of the context to which the conversation might have been addressed (Holstein & Gubrium, 1995:78). The researcher avoided any interpretation or analysis of the observational notes during the interviews. In this way the researcher tried to minimise imposing on the generative process of the interviews (Seidman, 1991:86). The field notes were transcribed as soon as possible after the interview and were later interpreted and analysed.

The interviews were conducted in Sesotho, because it is the official language of Lesotho. Therefore subjects were able to express themselves better. Sesotho is also the researcher's mother tongue. The taped interviews were transcribed verbatim in English as soon as possible (within 12 hours) after the interviews.

To facilitate member checking after data analysis, the researcher wrote down the names, addresses and telephone numbers of each subject during the interview. Only one interview was conducted with each subject and a maximum of two interviews were conducted per day.

An example of a phenomenological individual interview is given in Annexure H.

2.4.2 Phase II: Focus group interviews

The researcher used focus group interviews as a triangulation strategy to increase validity of the results (Morgan, 1997:22). It is important, at this stage, to remember that data obtained from focus group interviews are not identical to individual interview data. Focus group data are group data. They reflect the collective notions shared and negotiated by the group. Individual interview data reflect the views and opinions of the individual, shaped by the social process of living in a culture (Berg, 1995:78).

Robinson (1999:905) defines a focus group as *"an in-depth open-ended group discussion of one to two hours' duration that explores a specific set of issues on a predefined and limited topic"*. According to Berg (1995:68) focus group is an interview style designed for small groups. It is either a guided or unguided discussion, addressing a particular topic of interest or relevance to the group and the researcher.

2.4.2.1 Sample size

The focus groups consisted of between five and eight subjects, so that more information could be obtained on their experiences with their first pregnancy. The subjects would also be more open during the interview. A typical focus group according to Berg (1995:68), Holstein and Gubrium (1995:70) and Robinson (1999:905) consists of between five and eight subjects and is convened under the guidance of a facilitator. The Qualitative Research Council of the Advertising Research Foundation (ARF) (1992:48) warns against the use of groups of less than five subjects, because they lose the mutual stimulation among the respondents that makes the group setting unique. Large groups of more than eight subjects may be difficult to manage and less forward, and potentially valuable subjects may hesitate to speak. The researcher shares the same belief as Orkney (1981) in Berg (1995:71), and

Joseph, Griffin and Sullivan (2000:16) that, in focus group interviews, participation and flow of ideas and information is enhanced by being able to listen to each other's experience and interact with each other. A smaller group is less intimidating. The small focus group size limits the generalisability of the results. It is however, important to stress that focus group interviews are never intended to provide results that are representative of or generalisable to a population group as a whole. They are intended to indicate the possible range of experiences and attitudes but not to suggest numerical or proportional frequency of occurrence of particular experiences and attitudes (Powney & Watts, 1987:73).

2.4.2.2 Sampling technique

A list of all the clinics that offer antenatal services in the Maseru district was made and two clinics were selected from the list, using the simple random sampling method as described in the individual phenomenological interviews (Phase I) above. These two clinics were not used in the pilot study, nor in conducting individual interviews (Phase I). The researcher selected two clinics because data obtained from focus group interviews were used to verify and confirm the data obtained during individual interviews. The purpose was also to ensure that there were no more new experiences being revealed.

Convenience (accidental) sampling was used to organise subjects who met the sampling criteria into a group of between five and eight subjects. Focus group one consisted of five subjects and focus group two consisted of seven subjects.

2.4.2.3 Advantages of focus group interviews

- The phenomenological group provides an opportunity for subjects to describe in detail, in their own language, their real-life experiences.

- Because the researcher does not completely determine the structure of the interview beforehand, a focus group interview can produce unexpected and important results. The strength of focus group interviewing is therefore in the wide range of qualitative information that is produced by its lack of structure.

- Subjects tend to enjoy the experience in a natural and more relaxed setting.

- People who cannot read or write, or who have other specific difficulties are not discriminated against.

- The facilitator can seek clarification in the case of ambiguity and observe non-verbal gestures of subjects.

- This method is relatively inexpensive and flexible and can be set up quickly (An ARF, 1992:54-55; Morgan, 1997:13-14; Robinson, 1999:909; Watt & Vandenberg, 1995:361-362).

- In this study, the facilitator used probes and communication techniques such as validating and reflection to seek clarification and to elicit more information from the group members. The researcher observed non-verbal gestures of the subjects (group members) during the interview and wrote field notes.

2.4.2.4 Disadvantages of focus group interviews

- The interview process needs to be well managed so that: the less articulate can share their views; extreme views are tempered and bias caused by the domination of the group by one or two subjects reduced.

- Conflict may arise between personalities.

- Confidentiality can be a problem between participants when interacting in a group situation.

- The results cannot be generalised, as they cannot be regarded as representative of the wider population.

- The small sample size, convenience samples and lack of consistency in the way questions are asked when multiple groups are interviewed, make the external validity of focus group research generally poor (Morgan, 1997:13-14; Robinson, 1999:909; Watt & Vandenberg, 1995:362).

- In this study the facilitator ensured that all group members shared their experiences by pointing at the quiet members to speak. Group members gave each other turns to speak. The facilitator reminded group members of their responsibility to maintain confidentiality of group data. They also signed a statement of confidentiality (see Annexure F).

2.4.2.5 Characteristics of focus group facilitator

The facilitator should have the ability to:

- engage strangers quickly to talk about their experiences and to formulate their ideas, as well as draw out cognitive structures that previously have not been articulated;
- encourage free expression from respondents;
- be an attentive, sensitive listener, truly interested in subjects as human beings;
- be alert to non-verbal responses;
- be able to think and react quickly to unexpected occurrences;

- be instinctive and intuitive;
- be objective and capable of detaching him-/herself from personal feelings about a subject;
- refer subjects to appropriate people if need arises;
- have good knowledge of both the research question and of the group characteristics in order to ask relevant questions, and pick up on the subtle hints that group members exhibit (An ARF Research Reference Series Book, 1992:56; Joseph *et al.,* 2000:16; Robinson, 1999:907; Steward & Shamdasani, 1990:79; Watt & Vandenberg, 1995:362).

2.4.2.6 Roles of the focus group facilitator

According to ARF (1992:54-55), Joseph *et al.* (2000:17) and Robinson (1999:907) the focus group facilitator has two main roles.

The first role is to guide the discussion to fulfil research aims. This activity involves introducing the research and giving enough information for subjects to see the purpose and direction of the discussion. The research directs and encourages the flow of discussion over important areas using the topic guide. The researcher also recognises when the group is working well and maximises this, and allows enough time for the group to wind down at the end of the process.

The second role is to ensure that all subjects can make an effective contribution by creating a conducive atmosphere. For example making people feel relaxed, showing interest in what they say, and controlling dominant members of the group while drawing out the quieter subjects.

In this study the focus group facilitator was a psychiatric nurse who is competent in group, family and individual counseling. She also has a degree in Nursing Administration. She is currently involved in community mental health services for the adolescent health and juveniles rehabilitation programs

in prison. She encouraged free expression from group members, showed interest in group members as human beings. She used communication skills and knowledge of group characteristics to control dominant members and to draw out the quieter group members.

2.4.2.7 Data collection

Two focus group interviews were facilitated by a psychiatric nurse who is competent in facilitating group interviews and in conducting group counseling. Data obtained were used to verify and confirm the data obtained during individual interviews, and to ensure that there were no more new experiences of pregnancy revealed (Morgan, 1997:23). One focus group interview was facilitated in each of the two selected clinics.

As in phenomenological individual interviews, the facilitator, prior to data collection, did suspend all that was known about the experiences of pregnancy by pregnant unmarried adolescents in Maseru through the process of bracketing (Beck, 1996:99; Cutcliffe, 1999:106; Jacobson, 1994:96; Polit & Hungler, 1991:323).

The first five to eight subjects who met the sampling criteria and attended the antenatal clinic on the day of the interview and had signed or had their parent or guardian sign the informed consent form were interviewed in a group. Group one had five subjects and group two had seven subjects. To maintain confidentiality in a focus group, the researcher had every group member sign a statement of confidentiality. This allowed subjects who were not willing to maintain confidentiality to withdraw from the study. It also enhanced the quality of group data as only subjects who were willing to share their experiences and to maintain confidentiality participated in the study (Berg, 1995:82).

Permission was also sought from each subject to tape-record the interview in order to ensure accurate transcription. Typed transcriptions also provide the basis for deciding the method of content analysis (Robinson, 1999:908). Each subject was told that the tapes would be kept confidential, they would not be made available to anyone except the researcher.

The interviews, which on the whole lasted for one hour, were begun with the facilitator introducing herself and each group member introducing herself, including the researcher, who was going to write field notes. The facilitator and group members spent about 15 minutes talking to each other about their likes and dislikes. This allowed group members time to relax and to warm up to the discussion. The interviews were conducted in a quiet room that encouraged subjects to talk freely (Morgan, 1997:49; Watt & Vandenberg, 1995:361). The facilitator then introduced the research topic, the purpose of the research and the purpose of the interview and explained these to them in Sesotho (the subjects' official language, because the interview was going to be conducted in Sesotho), until the subjects could see the purpose and the direction of the interview. The facilitator also reminded them of their right to withdraw from the study at any time (Robinson, 1999:907). The interview revolved around the central question of the study, as stated in phenomenological individual interviews above. The facilitator used her communication skills, group processing skills and her knowledge of the group characteristics to obtain more information about the group members' experiences of pregnancy (Watt & Vandenberg, 1995:362). These skills were also used to ensure that all subjects made an effective contribution to the interview session, and to control dominant members of the group while drawing out the quieter subjects (An ARF Research Reference Series Book, 1992:54-55; Robinson, 1999:909).

Group members did not only describe their experiences with their pregnancy, but also described the feelings, thoughts and fears that were associated with those experiences and the context in which the experiences occurred (Burns & Grove, 1997:31; Kruger, 1988:143; Leininger, 1985:82; Morse, 1991:56).

The interviews were continued until no more new experiences were revealed by the group members. After the group session, some subjects wanted to talk to the facilitator individually and the facilitator allowed them. The information that they gave to the facilitator was written down as field notes as soon as the subjects left the interview room (Robinson, 1999:908).

During the interview the researcher observed the non-verbal cues of the subjects and the circumstances surrounding the interview, and recorded them as field notes. These provided details of the contexts in which the conversation might have been addressed. The field notes and the taped interviews were transcribed in English as soon as possible (within 12 hours) after the interview (Holstein & Gubrium, 1995:78). The facilitator ended the interview by thanking all the subjects for sharing their experiences with each other and with her. She once again reminded them to keep the group data confidential. The subjects' names were not used in the interview nor in the transcriptions. In order to facilitate member-checking after data analysis, the subjects were asked to write down their names, address and telephone numbers.

An example of a focus group interview is given in Annexure I.

2.5 MEASURES TO ENSURE TRUSTWORTHINESS OF THE RESULTS

Guba's (1981) model of assessing trustworthiness as presented in Krefting (1991:214-222) and Lincoln and Guba (1985:290-331) was used to ensure trustworthiness of the results in both individual and focus group interviews. Guba's model identifies four criteria for assessing trustworthiness in qualitative research:

2.5.1 Truth value (credibility)

Credibility asks whether the researcher has established confidence in the truth of the findings of a particular inquiry for the subjects with which and the context in which the inquiry was carried out. That is, how confident the researcher is with the truth of the findings (experiences of pregnant unmarried adolescents with their first pregnancy), based on the research design, informants and context (Krefting, 1991:215; Lincoln & Guba, 1985:290). According to Lincoln and Guba (1985:296) the implementation of the credibility criterion is a two-fold task:

- First: To carry out the inquiry in such a way that the probability that the findings will be found credible is enhanced.

- Second: To demonstrate the credibility of the findings by having them approved by the constructors of the realities being studied.

Krefting (1991:216) suggests that a qualitative study is credible when it presents such accurate descriptions or interpretation of human experience that people who share that experience would immediately recognise the descriptions.

2.5.1.1 Measures to enhance credibility

❒ Prolonged engagement

Prolonged engagement is intended to provide the researcher with an opportunity to build trust. Lincoln and Guba (1985:303) point out that building trust is not a matter of applying techniques to guarantee it, but a process to demonstrate to the subjects/respondents that their confidences will not be used against them. It ensures that; pledges of anonymity will be honoured; hidden agendas are not being served; the interests of the subjects will be honoured as much as those of the researcher; and the subjects will have input into and influence the inquiry process.

Both the individual phenomenological and focus group interviews were conducted at the clinic setting during the antenatal clinic visits of the subjects. So on the day of the antenatal clinic the researcher assumed two stances:

- **The first stance:** Was that of a midwife where the researcher conducted the antenatal clinic (did the routine examination of a pregnant woman and conducted a health talk session). It was at this stage that the researcher introduced herself to all the pregnant women: *"although you realise that I am a midwife* (researcher was in nurse's uniform), *I am not here today as a midwife but as a researcher because I am a student and I am studying pregnancy. There are some clients among you that I would request to talk to, about their experiences with their pregnancy. This would not involve all of you".*

  This was to eliminate incorrect assumptions about the researcher's conversation with the subjects-to-be; to build trust by showing that the researcher is really interested in knowing more about pregnancy; to learn about the language (terminology) they use when talking about pregnancy

and to try to come to their level. This would help them to trust the researcher and see her as somebody they could talk to about their pregnancy.

- **The second stance:** Was that of a researcher, where the researcher spent about 15 to 20 minutes with each of the subjects-to-be alone or together with their parents, building rapport; explaining the topic and purpose of the study and ethical issues involved. They were allowed time to ask questions or for clarification and then sign an informed consent form. The researcher also spent 45 to 60 minutes in conversation with the subject. The fact that the researcher is a Mosotho and speaks Sesotho made the subjects feel at ease and free to verbalise their experiences in their own language.

❒ Persistent observation

The purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the issue being studied, and to focus on them in detail (Lincoln & Guba, 1985:304).

The researcher constantly observed the non-verbal communication of the subjects (like laughter, silence, cry, tone of voice) and other elements in the context of the conversation. She sought explanation or clarification where necessary and did not take issues for granted or make assumptions of what the subjects said or meant about their experiences with pregnancy.

The researcher also took a course in interpersonal skills before undertaking this research, in order to improve her communication skills.

❒ Triangulation

Triangulation as a technique for improving the probability that the findings and interpretation will be found credible is recommended by Fichardt *et al.* (1994:17), Lincoln and Guba (1985:305) and Padgett (1998:97). They also suggest that four different modes of triangulation exist, of which the researcher only used two.

• *Data triangulation*

Data triangulation involves the collection of data on the same subject from multiple sources (Burns & Grove, 1997:241; Lincoln & Guba, 1985:305; Padget, 1998:97). These data sources provide an opportunity to examine how an event is experienced by different individuals; at different times; or in different settings. The researcher interviewed a large number of pregnant unmarried adolescents about their experiences with their first pregnancy. Sixteen individuals and two focus groups of five and seven members respectively. These adolescents were from different families, different places in four HSAs in the Maseru district, and had different backgrounds.

• *Method triangulation*

Method triangulation is the use of two or more research methods in a single study (Burns & Grove, 1997:242; Lincoln & Guba, 1985:306). Individual phenomenological interviews and focus group interviews were used to collect data on the experiences of pregnant unmarried adolescents with their first pregnancy.

- ***Investigator triangulation***

In investigator triangulation, two or more investigators with diverse research training backgrounds examine the same phenomenon (Burns & Grove, 1997:241; Lincoln & Guba, 1985:306). Investigator triangulation was not used in this study.

- ***Theoretical triangulation***

Theoretical triangulation is the use of all the theoretical interpretations *"that could conceivably be applied to a given area"* as a framework for a study (Burns & Grove, 1997:242; Lincoln & Guba, 1985:306). Theoretical framework was not used in this study because it would only convey the image of the researcher and would not be representative of the experiences of pregnant unmarried adolescents in Maseru.

2.5.1.2 Measures to demonstrate credibility of the findings

- **Peer debriefing**

Peer debriefing is a process of exposing oneself to a peer for the purpose of exploring aspects of the inquiry that might be implicit within the inquirer's mind. Lincoln and Guba (1985:809) recommend that the debriefer should be someone prepared to take the role seriously, playing the devil's advocate even when it becomes apparent that to do so produces pain for the researcher. The task of the debriefer is to be sure that the investigator is fully aware of his or her posture and process (Padgett, 1998:99). The researcher's supervisor, who is an experienced qualitative researcher and has a Ph.D. in Nursing, served as the researcher's debriefer.

❒ Member checking

Lincoln and Guba (1985:314) say *"if the researcher is to be able to purport that his/her reconstructions are recognisable to audience members as adequate representations of their own realities, it is essential that they be given the opportunity to react to them".*

After each interview, the interview was played back to the subject(s) who provided it, for reaction. After the playback, subject(s) was (were) asked to make corrections to the tape or to add to the tape. Also a copy of the analysed data was given to three of the subjects to confirm if they are a true reflection of their experiences (Jacobson, 1994:97).

2.5.2 Applicability/transferability

Transferability refers to the degree to which the findings can be applied to other contexts or the ability to generalise from the findings to the larger population (Krefting, 1991:216; Morse, 1995:191).

The purpose of a phenomenological interview study is to understand the experience of those who are interviewed (the experience of pregnancy by pregnant unmarried adolescents) not to predict or to control that experience. Also because hypotheses are not being tested the issue is not whether the researcher can generalise findings of an interview study to a broader population. Instead the researcher's task is to present the experience of the people he/she interviewed in compelling enough detail and in sufficient depth that those who read the study can connect to that experience, learn how it is constituted and deepen their understanding of the issues it reflects (Krefting, 1991:221; Lincoln & Guba, 1985:316; Seidman, 1991:41).

This was ensured by:

❒ Sampling

Although the researcher used a convenience sample, all the subjects expressed their willingness to participate in the study and their commitment to be open to share their experiences with the researcher. In the focus group subjects were also made to sign a statement of confidentiality which gave those who were not willing to participate in the study or to keep the interview data confidential, an opportunity to withdraw. It also enhanced the quality of focus group data (Berg, 1995:82). The simple random sampling method was used in selecting the clinics.

❒ Data collection

Both individual and focus group subjects were interviewed on their experiences until no more new experiences were being revealed (that is, saturation of data was reached). The researcher and the focus group facilitator used their communication skills to obtain more information about the subject(s) experiences. For individual phenomenological interviews, saturation of data was reached after 16 interviews.

2.5.3 Consistency/dependability

The criterion of dependability refers to whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects in the same (or similar) context (Krefting, 1991:216; Lincoln & Guba, 1985:290). Dependability is however not possible in qualitative research because experiences differ.

❒ Dependability strategies

The following strategies as outlined in Krefting (1991:221) were used to ensure dependability.

- The exact methods of data collection, analysis and interpretation have been thoroughly explained in this study. This dense description of the methods provides information as to how repeatable and audible the study might be.

- The researcher also used the code-recode procedure on her data during the analysis phase of the study. After coding a segment of data, the researcher waited for two weeks and then returned and recoded the same data and compared the results.

- The use of method triangulation as described above ensured that the weaknesses of one method of data collection were compensated by the use of an alternative data collection method.

- The researcher also used her supervisor who has experience with qualitative research to check the research plan and the implementation of the plan.

- The researcher used an independent coder who is experienced in qualitative research during the analysis stage. The researcher and an independent coder compared their analysis results and discussed and reached consensus on the data.

2.5.4 Neutrality/confirmability

The confirmability criterion refers to the degree to which the findings of an inquiry are a function solely of the informants and conditions of research and not of the biases, motivations, interests or perspectives of the researcher (Krefting, 1991:217; Lincoln & Guba, 1985:319).

Confirmability strategies that the researcher used are:

- Triangulation strategy as described under credibility strategies above.

- Reflexive analysis: Refers to the assessment of the influence of the investigator's own background, perceptions, and interests on the qualitative research process. Aamode (1982) in Krefting (1991:218) noted that the qualitative approach is reflexive in that the researcher is part of the research, not separate from it. The researcher is a participant, not merely an observer. Therefore the researcher analysed herself in the context of the research. On entering the research field, the researcher continuously reflected on her own characteristics and examined how they could influence the data collection and analysis.

- Bracketing and intuition: The researcher used bracketing and intuition during the data collèction and analysis phases in an attempt to control judgement that may be based on values, motivations and preconceptions, thus helping to eliminate bias.

2.6 ETHICAL ASPECTS

Maxwell (1996:7) states that in interactive research, ethical concerns should be involved in every aspect of the research design. Therefore in this research the following concerns were addressed.

2.6.1 The quality of research

Burns and Grove (1997:195) and the South African Society for Nursing Research (SASNR) (1996:74) maintain that the conduct of nursing research requires not only expertise and deligence but also honesty and integrity. The researcher approached this study with integrity and tried at all levels of this study to be aware of personal biases and values that could influence the results of the study.

Before undertaking this study, the researcher took a course on interpersonal skills. The researcher's supervisor is also an experienced qualitative researcher and has a Ph.D. in Nursing.

2.6.2 Access through formal gatekeepers

Gatekeepers are individuals or institutions in an organisation who have the power to withhold access for the purpose of research (Padgett, 1998:36; Seidman, 1991:34).

Permission was obtained from the Ethics Committee of the Faculty of Health Sciences of the University of the Orange Free State; the Director-General of Health Service (Ministry of Health Lesotho); the Director of the Christian Health Association of Lesotho, the respective health service areas and the concerned clinics, to conduct this study. These gatekeepers control access to subjects in this study because:

- the researcher is a student at the University of the Orange Free State; and
- the interviews were conducted in the clinic (see Annexures A, B, C and D).

Because some subjects in this study were below the age of 18 (minors), permission was also obtained from their parents/guardians. However there is no law in Lesotho that stipulates the age at which an adolescent can give consent for participation in research (that is, responding in an interview or to a questionnaire) (Burnard & Morrison, 1990:9; Creswell, 1994:148; Seidman, 1991:36).

2.6.3 Informed consent

The Nuremburg Code adopted by the United Nations general Assembly in 1946 stated that *"the voluntary consent of human subjects is absolutely essential"* (Burns & Grove, 1997:197; Seidman, 1991:47). In a phenomenological interview, the topic of inquiry, no matter how apparently innocent, is placed within the total life context of the subject. That contextual exploration is likely to raise sensitive issues. Also because interviews are tape-recorded and the identity of the subject, even disguised, is potentially discernible by someone who knows him/her, it is ethically and methodologically desirable to seek the informed consent of the subject (Burns & Grove, 1997:209; Padgett, 1998:35; Seidman, 1991:47).

Berg (1995:212) defines informed consent as the knowing consent of individuals to participate as an exercise of their choice, free from any element of fraud, deceit, duress or similar unfair inducement or manipulation.

To ensure informed consent from the subjects, the following concerns were addressed:

2.6.3.1 Right to know

In phenomenological interviews the subjects are asked to reconstruct the details of their experience within the subject area being studied, and their responses are the data for the study. Subjects therefore have a right to be told explicitly what is going to happen to the interview material, in a way that is clear and understandable to them (Parse *et al.,* 1985:19; SASNR, 1996:74; Seidman, 1991:48).

Since the researcher and the subjects spoke Sesotho (same language), the researcher explained the following to the subjects in terms that they understood:

- the purpose of the study;
- the nature of the study;
- the time commitment;
- the involvement of the subjects; and
- the subjects' right to participate voluntarily and to withdraw from the study at any time without penalties.

The researcher also offered to answer any questions concerning this study.

Subjects who agreed to participate in this study signed the informed consent form (see Annexures E and F). Permission was also sought from each subject to tape-record the interviews.

2.6.4 Confidentiality and anonymity

Confidentiality and anonymity were assured. To maintain confidentiality in focus group interviews, every focus group subject was asked to sign a statement of confidentiality (see Annexure F). Only those who signed it participated in the study (Berg, 1995:82). Only the researcher, her supervisor

and an independent coder had access to raw data. It was withheld from any unauthorised persons.

As mentioned earlier, no names were used in the tapes and transcriptions. Instead numbers were used to maintain subject anonymity. Subjects were also informed that if the descriptions are published, no names would be associated with the data. Signed consent forms were kept separate from the rest of the interview data (Burns & Grove, 1997:204; Parse *et al.,* 1985:18). The researcher will destroy the interview tapes after the examination results.

2.6.5 Right to privacy

The right to privacy was maintained as the subjects were asked to voluntarily consent to participate in the study and to share private information concerning their pregnancy with the researcher (Burns & Grove, 1997:203). No personal details other than those concerning their pregnancy were requested.

2.6.6 Protection from harm and discomfort

Although the study involved minimal risks, some mild discomfort could result, as the interview could require that subjects reveal some uncomfortable experiences. Where the subject's emotions were raised, the researcher managed the situation well and used her interviewing skills to avoid asking questions in a way that would cause emotional discomfort. However, some of the subjects were referred for counseling (Burns & Grove, 1998:206).

2.7 DATA ANALYSIS

Analysis is the organising of data in order to answer the problem statement and to make it known to others (Wilson, 1989:454). Qualitative data analysis involves bringing order, structure and meaning to a large body of information so that conclusions can be made and communicated, without loss of context, detail and richness (Clarke, 1999:531; Polit & Hungler, 1991:500). Burns and Grove (1997:532), Fichardt *et al.* (1994:17), Mateo and Kirchhoff (1991:206) state that qualitative data analysis consists of three interactive activities:

- **data reduction** – the process of translating "raw" data into organised format to permit analysis (according to concepts, events and others);

- **data display** – the organisation of data in such a way that the researcher can form conclusions and take action (charts and graphs);

- **drawing conclusions and verification** – the continued notation of the emergence of patterns and explanations, coupled with testing of findings for validity.

Prior to data analysis, the researcher clarified her own preconceptions of the phenomenon under study (experiences of pregnant unmarried adolescents) through bracketing (Tesch, 1990:92). *"Bracketing"* is the process of suspending personal beliefs so that the researcher can enter the world of the research subject/participant. This enabled the researcher to analyse data without trying to confirm her own presuppositions (Clarke, 1999:532; Hopkinson, 1999:204; Jacobson, 1994:96; Tesch, 1990:92). The qualitative researcher, according to Wilson (1989:454), aspires to capture what other people and their lives are about without preconceiving the categories into which information will fit.

According to Clarke (1999:532), Creswell (1994:153), Riessman (1993:60), Seidman (1991:86) and Tesch (1990:95), data analysis in qualitative research is conducted simultaneously with data collection. The two stages become integrated so that each stage informs the other. Creswell (1994:154) also notes that these activities proceed well simultaneously, especially for an experienced researcher. However, beginning researchers may want to treat them separately. The researcher (who is a beginner) treated them separately and followed Seidman's approach of avoiding any in-depth analysis of the interview data until all the interviews had been completed. Therefore, the researcher first completed all the interviews, then studied all the transcripts. In that way the researcher tried to minimise imposing on the generative process of the interviews what she had learned from other transcripts (Seidman, 1991:86).

The transcribed interviews (for both individuals and focus groups) and field notes were analysed, using Tesch's method of analysis. The following eight steps were used:

- Get a sense of the whole by reading through all of the transcriptions carefully. Jot down some ideas as they come to mind.

- Pick one interview and go through it whilst asking yourself what is this interview about? Do not think about the *"substance"* of the information but rather its underlying meaning. Write thoughts in the margin.

- Do the same with other interviews and then make a list of all topics. Cluster similar topics together. Form these topics into columns that might be arrayed as major topics, unique topics and left over.

- Now take this list and go back to the data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try out this preliminary organising scheme to see whether new categories and codes emerge.

- Find the most descriptive wording for your topics and turn them into categories. Look for reducing your total list of categories by grouping topics that relate to each other. You may draw lines between your categories to show interrelationships.

- Make a final decision on the abbreviation for each category and alphabetise these codes.

- Assemble the data material belonging to each category in one place and perform a preliminary analysis.

- If necessary, recode your existing data (Creswell, 1994:155; Tesch, 1990:93).

These eight steps engage a researcher in a systematic process of analysing textual data. This method scrutinises the data obtained for emergence of themes. The aim is to capture the *"essence"* of the experience being studied, by identifying its constituent parts (Clarke, 1999:532; Creswell, 1994:155).

The researcher transcribed verbatim each tape-recorded interview. The researcher made a list of all topics that emerged from the transcripts and developed categories by clustering together similar topics (Creswell, 1994:155; Tesch, 1990:93). Open coding was then performed where the researcher and an independent coder located themes and assigned codes in an attempt to condense the mass of data into categories (Neuman, 1997:422). Coding is described by Burns and Grove (1997:532) as a means of categorising. In open coding, each word, line or paragraph is examined and

coded in an attempt to encapsulate the participant's meanings. The codes may consist of symbols, words or phrases used by the participants and are written in the margin of the transcript (Clarke, 1999:532). Burns and Grove (1997:535) state that there are three types of codes:

- **Descriptive codes:** These codes classify elements of the data using terms that describe how the researcher is organising the data. Descriptive codes remain close to the terms used by the participant being interviewed.

- **Interpretative codes:** These codes are used when the researcher begins to move beyond simply sorting statements using the participant's terms to attaching meanings to these statements.

- **Explanatory codes:** These codes are part of the researcher's attempt to unravel the meanings inherent in the situation.

According to Morgan (1997:60) the fundamental unit of data analysis in focus groups is the group, not the individual. Morgan (1997:60) also suggests that there are three most common ways of coding focus group transcripts which are to note:

- all mentions of a given code;
- whether each individual participant mentioned a given code; or
- whether each group's discussion contained a given code.

In practice, according to Morgan (1997:60), these three strategies are nested within each other because coding all mentions of a topic will also determine whether the topic was mentioned by a specific individual or in a particular group. Coding that is truly at the group level often requires judgements that go beyond aggregating codes at the individual level.

Transcribed interviews, field notes and the protocol for data analysis (see Annexure G) were sent to an independent coder who is an experienced researcher in qualitative research and has a Ph.D. in Nursing. The researcher and an independent coder met to have a consensus discussion on analysed data. To ensure content validity, the researcher used an iterative approach, where the researcher derived themes from the narrative materials. After two weeks she went back to the transcripts with these themes in mind to see if the materials really do fit. The independent coder also checked the analysis process (Polit & Hungler, 1991:505).

The framework for content analysis (Figures 3.2 and 3.3) therefore developed from the verbatim transcripts so that the experiences of pregnant unmarried adolescents could be conveyed. The theoretical framework was not used for the classification, because it would only convey the image of the researcher and not be representative of the experiences of pregnant unmarried adolescents in Maseru. Data were therefore analysed from the perspective of the categories that emerged (Figures 3.2 and 3.3).

According to Burns and Grove (1997:536) and Polit and Hungler (1991:505) qualitative researchers can use *"quasi-statistics"* which involve a tabulation of the frequency with which certain themes, relations or insights are supported by the data. The essential objective of quasi-statistics is to decide if the concepts or the categories in the analysis represent typical and widespread patterns distributed in the data, thereby giving the analytical scheme more credibility (Wilson, 1989:468).

In this study, the researcher used a frequency table (Table 3.1) to present the experiences of pregnant unmarried adolescents from their highest to their lowest frequencies. However, these frequencies were not interpreted in the same way as the frequencies generated in survey studies, because of the imprecision in the sampling of cases and enumeration of the themes (Polit & Hungler, 1991:505).

Counting codes in focus group transcripts is a controversial issue. Some qualitative researchers argue that it violates the assumption of independence that is necessary for many statistical analyses. Morgan (1997:61) on the other hand argues that one could present simple counts of codes without performing any statistical tests on focus group data.

In this study a frequency table was not used to present the experiences of pregnant unmarried adolescents in a focus group.

According to Clarke (1999:533), Krefting (1991:215), Lincoln and Guba (1985:314) one of the strategies to maximise the validity of findings is to undertake member checks. These involve taking the analysis back to subjects/participants to ensure that it represents a reasonable account of their experience. The analysed results were therefore given to three of the research subjects to confirm that they are representative of their experiences.

2.8 CONCLUSION

The research methodology was discussed in this chapter. In the next chapter the presentation of data and literature control will be discussed.

CHAPTER 3

Data presentation and literature control

3.1 INTRODUCTION

The research methodology followed in this study was discussed in the previous chapter. In this chapter data presentation and literature control will be discussed, under individual data, focus group data and field notes.

3.2 INDIVIDUAL DATA

3.2.1 Age structure of respondents

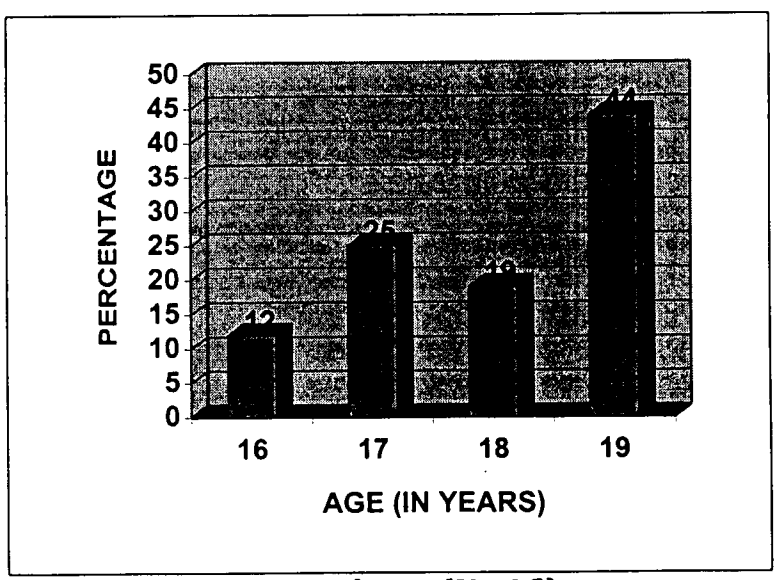


FIGURE: 3.1: Age of respondents (N=16)

Seven (44%) of the respondents were 19 years old, 4 (25%) were 17, 3 (19%) were 18, and 2 (12%) were 16 years old. These data support the general perception that adolescent pregnancy is higher in later adolescence (18, 19), followed by mid-adolescence (15 to 17) and lower in the early adolescence (13, 14) years of age.

3.2.2 Data analysis

The framework for content analysis (see Figure 3.2, p.63) was developed from the verbatim transcripts, so that the experiences of pregnant unmarried adolescents could be conveyed. A theoretical framework would only convey the image of the researcher, and would not be representative of the experiences of pregnant unmarried adolescents. Therefore it was not used for the classification. Data were analysed from the perspective of the categories, which appear in Figure 3.2.

According to Burns and Grove (1997:536), and Polit and Hungler (1991:505) qualitative researchers can use *"quasi-statistics"* which involve a tabulation of the frequency with which certain themes, relations or insights are supported by the data. In this study, the researcher used a frequency table (see Table 3.1, p.64) to present the experiences of pregnant unmarried adolescents from their highest to the lowest frequencies. However, these frequencies were not interpreted in the same way as the frequencies generated in survey studies, because of the imprecision in the sampling of cases and enumeration of the themes (Polit & Hungler, 1991:505).

INDIVIDUAL INTERVIEWS DATA ANALYSIS

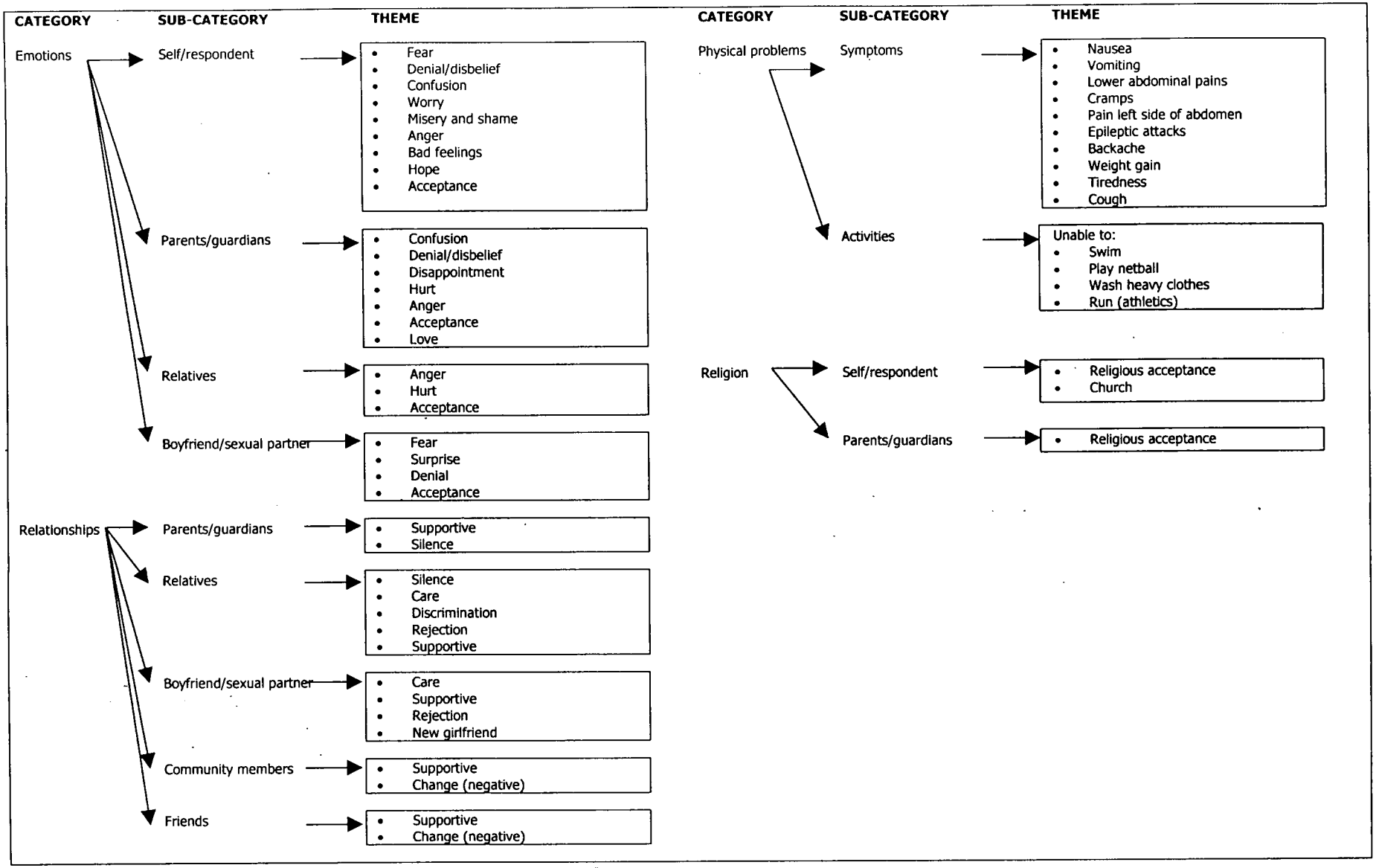


FIGURE 3.2: Framework for content analysis

Figure 3.2 groups data from the individual interview transcripts into four main categories (emotions, relationships, physical problems and religion), and sub-categories. Comprehensive themes are developed to support each category and sub-categories.

TABLE 3.1: Experiences of pregnant unmarried adolescents in order of their frequency (N=16) (to be continued)

POSITIVE AND NEGATIVE EXPERIENCES	Frequency (F)	Percentage (%)
Fear of parents/guardians	14	87.5
Acceptance of pregnancy by parents/guardians	14	87.5
Anger from parents/guardians	13	81.3
Support from parents/guardians	13	81.3
Worry about care of the baby	13	81.3
Discontinuation of school	12	75
Acceptance of pregnancy by boyfriend/sexual partner	11	68.8
Anger from relatives	10	62.5
Support from relatives	10	62.5
Negative feelings about being pregnant	10	62.5
Support from friends	9	56.3
Ashamed to face other people	9	56.3
Miserable life	9	56.3
Desire to go back to school	9	56.3
Not ready for marriage	7	43.8
Acceptance by pregnant adolescent	7	43.8
Rejection by community members	7	43.8
Physical symptoms (like vomiting)	7	43.8
Disbelief/denial	7	43.8
Rejection by friends	6	37.5
Support from boyfriend/sexual partner	6	37.5
Relationship with boyfriend/sexual partner stopped	6	37.5
Desire to get a job	5	31.3
Impregnated by a student	5	31.3
Anxiety – baby as her substitute in the family	5	31.3
Disappointment to the parents/guardians	4	25
Thought of abortion	4	25
Lied about being pregnant	4	25
Relatives prefer marriage	4	25
Boyfriend proposed marriage	4	25
Denial of pregnancy by boyfriend/sexual partner	4	25
Boyfriend/sexual partner has a new girlfriend	4	25
Threats from boyfriend and relatives	4	25
Mood swings	4	25
Shock	2	12.5

TABLE 3.1: Experiences of pregnant unmarried adolescents in order of their frequency (N=16)

POSITIVE AND NEGATIVE EXPERIENCES	Frequency (F)	Percentage (%)
Afraid to tell boyfriend	2	12.5
Underwent counseling	2	12.5
Lack of support from relatives	2	12.5
Boyfriend/sexual partner wanted abortion	2	12.5
Support from community members	2	12.5
Worried about physical appearance	1	6.3
Anger towards boyfriend	1	6.3
Thought of leaving home	1	6.3
Rejection from parent	1	6.3
Parent took this matter up to the local court	1	6.3
Relatives terrified	1	6.3

Table 3.1 shows that some of the experiences of pregnant unmarried adolescents in the study were positive (like acceptance of pregnancy by parents/guardians and boyfriend/sexual partner; support from parents/ guardians, relatives, friends and community members) while others were negative (like being rejected by parents, boyfriend/sexual partner, friends and community members).

3.2.3 Findings and literature control

Qualitative data analysis is the non-numerical organisation and interpretation of data in order to discover patterns, themes, forms, exemplars and qualities found in field notes, interview transcripts and others (Wilson, 1989:454). In this study, respondents were asked to tell/relate in depth their experiences with their pregnancy from the time they realised that they were pregnant until the time of the interview. The question read as follows:

> ***"Can you tell me more about your experiences with this pregnancy from the time you realised that you were pregnant until now?"***

Data from the transcripts were grouped into four categories with sub-categories. Themes were developed to support each category and sub-categories (Figure 3.2) (Polit & Hungler, 1991:504).

The main categories, as seen in Figure 3.2, are:

- Emotions
- Relationships
- Physical problems
- Religion

The sub-categories are as follows:

- Emotions
  - Self/respondent
  - Parents/guardians
  - Relatives
  - Boyfriend/sexual partner
- Relationships
  - Parents/guardians
  - Relatives
  - Boyfriend/sexual partner
  - Community members
  - Friends
- Physical problems
  - Symptoms
  - Activities
- Religion
  - Self/respondent
  - Parents/guardians

Description of the experiences (findings) will be made using the identified categories as the main headings (Figure 3.2). Relevant quotations from the interview transcripts will be given and will be supported by the literature.

3.2.3.1 Emotions

The respondent, parents, relatives and boyfriend/sexual partner experienced some emotional reaction in relation to the pregnancy in question.

3.2.3.1.1 Self/respondent's reaction to pregnancy

The emotional reactions experienced by the respondent as listed in the themes (Figure 3.2) will be described.

3.2.3.1.1.1 Fear to disclose pregnancy

According to the Oxford Dictionary (1996:16) fear refers to panic or distress caused by a sense of impending danger, pain and others. Some of the respondents when describing their experience of fear to tell parents about their pregnancy said:

> *"I was scared to tell my parents."*

> *"I was afraid to tell my mother and I wished that she would not know forever. I told my elder and younger sisters ... 'I stayed at the mission premises for two days and went home on the third day."*

> *"I thought of my mother, how I would break the news to her. I was afraid to tell her. I told my sister."*

"I was afraid to tell my mother ... I did not go home. I stayed at my aunt's place, I was afraid of what my mother would say."

"I was afraid to tell my parents myself. I requested one of my friends to tell them for me."

Some of the respondents were also afraid to tell their boyfriends/sexual partners about their pregnancy and they said:

"I was afraid to go to my boyfriend ... So I did not tell him."

"I was afraid to tell my boyfriend myself because ... So my mother told him."

Some of the reasons given for this fear included:

"It is because in Sesotho, only married people could get pregnant. So when I realised that I was not married, I was still young and I was still attending school, I was afraid to tell anyone."

According to MOHSW/WHO (1997:9) cultural taboos in Lesotho tend to determine the extent to which adolescents can be taught about sexuality. This frequently manifests itself in lack of community involvement and commitment in teaching the youth about family life and family planning. The reasons for this lack of commitment are that: Some parents say that they do not feel comfortable discussing the topic with their children, as premarital sexual relations are still considered a taboo in Lesotho. So many parents feel that they are not capable of teaching their children on the subject as they lack training (MOHSW, 1993:95). Therefore pregnant unmarried adolescents were afraid to tell their parents. They did not know how their parents would react when discovering that they had been engaged in sexual relations outside

marriage and furthermore that they were pregnant and were going to bring a new member into the family.

These statements are supported by Parekh and de la Rey (1997:223) when they say that discussion of teenage pregnancy cannot be understood in isolation from the cultural differentials which shape people's realities. Teenage pregnancy in the context of African (including Lesotho's) communities has been partly linked to cultural values about womanhood and fertility. The minimal negative repercussions either on the part of parents or the community at large following the birth of a child to an adolescent girl, also play a role.

Parekh and de la Rey (1997:226) also reported, in their study on intragroup accounts of teenage motherhood, that most participants said that their mothers or other older women in the house were usually the first to suspect that they were pregnant. When confronted by them the participants' initial reaction was to deny the pregnancy until circumstances (body changes) later forced them to confess.

Their findings are consistent with the findings in this study where, because of fear, pregnant adolescents also hid their pregnancy until their mothers or relatives suspected that they were pregnant. When confronted by their mothers, pregnant adolescents initially lied about being pregnant. Some of the respondents when describing this reaction said:

> *"My mother asked me if I was still having my menses. I lied to her and said yes I have menstruated last month."*

> *"My mother asked me if I was still observing my monthly periods. I said no. She asked me if I ever had sexual intercourse. I said no. She asked me again, now in a serious manner, and I said yes."*

Most of the studies done on the experiences of pregnant unmarried adolescents in western countries do not mention the experience of fear but studies done in African communities do, because of the cultural overtones that surround sexuality in the case of the latter. Parekh and de la Rey's study on intragroup accounts of teenage motherhood: a community based psychological perspective which was done in a semi-rural area in KwaZulu-Natal, does confirm that pregnant unmarried adolescents experience fear in breaking the news about pregnancy to their next of kin, because of the cultural values and norms that govern sexuality issues.

3.2.3.1.1.2 Denial/disbelief of pregnancy

Most respondents reported that they first sensed they might be pregnant when they stopped menstruating. In most instances, it took a few months of *"missed periods"* before respondents acknowledged the possibility that they could be pregnant. Some respondents reported that they had to consult more than one doctor before they could be convinced of their pregnancy. Respondents when describing their disbelief said:

> *"I was shocked and I cried because I did not know that I was pregnant. I did not believe that I was pregnant. I had to come to the clinic here several times to talk to the doctor and the nurses about this before I could accept that I was really pregnant (counseling sessions)."*

> *"I did not believe that I was pregnant as I used to miss some periods. But after three months I suspected that I could be pregnant and I told my boyfriend. We went to the chemist for confirmation."*

"At the beginning of this pregnancy, I did not believe that I was pregnant. I went to two doctors to check whether I am really pregnant or not."

"I could not believe it. I really got disturbed. I could not believe that it was true. I sometimes asked myself how such a thing could happen to me because I am so poor that I do not know how I am going to manage with this baby."

In Parekh and de la Rey's study, most participants also took a few months of *"missed periods"* before they acknowledged that they could be pregnant. For some participants, the initial feelings of worry and anxiety were replaced at a later stage by rationalisation and denial (Parekh & de la Rey, 1997:225). These results support Kekesi and de Villiers' findings where 85.7% reacted with surprise, shock and disbelief when they discovered that they were pregnant (Kekesi & de Villiers, 1999:43). According to Wang and Chou (1999:418) and Bloom and Hall (1999:299) adolescent primigravidas tend to have a later awareness of their pregnancy and higher rates of unintended pregnancy than adults. Kekesi and de Villiers (1999:44) and Moore and Rosenthal (1993:156) maintain that denial of pregnancy until a relatively late stage contributes to the increased health risks for adolescents, because they tend to have later first prenatal visits and fewer total prenatal visits. This statement supports the findings of this study because most of the respondents (due to denial and shame) first attended the prenatal clinic after six months of pregnancy. They therefore had fewer total prenatal visits.

The findings of this study show that adolescents still lack family life education because they still believe that they would not fall pregnant if they engage in unprotected sexual intercourse. They have no sense of appreciation that this risk-taking behaviour does not only predispose them to unplanned pregnancy, but also to sexually transmitted diseases, including HIV/AIDS. They are usually influenced by a lot ignorance in these matters. These findings are

supported by other studies that uncovered a lack of knowledge about reproduction among many teenagers (de Visser & le Roux, 1996:103; Kimane, Molise & Ntimo-Makara, 1999:87). What can also be gathered from the data is that the majority of adolescent pregnancies are unplanned and come as a complete shock.

3.2.3.1.1.3 Confusion

Confusion, according to the Oxford Dictionary (1996:175), refers to a state of being mixed up in mind. Some pregnant adolescents experienced confusion at the beginning of their pregnancy; especially at the time when they were experiencing fear to tell their parents about their pregnancy. Following are some quotations from the transcripts to describe this experience:

> *"I started asking myself many questions as to whether I should tell my parents about this pregnancy or not. I did not tell them until I was three months pregnant. I told one of my relatives ... and asked for her opinion on whether I should tell them or not ... I asked her not to tell them immediately. I asked her to give me a week so that I could make up my mind as to whether I really want to tell them or not."*

> *"I want him to marry me because it has happened. I am now pregnant with his child. It is true my mother has accepted the situation and has promised to send me back to school after the baby is born, but I think it would be best if he married me."*

> *"I ask myself many questions like: will my mother really love my baby, will she end up buying clothes for my baby, will she help me after delivery and teach me how to care for the baby?"*

"I usually ask myself the question how am I going to manage with this baby, especially now that my mother is no longer working and I do not have a father (he is dead). I already struggle to get everything in life and the next minute here I am, pregnant. What is my mother going to do with all this?"

In this confused state, some respondents thought of many things as described by the following statements:

"After discovering that I was pregnant, my boyfriend advised me to have an abortion. We both sought for an abortion but the nurses and the doctors said they did not do abortions (this is because abortion is not legalised in Lesotho). So I failed to have an abortion."

"I did not know what to do. I thought of leaving home and going somewhere but I did not know where."

"I sometimes ask myself why I did not abort this baby ... I went to someone whom I was told to consult if I wanted an abortion. But when it was my turn to go in, my conscience could not allow me. I was afraid and I asked the next patient to go in saying that I am going to the toilet and I never went back."

These results support the results of de Visser and le Roux, where some of their participants were uncertain whether they should feel happy or unhappy about their pregnancy. Nine out of 27 participants in their study stated that they were confused, as they felt youthful but were regarded as adults in their community (de Visser & le Roux, 1996:103-104). Sixty out of seventy (85.7%) respondents in Kekesi and de Villiers' study reacted with confusion when discovering that they were pregnant (Kekesi & de Villiers, 1999:43). In the present study 8 (50%) out of 16 respondents reported to have

experienced confusion. These results support the results of previous studies that pregnancy and motherhood during adolescence compound the stresses of two normative developmental stages (adolescence and adulthood), and endangers the successful resolution of either one.

Studies on the consequences of adolescent pregnancy confirm that, in their confused state, pregnant adolescents opt for abortion. In countries where abortion is legalised, pregnant adolescents opt for abortion to be conducted in safer institutions (Moore & Rosenthal, 1993:151). Where abortion is not legalised (like in Lesotho) backstreet abortion is common among adolescents (MOHSW/WHO/UNFPA, 1994:26; Mutungi, Karanja, Kimani, Rogo & Wango, 1999:556; Pinto & Silva, 1998:5154). In this study only four out of 16 (25%) respondents thought of abortion during their confusion, and only one (6.3%) actually consulted doctors and nurses, but she was turned down because abortion is not legalised in Lesotho. At least she would have liked it to be done in a professional way; not through the backstreets. One respondent refused her boyfriend's advice to abort the baby.

3.2.3.1.1.4 Worry about the responsibility of being a mother

Most (80%) of the respondents in this study reported to be worried. Their main worry was about the responsibility of caring for the baby. None of the respondents mentioned that they had planned the pregnancy. Respondents regarded themselves as kids, and were being treated as such by their families. Suddenly they had to assume the role of a mother; something for which they were not yet ready (Lesser *et al.,* 1998:7). This experience was described by one respondent as follows:

"I keep asking myself, what I am going to do with this baby at my age (16 years old)? I am worried, because I do not know who will assist me with the baby after delivery."

However, many of the respondents were mainly concerned about the financial implications of raising a baby and their concerns were:

"My parents are both not working, that is why I had to discontinue school. So this is a problem, because if they could not manage to pay for me at school, how will they manage with this baby? It is difficult to raise a baby. I keep wondering how they will manage to make ends meet in raising this baby."

"I am really worried about how I am going to raise this baby. I had a good upbringing. My parents cared for me. So I am worried as to how my child is going to make it, when I am still this young (17 years old) and I do not have both parents, in relation to clothes, nice things that a child sometimes needs. I do think that sometimes my child will not have them even at Christmas."

"I ask myself many questions like will my mother really love my baby, will she end up buying clothes for my baby, will she help me after delivery and will she teach me how to care for the baby?"

"I am worried as to how I will manage with this baby, because we are struggling to make ends meet at home. I used not to get things like new clothes at Christmas that most children got, because my parents could not afford it. They rarely ever bought me new clothes. I therefore wonder what they are going to do with this baby."

"I usually ask myself the question, how am I going to manage with this baby now that my mother is no longer working and I do not have a father (he is dead)? I already struggle to get everything in life and the next minute here I am pregnant. What is my mother going to do with all this?"

For some respondents, being pregnant and a mother-to-be meant that they were no longer children. They were now being treated like women/adults at home, not like kids anymore. This seemed to worry them and they expressed their concern like this:

"Even at home, it is going to be hard for me because I am no longer going to be handled like a kid, where I was sent to school, clothed and had other things done for me. All those are no longer going to be done for me, but for this baby."

"One time my mother said that I should know that I am no longer a child, but a woman. So when I am at home, I try to behave like an adult."

One of the respondents also expressed concern about her physical appearance after delivery by saying:

"I wonder if after delivery I will be myself again. Sometimes I see pregnant people who have enlarged veins at the back of the knee. I wonder if I will still look nice in my mini skirts or my trousers after delivery, like I used to before pregnancy."

As stated in Chapter 1 of this study, the unemployment rate is high in Lesotho and most of the respondents in this study reported to be staying with single parents (mothers). It is therefore clear that their pregnancy brought into their families an added economic load. According to Moore and Rosenthal (1993:157) and WHO (1998:4.3), for many adolescent mothers, dependence on the family for financial and emotional support is prolonged. Much of the energy that would normally be devoted to acquiring self-knowledge and psychological independence is necessarily diverted to child care.

3.2.3.1.1.5 Misery and shame

Misery refers to a wretched state of mind or of outward circumstances (Oxford Dictionary, 1996:697). The demands of being an adolescent and those of being a mother are often divergent; the youngster who tries to be both at once may compromise one or the other or fail at both (de Visser & le Roux, 1996:104). The majority of respondents stated that they did not have positive (good) experiences with their pregnancy. Respondents felt robbed of their adolescence, their educational possibilities in the future and their chances for a good life socio-economically. The following remarks reflect the respondents' feelings of misery and shame:

> *"Ever since I got pregnant I feel miserable, life is not interesting anymore. I still wanted to attend school, but because of this pregnancy I cannot. This makes me miserable."*

> *"After some two, three days, my mother changed. She did not talk to me or she was rude when talking to me. My life became miserable. I did not know what to do. I thought of having an abortion. I did not know where to go for an abortion."*

"After I knew that I was pregnant, my life changed and became miserable. I did not know what to do. I thought of leaving home and going somewhere, but I did not know where. If only my boyfriend had given me support, I do not think I could have thought about all this. I could at least have had a shoulder to lean on. But he decided to desert me when I had problems and needed him most."

"My mother is angry with me. She keeps telling me that she does not know what she is going to do with this baby (respondent cried) ... I sometimes ask myself why I did not abort this baby."

"I liked to play, but now nothing is interesting anymore. When I talk to my neighbour's children, they (children) insult me and when I tell their parents they (parents) also insult me. So I prefer to be alone."

Three respondents described their shameful feelings like this:

"I do not feel like going around with my friends anymore. They still want me to join them but I am not comfortable, because when I look at them and myself I realise that I am different from them. I am pregnant, they are not. Even when people look at us, they look at us like that. I also think that people talk about me, so I do not want to be seen. My family's enemies might be happy."

"I do not go for entertainment (like concerts) anymore. I do not want to mix with others anymore, except my family because I am pregnant. Some people talk about you when you are pregnant and sometimes they say false things about you, so I

want to stay away from them, so that they can just see me from a distance."

"I stopped going to school after discovering that I was pregnant. I was ashamed to mix with other students who were still 'normal' and I was pregnant. I also thought they would gossip about me or reject me."

The fact that respondents were all not working and were dependent on someone else (mainly the parent) for their welfare and that of the baby. was frustrating. They were not able to plan for the baby's future. This is because according to cultural overtones, pregnancy before marriage is still a shameful act in Lesotho.

There is no literature that supports the experience of misery. Available literature is about depression, not misery. Therefore this will be considered under the theme depression. However Kekesi and de Villiers (1999:43), Teagle and Brindis (1998:20), and Li, Yin and Chan (1999:429) also discovered in their studies that some participants did not want to associate with their non-pregnant peers and had a late first prenatal clinic visit because they were ashamed to be seen in public.

3.2.3.1.1.6 Bad feelings for being pregnant

According to Moore and Rosenthal (1993:156) *"the girl who has an illegitimate child at the age of 16 suddenly has 90% of her life script written for her".* Respondents in this study perceived themselves as being the worst adolescents in the world (Beck, 1996:98). Respondents generally felt bad for being pregnant at an early age, because they felt they had disappointed their parents, increased the burden on their families and had to drop out of school. This is how they said it:

"I was afraid to tell my mother and I wished that she would not know forever because I felt I had betrayed her. She loved me and trusted me so much. I have disappointed her (respondent cried)."

"I told my sister of my plan to have an abortion. I told her it is because I feel I have sinned against my mother and my mother does not forgive me even though I asked for forgiveness. The way my mother treats me shows that she has not forgiven me. So I think it would be best to have this baby aborted."

"My mother is still angry with me. She does not forgive me (voice shaking). I think I have offended her (respondent cried)."

All the 16 respondents mentioned that they felt bad for being pregnant at their age, as they all regarded their pregnancy as unplanned. This supports the results of other studies which found that adolescents felt bad for being pregnant at an early age (de Visser & le Roux, 1996:103). They also described their bad feelings about having dropped out of school as follows:

"I do not like it because my parents had sent me to school to study to be able to have a better future, but I became pregnant before finishing my studies."

"It is not nice. It is bad because I was born in 1983 and I am still young. This hurts me, because due to this pregnancy I had to leave school. It is difficult to accept it. If only I was married, it would be better. I have enemies."

Research, according to Kekesi and de Villiers (1999:44) and Moore and Rosenthal (1993:158) shows that teenage mothers drop out of school earlier and are less likely to go to college or university study than older women. It also shows that some high schools, especially those belonging to christian denominations, are hostile and difficult environments for pregnant adolescents, so that there is little incentive to remain at school or to return after the baby's birth. This interruption to school or termination of education has long-term educational and economic implications for them.

All 16 respondents reported to have finally come to terms with their pregnancy and accepted that it had happened. They realised that there was nothing that could be done to reverse the situation.

3.2.3.1.1.7 Hope for a positive future

Hope is defined by Yarcheski, Scoloveno and Mahon (1994:288) as the degree to which an adolescent possesses a comforting, life-sustaining belief that a personal and positive future exists. They also proposed that *"a nurturant environment and competent, supportive others lead to hope"*. This therefore suggests that a mutuality exists between hope and help and that the perceived helpfulness of significant others contributes to hope. Other individuals in one's life influence the continuation of hope by their loving support, affirmation and encouragement as well as their willingness to listen and to share hopes, associated thoughts and feelings (Connelly, 1998:207; Yarcheski *et al.,* 1994:207).

Some adolescent mothers-to-be, however, described being pregnant as a positive force from a previously self-destructive path to a more productive and hopeful one (Lesser *et al.,* 1998:7). Qualitative studies, according to Lesser *et al.* (1998:8) and William and Vines (1999:21), also identified surprising strengths in pregnant adolescents, including a more hopeful

perspective on life (like eating right, staying away from drugs, intention to finish school and to find *"gainful"* employment). It seems therefore that for girls who have the ability and motivation to continue with their education, pregnancy does not mean an end to their dreams, as some of the respondents described it.

> *"I told my boyfriend that I am not yet ready for marriage because there are still some things that I would like to do first before getting into marriage, like going to school again."*

> *"I do not think I will have a brighter future if I cannot further my studies after the birth of the baby. So I still intend to go to school after the baby is born."*

> *"I do not want to get married now. I still want to go to school after the baby is born. My brothers have promised to send me back to school after the baby is born, I wish I could go to school soon."*

> *"I loved my boyfriend a lot and I never thought even for once that he could desert me like this. However, I still think this is not the end of the world for me. I want to get a part-time job at the South African Airways (SAA) then go back to school to study to be an air hostess."*

> *"What is going to happen is that next year I am going back to school. My mother has promised me that I will go to school and she will look after the baby."*

"I want to work harder because I will eventually have to raise my child and do everything for him/her. So I have to start now working hard for him/her. I intend to write the final examinations for form E, as I had already paid the examination fee."

Other than school, other positive thoughts that were raised, included the desire to get a job where it was not possible to go to school again.

One respondent, when describing her experience of hope said:

"I am consoled when I feel the baby's movements, because I then know that the baby is still alright. I have been told that I should not worry a lot because if I am depressed, the baby will not move/play well. So every time I try to keep myself in a condition in which the baby will not stop moving/playing."

3.2.3.1.1.8 Anger

Respondents in this study expressed anger that was directed towards either: self, boyfriend, family members or the baby.

- **Anger towards self**

Respondents expressed anger towards themselves for not preventing the pregnancy from occurring. One respondent said:

"I had heard about family planning and contraceptives, but I did not use them. We were also taught at school that if you have unprotected sex, you can fall pregnant. This is exactly what happened to me."

- **Anger towards boyfriend**

Respondents expressed anger towards their boyfriends for impregnating them. Two respondents said:

> *"I am angry with him, because he is still attending school, whereas he has wasted my time and I am now not attending school because of this pregnancy".*

Another respondent said:

> *"The other thing that makes me angry is when I see my boyfriend with another girlfriend. I start asking myself whether he really loved me or not (tone of voice lowered and voice vibrated)".*

- **Anger towards family members**

Respondents expressed anger towards their family members who did not accept their pregnancy because it had happened and there was nothing that could be done to reverse the situation. For an example:

> *"My eldest brother does not accept me and that hurts me."*

This statement, however, suggest anger combined with frustration resulting from rejection by someone close.

- **Anger towards the baby**

Respondents expressed anger towards the baby for disrupting the harmony that existed between the adolescent and her family members or the boyfriend. One respondent said:

> *"I feel I have sinned against my mother and she does not forgive me. I think it would be best to have this baby aborted".*

These findings support Kekesi and de Villiers' findings, where 85.7% of participants reacted with anger when discovering that they were pregnant (Kekesi & de Villiers, 1999:43). They also support the findings of previous studies that children are deprived of *"loving care and support in personal problems"* (de Visser & le Roux, 1996:101).

The emotional reactions experienced by respondents in this study are similar to those available in the literature, both in western and African countries.

3.2.3.1.2 Parents' reactions towards a daughter's pregnancy

Most respondents mentioned their parents/guardians being initially hurt and angry, followed by disappointment over the pregnant adolescent's apparent failure to live up to their aspirations and expectations, and concerns about the family's reputation in the community. Some parents also experienced confusion and denial. The following statements best exemplify these feelings:

"My mother changed. She did not talk to me or she was rough when talking to me. My father was disappointed and he told me that I have disappointed him, because he had hoped to send me to school so that I could have a better future. But here I am, I am pregnant. I asked for his forgiveness. He told me that he still loves me very much."

"After two days, my mother changed. She did not talk to me when she came back from work, she looked angry ... She is still angry with me even today. She does not forgive me. She does not even want to talk to me about anything, not only my pregnancy. She has not bought clothes for my baby."

"My mother was really confused. She could not believe it. That is why she decided to go to my boyfriend's home, to tell them about what has happened to me (my father is dead)."

Fathers of the respondents were reported to have expressed their anger more visibly than mothers. Two respondents reported that their fathers insulted them and dismissed them from home as follows:

"My father was very angry with me. He rebuked me and dismissed me from home. He told me to go to my boyfriend's home. He told me never to come to his house again ... I stayed with a neighbour. But later he called me back to the house, saying that he has accepted."

"My father said he did not want me at his house (respondent cried). He insulted me and my mother. He called me a prostitute and said that he would not stay with prostitutes in his house. He blamed my mother for my pregnancy, because he said she loved me very much. He did not like it when my

mother covered for me when he dismissed me from home. He did not talk to me for three weeks."

Some of the fathers were reported to have expressed their feelings of love towards their daughters, despite the disappointments their daughters caused for them. An interesting trend which also emerged from the transcripts was that mothers were often blamed by fathers for not exercising control and discipline and for allowing the adolescent to *"fall pregnant".* In spite of these initial reactions, most (14 out of 16) respondents reported that their parents/guardians eventually displayed tolerance and acceptance, and encouraged them to resume their schooling after the birth of the baby. Here are some quotations from the transcripts:

"My mother was very hurt, especially because she had sent me to school to study. But she did accept that it has happened. She promised to send me to school again after the baby is born and has offered to look after the baby when I go to school. She has already bought the baby's clothes."

"What I know is that my mother was hurt. But she did accept that it has happened because she was even able to talk to my father to calm him down. She requested a family counseling session with the nurse here at the clinic."

"My father has accepted even though he cannot say openly to me that he has accepted. But I can see from his actions that he has accepted. It is true that sometimes he shows that anger when talking to me, but seldomly.

Few respondents did not know what their parents felt, suggesting a suprising lack of communication. That is:

> *"When I told my mother, she did not say anything to me up to today. But she told other family members who also have not said or done anything."*

> *"My father did not complain to me about my pregnancy until today. But he talks to me nicely, he is not rude to me. So I sometimes ask myself whether he has really accepted or not."*

> *"My parents have changed. I do not really know their standpoint when it comes to me. In most cases there are threats in their words when they talk to me. They are rude to me and harass me verbally, especially my mother."*

The emotional reactions of parents reported in this study support the findings of earlier studies that most pregnant adolescents experience no rejection by their parents; and that parents are upset and often outraged or deeply disappointed. But parents take no decisive action to sanction those concerned (de Visser & le Roux, 1996:101). In this study, however, some parents rejected their pregnant adolescents.

3.2.3.1.3 Relatives' reaction towards the adolescent's pregnancy

Like with the parents/guardians, respondents reported that relatives also initially reacted with anger and were hurt, but later they accepted that it has happened, and nothing could be done to reverse the situation. Consider in relation to their reaction the following quotations from the transcripts:

"My brother started threatening me. He slapped me six times. He insulted my grandmother when she tried to cover for me. He stopped talking to me, stopped buying groceries or doing anything in the house because my grandmother covered for me. He went all out to buy a gun to shoot me and my boyfriend. He fetched my boyfriend, put us together in the room, loaded the gun and when he was about to shoot, somebody knocked at the door. It was his friend. His friend asked him not to shoot at us ... Since then we are in talking terms like a brother and a sister. Everything is okay now."

"My relatives were angry but not like my father. They have now accepted the situation."

"My brother was hurt and was angry with me more than anyone else. He did not want to talk to me. When he talked to me I could tell from the tone of his voice that he was angry. But now he has accepted and has encouraged me to go back to school after the birth of the baby."

"My relatives accepted. My two sisters also got pregnant outside of marriage; now it is me. It is therefore not something new in my family that someone gets pregnant outside of marriage. I think that is why everybody accepted my condition so easily."

Literature is not specific about the emotional reaction of the relatives when the unmarried adolescent becomes pregnant. Available literature only explains the support that the pregnant adolescent gets from the relatives.

3.2.3.1.4 Boyfriend/sexual partner's reaction to pregnancy

With three exceptions, all sexual partners were unemployed and the majority were still at school. Their initial reaction, as reported by respondents, was one of surprise and fear over what their own parents' reaction would be. The latter was the main cause of anxiety in partners and centred around the fear that their parents (especially fathers) would force them to leave school and begin working so as to assume their share of the financial responsibility of child care. Due to fear, some sexual partners advised their partners to have an abortion. Here are some extracts from the transcript:

> *"When I told my sexual partner he looked surprised and did not do anything. I think he is afraid to face my parents."*

> *"My boyfriend accepted the responsibility, but he said he would not tell his parents. I should tell my parents that I have told him and what he has said so that they could go to his parents."*

> *"When I told my boyfriend he accepted but due to fear, he advised me to have an abortion. His parents have not sent him to school again because of this pregnancy."*

> *"When I told my boyfriend about my pregnancy, he wanted me to have an abortion. I refused. He deserted me."*

Four (25%) respondents reported that their partners initially denied that they were the fathers and thereafter disappeared. Three other respondents' partners initially accepted but as pregnancy advanced they denied parentage of the child. Respondents said:

"At first my boyfriend agreed that he impregnated me. But as pregnancy advanced, he told me that he is not the one who impregnated me. It must be somebody else. He also threatened me by saying that if he could see one of my family members going to his parents about my pregnancy, he would go to my home and he would kill me there."

"When I told my boyfriend that I was pregnant, he initially agreed that this was his child, but later he denied it. He said he did not want to hear that my parents went to his parents about this. If he could hear that, I would know well how silly he was."

Nine (56.3%) of the partners accepted their parentage status and four (25%) of them proposed marriage.

These findings support Parekh and de la Rey's findings that the initial reaction of partners is usually that of surprise, dismay and fear. Some deny parentage while others accept their parentage status even though they might not be able to provide financial support for the mother-to-be and the child (Parekh & de la Rey, 1997:226). Other studies, according to Moore and Rosenthal (1993:161), report that a substantial minority of adolescent fathers never acknowledge their parenting partly through ignorance, partly through disbelief and partly because they refuse to accept the responsibility of fatherhood. These studies also report that many young fathers doubt their ability to support their new family either financially or emotionally.

Some respondents reported that their sexual partners were much older than them (respondents) and one respondent experienced sexual abuse by her guardian, which resulted in her pregnancy. Garrett and Tidwell (1999:100) and Guijarro, Naranjo, Padilla, Gutierez, Lammers and Blum (1999:170) found that abuse (physical and sexual), neglect, and family dysfunction were found to be more pronounced among pregnant adolescents and adolescent mothers

than non-pregnant adolescents. According to Renker (1999:380) pregnant adolescents who experience physical abuse tend to give birth to low birth weight babies.

3.2.3.2 Relationships

3.2.3.2.1 Parents and friends' positive reaction

Respondents reported that their parents and some of their friends were very supportive to them during their pregnancy. This could be due to the fact that most parents (especially mothers) accepted their daughters' pregnancies.

Acceptance can be considered as approval or positive affirmation received from another person for one's actions. Kathryn (1994:792) states that acceptance has elements of affection and belonging which, according to Maslow's theory of needs are the basic human needs. During adolescence acceptance is a need that is met through interaction with two primary reference groups: the family and the peer group. Acceptance is gained through performance of roles in respect to each reference group (Kathryn, 1994:792).

Peer acceptance and interaction for the pregnant unmarried adolescent are dependent on the norms of each peer group. Some peers consider adolescent pregnancy as violation of social norms, whereas others do not. Research, according to Kathryn (1994:792) and Klein (1998:344) has documented that, in general, pregnancy isolates adolescent from peers and leads to a less cohesive network of friends and less acceptance. These may cause psychological distress, which could lead to high suicide rates among pregnant adolescents or illegal abortion (see definition, p.9). For many adolescent mothers-to-be, much of the energy that would be devoted to acquiring self-

knowledge and psychological independence is diverted to pregnancy and child care.

Establishment of her close relationships with peers of both sexes may be negatively affected and many young boys may be uninterested in dating her after the birth of the baby (Moore & Rosenthal, 1993:157).

Although pregnant unmarried adolescents may have less supportive peer networks than pregnant adults, this lack is usually compensated by increased acceptance and support from family members (Kathryn, 1994:792; Klein, 1998:344). Participants in Kathryn's (1994) study reported a higher level of family acceptance and support than that of peers. In this study 87.5% of respondents reported acceptance and support from the family whereas only 56.3% experienced acceptance and support from peers/friends.

- ***Social support granted by family and associates***

Yarcheski *et al.* (1994:288) define social support in terms of six relational provisions: attachment; social integration; opportunity for nurturant behaviour; reassurance of worth; a sense of reliable alliance and obtaining guidance in stressful situations. Respondents' mothers and grandmothers were the ones who mainly provided social support. Friends were found to vary in their level of support. Some friends were supportive and encouraged the pregnant adolescent to move on with her life, while others no longer expressed a desire to associate with her. Some respondents explained:

> *"The other thing that makes me feel good about myself is that my friends are very good to me, they console me and encourage me to go on with my life. They are supportive to me, they care about me, they take me out for refreshments."*

"My friends have left me except for one who has remained and with whom I share both positive and negative experiences. She is the one who told my parents about my pregnancy as I was afraid to tell them."

"My friends no longer visit me and when we meet we just greet each other and do not talk like we used to anymore. It is only one friend who still visits me and I tell her of my problems and experiences and she advises me and gives me support."

"I have observed that my friends are no longer interested in associating with me, they also gossip about me and my mother."

"My friends give me support and encourage me not to abandon this baby after it is born or not to kill the baby after it is born."

Socially supportive networks have been determined to exert a favourable impact on the course and outcome of pregnancy, as well as on the individual's general health. Furthermore social support has been found to be a significant predictor of prenatal attachment in adolescents. Through its stress-buffering and direct effects, social support is believed to exert a mediating influence on psychological well-being and maternal behaviours that may beneficially affect the developing mother-child relationship (Lesser *et al.,* 1998:12; Ponrakis, Susman & Stifter, 1998:170). Kathryn (1994:792) maintains that pregnant adolescents who have high stress and low social network support are also likely to suffer physiological effects such as illness. A high quality relationship with parents is associated with decreased depression and anxiety in pregnant adolescents (Moore & Rosenthal, 1993:157; Stevenson, Maton & Teti, 1999:119).

- ***Material support provided by family and associates***

Some respondents mentioned that their parents, relatives, boyfriend/sexual partner, and friends provided material support. This was mainly in the form of provision of clothing for the baby and provision of money for transport to the clinic and the antenatal clinic services. Respondents described it like this:

> *"My sexual partner has bought the baby's clothes and he showed them to me."*

> *"The positive experience is that my parents are no longer angry with me and they have bought the baby's clothes."*

> *"The consoling experience is that at least I still manage to get money for the clinic and things like fruits from my parents."*

> *"My friends bought shoes for me and clothes for the baby."*

Two respondents, however, reported that their parents were silent and did not offer them either material or social support. They said:

> *"I told my mother and she told other family members. I thought they would come here to ask my sexual partner (sister's husband), but they did not come. My mother is still silent and she has not bought the baby's clothes."*

> *"My mother keeps telling met that she does not know what she is going to do with this baby. She tells me that I should know that I am no longer a child but a woman. She generally does not talk to me and she has not bought the baby's clothes."*

Lesser *et al.* (1998:12) also found that most pregnant adolescents in their study experienced a lack of family support particularly from their mothers.

One respondent in this study mentioned that her mother took this matter up with the local court so that the boyfriend's family could pay the damages caused to her daughter (breaking the hymen).

3.2.3.2.2 Relatives' supportive reaction

Ten (62.5%) of the respondents stated that their relatives were caring and supportive in that they provided material and social support. Some relatives were however reported to have changed and became negative and unsympathetic to the pregnant adolescent. They even discriminated against her. Some relatives preferred marriage compared to the pregnancy. Respondents said:

> *"My eldest brother does not accept me and that hurts me a lot. He treats me differently from the rest of the family members. The other members relate well with me and they advise me where I go wrong. They help me with the little that they have. They have promised to send me to school again after the baby is born."*

> *"My mother, my sister, in fact the whole family gives me necessary support. I think I am coping well."*

> *"My brother cares for me and supports me very much. He is the only one whom I am free to talk to. He promised to assist me even with the baby's clothes if my mother could harden her heart forever."*

"My relatives gossip about my pregnancy and my family."

"Maybe my relatives will assist me with the baby's clothes. I am just assuming because they have not changed and they seem to have accepted my pregnancy."

One respondent mentioned that her relatives, like her mother, have been silent. They have not said or done anything. These findings are consistent with the findings of previous studies on the relationships of the pregnant unmarried adolescent and their relatives (de Visser & le Roux, 1996:100; Parekh & de la Rey, 1997:226).

3.2.3.2.3 Boyfriend/sexual partner's supportive reaction

Six percent (37.5%) of respondents mentioned that their boyfriends/sexual partners were supportive and caring as the following quotations state:

"He is supportive. He has bought the baby's clothes and he showed them to me. He cares for me."

"He is very supportive. His parents agreed to pay the damages (sum of money my parents will ask for impregnating me) and they have agreed to support the child."

"He is okay. We love each other and he supports me."

Bloom (1998:428), Parekh and de la Rey (1997:224) maintain that a close and satisfying relationship with the father of the baby has a positive influence on the maternal-fetal attachment and maternal-infant attachment. It relieves the pregnant adolescent from psychological distress. A high quality relationship with the father of the child is also believed to be associated with

the pregnant adolescent's increased self-esteem and to influence her decision to continue with her pregnancy (Alpers, 1998:115; Henderson, 1999:91; Smith & Grenyer, 1999:31; Stevenson *et al.*, 1999:119).

However two respondents mentioned that their partners provided no support whatsoever by saying:

> *"My boyfriend deserted me. He has a new girlfriend. He is a drunkard, likes a nice time and has many friends. He did not give me support when I needed it most. I never thought he could desert me like this."*

> *"He does not care about me. He is a drunkard, a nevermind, somebody who is useless. The only thing he cares about is alcohol. He is always drunk and the mind of a drunkard is useless."*

These findings are supported by Clifford and Brykczynski (1999:13) when they say that a pregnant adolescent who has a supportive strong male partner feels less powerless. If deserted or unsupported, the adolescent feels powerless and her trust on males is eroded.

3.2.3.2.4 Community members' positive reaction

Most respondents in this study reported that they did not mind their relationship with community members. As long as relations were well in the family, they were satisfied. Few mentioned that community members have been very supportive, mainly in providing shelter for them when they were being dismissed from their families. For some respondents, the community members were unsympathetic and happy that they fell pregnant outside marriage. This is how they put it:

"Some community members started behaving in a funny way. They would talk about me indirectly whenever I met them."

"Some community members are not happy. They influenced my boyfriend not to marry me. Only a few still talk to me nicely like before I got pregnant."

"My neighbours have changed, when I talk to the children, the children insult me, when I tell their parents, they (parents) also insult me."

These findings support Parekh and de la Rey's (1997) findings where community members were found to be unsympathetic to pregnant adolescents (Parekh & de la Rey, 1997:226).

3.2.3.3 Physical problems

Respondents experienced physical symptoms like nausea, vomiting, cramps, backache, weight gain and tiredness. These were due to the physiological changes that occur during pregnancy. Sweet and Tiran (1997:186, 497, 501, 507) maintain that pregnancy carries with it some minor ailments, that are sometimes considered to be part of normal pregnancy. One respondent mentioned that she experienced more epileptic attacks during pregnancy than before. Another one experienced coughing and abdominal pains. These were advised to consult a doctor about their complaints.

Also, due to physiological changes, respondents reported being unable to perform some of the activities that they used to do before pregnancy like: swimming, playing netball, washing heavy clothes and running as an athlete. One respondent said:

> *"I liked swimming and playing netball a lot but now I cannot play anymore because I get tired very quickly, I do not have the energy anymore and I feel heavy".*

Still some respondents stated that they experienced food preferences which they did not have before they got pregnant. Skinner, Pope and Carruth (1998:47) also found in their study that adolescents have increased sensory taste preferences during pregnancy and post partum.

3.2.3.4 Religion

3.2.3.4.1 Self/respondent's own rectioin

Respondents mentioned that although it was difficult to accept the pregnancy, they eventually accepted it because "*God*" had made it to happen and there was nothing that they could do about it. One respondent described her experience like this:

> *"From my conscience, I believe that I did the right thing by not aborting this baby. I go to church and I pray a lot, so I believe that God will help me and this will pass."*

Although respondents believed that God had made their pregnancy happen, they still considered it bad according to societal norms. Therefore they were still filled with shame. They said:

"I do not go to church every Sunday so that the church members will not be surprised when I do not go anymore because as this pregnancy advances I will no longer go to church. I will be ashamed to mix with the church members in this condition."

"I liked to go to church and I was a member of the Christian Youth Association, but I do not attend church anymore, because I feel like I am an outcast, because others are still 'normal' and I am pregnant."

However, one stated that she still went to church. Parekh and de la Rey (1997:224) found that the effects of church attendance on pregnant adolescents' (in their study) psychological distress were negligible.

3.2.3.4.2 Parents' religious acceptance

Some respondents mentioned that their parents accepted their pregnancy in a religious way by saying:

"My mother did not seem to be hurt or angry with me. She just said okay there is nothing that we can do. It has happened. God has made it happen."

"I told my father that this is how God has made it to be, there is nothing that we can do. He accepted and said thank you."

The researcher did not find literature that relates the experiences of pregnant adolescents or of their parents to religion.

3.3 FOCUS GROUP DATA

3.3.1 Data analysis

The framework for content analysis for focus group data (Figure 3.3) was developed from the verbatim transcripts, so that the experiences of pregnant unmarried adolescents could be conveyed. A theoretical framework was not used for the classification, because it would only convey the image of the researcher and would not be representative of the experiences of pregnant unmarried adolescents in Maseru. Data were therefore analysed from the perspective of the categories as they appear in Figure 3.3.

Counting codes in focus group transcripts is still a controversial issue. Some qualitative researchers argue that it violates the assumption of independence that is necessary for many statistical analyses. Morgan (1997) on the other hand argues that one could present simple counts of codes without performing any statistical tests on focus group data (Morgan, 1997:61). In this study the researcher did not use any quasi-statistics for presenting focus group data.

FOCUS GROUP INTERVIEW TRANSCRIPTS
DATA ANALYSIS

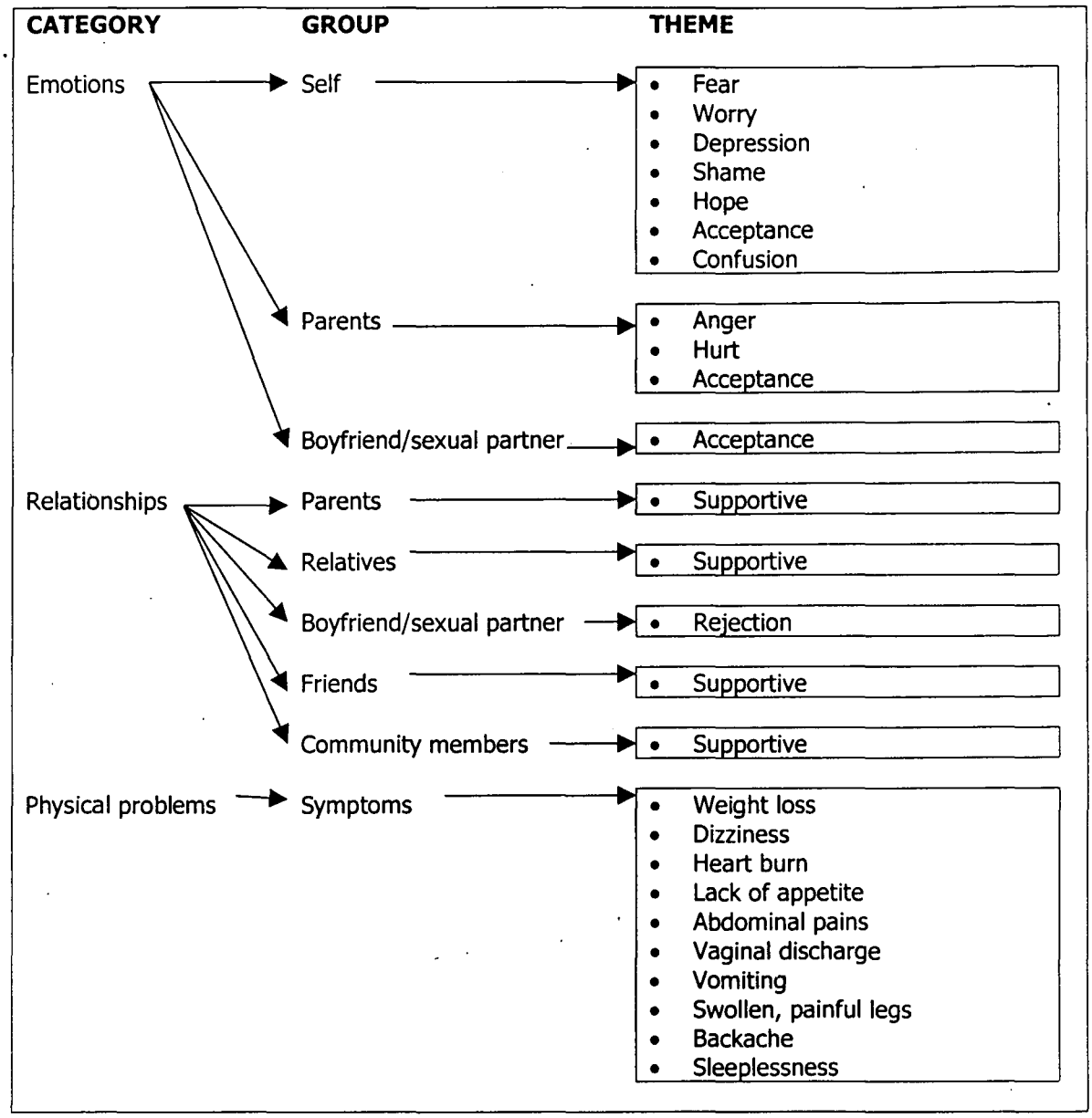


FIGURE 3.3: Framework for focus group content analysis

Figure 3.3 shows that the framework for content analysis that was developed from the focus group interview transcripts is similar to the one that was developed from individual interview transcripts. This similarity could be attributed to the socio-cultural beliefs and norms that surround sexuality and pregnancy outside of marriage in Maseru.

3.3.2 Findings and literature control

Focus group interviews were conducted as a triangulation strategy to verify and validate the individual interviews' data. In general the findings of the focus group interviews were similar to, and support those of the individual interviews.

Group members were asked to respond to the following study question:

> ***"Can you tell me more about your experiences with this pregnancy from the time you realised that you were pregnant until now?"***

Data from the focus group interview transcripts were grouped into three categories, with sub-categories. Themes were developed to support the categories (Figure 3.3) (Polit & Hungler, 1991:504).

The main categories, as seen in Figure 3.3, are:

- Emotions
- Relationships
- Physical problems

Each of the three categories has sub-categories, as follows:

- Emotions
  - self/group member
  - parents
  - boyfriend/sexual partner

- Relationships
  - parents
  - relatives
  - boyfriend/sexual partner
  - friends
  - community members
- Physical problems
  - symptoms

A description of the experiences (findings) will be made using the identified categories as the main headings (Figure 3.3). Relevant quotations from the transcripts will be given and supported by the literature.

3.3.2.1 Emotions

3.3.2.1.1 Self/group member's reaction to pregnancy

The group members experienced:

3.3.2.1.1.1 Fear to disclose pregnancy

Group members mentioned that they were afraid to tell their parents about their pregnancy, because their parents (especially their fathers) were very strict. So they did not know how they would react. They also did not know what the reaction of their boyfriends/sexual partners would be. The major cause of fear as stated by the group members was that in Sesotho, only married people could get pregnant and they were unmarried and still very young. They also reported that their mothers were the first ones to suspect that they were pregnant. This finding supports the previous findings, including the present study, that pregnant adolescents' mothers or other older women in the house are usually the first to suspect the pregnancy (Parekh &

de la Rey, 1997:226). When confronted by their mothers, group members said they initially denied being pregnant. In describing how this pregnancy and fear to break the news to the parents affected them some group members said:

> *"Whenever I thought of it, I would lose concentration on whatever the teacher was saying or what I was doing at that time."*
>
> *"It actually affected me generally, body, mind and soul, I do not know how to explain it."*
>
> *"It affected me the way my group mates have explained it because I could not even walk around. Wherever I went, I thought everyone was aware that I was pregnant and that I was hiding it. So I could not do anything freely."*
>
> *"It affected me especially when I was alone and also because my boyfriend had denied it. I kept worrying about it and about how my parents were going to take it. I sometimes felt sad and cried."*

Others added that they also cried when they were in that state of panic/fear.

3.3.2.1.1.2 Worry about the responsibility of raising the baby

Group members reported that they were worried about raising the baby, not being educated (as they had to drop out of school), and not working, as one of them explained:

"I am worried about my baby. It is difficult to raise a baby. I wonder if I will be able to raise this baby well, give him/her things that a baby needs, when I am not educated and not working. I am worried about his/her future."

These findings are similar to those of the individual interviews where respondents were mainly worried about how they were going to raise their babies.

3.3.2.1.1.3 Depression related to pregnancy

Depression, according to the Oxford Dictionary (1996:276), refers to a state of morbidly excessive melancholy, a mood of hopelessness and feelings of inadequacy, often with physical symptoms.

Group members stated that they mainly experienced depression before telling their parents about their pregnancy. But after their parents knew, they were relieved and felt a lot better. The following statement best exemplifies this feeling:

"I actually lost weight because I was worrying. I sometimes felt sad and cried. I was not happy. But after my mother knew about my pregnancy I felt a lot better."

Others added that they also cried sometimes when they were in that state of sadness. Sweet and Tiran (1997:153) maintain that during pregnancy the woman's emotional state is different to that of her pre-pregnancy condition. During pregnancy the woman is more emotional than usual and more prone to anxiety and worry. They have also found that women with inadequate emotional support from those around them usually suffer from depression.

The changes that occur in the woman's emotional state are often revealed by episodes of sadness, tearfulness and sleeplessness.

Available data confirm that on confirmation of pregnancy most adolescents suffer depression (Moore & Rosenthal, 1993:157; Parekh & de la Rey, 1997:225; Wagner, Berenson, Harding, Joiner, 1998:1231). According to Lesser *et al.* (1998:7) data suggest that the prevalence of depressive symptoms in pregnant adolescents may be as high as 59%. However, Wagner *et al.* (1998:1231) are of the opinion that pregnant adolescents with a pessimistic attributional style are less depressed than those with an optimistic attributional style. Studies also show that adolescent mothers who experience chronic depressive moods along with social isolation during pregnancy may be at increased risk of problematic maternal behaviours (Lesser, Koniak-Griffin & Anderson, 1999:146).

3.3.2.1.1.4 Shame to associate

Pregnancy outside marriage is considered antisocial in Lesotho. Therefore group members reported to have been ashamed to mix with other "*normal*" adolescents or to be seen by other people. They had this to say:

> *"I was ashamed of facing other people, but my mother told me to accept myself and to face the world."*

> *"I could not even walk around. Wherever I went, I thought everyone was aware that I am pregnant and I am hiding it. I could not do anything freely."*

> *"I no longer go to some places that I used to go to because I think people will talk about me."*

But the encouragement and support from their parents motivated them to accept their pregnancy and move on with their lives. So they stated that they have accepted.

This finding supports the findings of the individual interviews, where respondents were ashamed to mix with other "*normal*" adolescents because they were pregnant. It also supports the findings of previous researchers. Participants in Kekesi and de Villiers (1999:43) and Teangle and Brindis' (1998:20) study, reported that they were too ashamed to be seen in public, therefore they did not attend the prenatal clinic.

3.3.2.1.1.5 Hope for a positive future

Most of the group members expressed their desire to continue with their studies after the birth of the baby. The fact that their parents promised to send them back to school and their mothers offered to look after the baby whilst they are at school motivated group members a lot. Group members described this as the "*good experience*" of their pregnancy. They had this to say:

> *"The good experience was when my father told me that after the baby is born, I will go to school again. This was good because I did not think he would still send me to school after what I have done."*

> *"The nice experience for me was when my mother went to my school to secure my place in the final examination."*

This desire to go back to school demonstrates the hope that pregnant adolescents in this study had about their future. They did not regard their pregnancy as the end of their career paths. Moore and Rosenthal (1993:158) state that for girls who have the ability and the motivation to continue with their education, pregnancy and motherhood do not necessarily mean the end to their dreams.

3.3.2.1.1.6 Confusion

Some group members experienced confusion when discovering that they were pregnant. They did not know who to tell. As pregnancy advanced, their mothers and other older women in the family gave them half information and sometimes misinformed them about labour. The girls described:

> *"I have heard that when one gives birth, there are some risks involved. So I am scared and I wonder if I will manage through those risks."*

> *"I have heard that it is very painful to give birth, so I wonder if I am going to stand such pain."*

> *"I liked to sleep during the day, so they said the baby will sleep during birth and will not be born on time; I liked to stand at the door entrance and they said the baby will be stuck at the pelvic outlet during birth; I liked to eat eggs and they said the membranes (fore waters) will not rupture and I will roam about like a chicken when it wants to lay an egg. So I was told not to eat eggs and that if I feel sleepy during the day, I must do something to keep myself awake most part of the day. So I do that."*

"I was told that if I sleep during the day, the baby will also sleep during birth and will not cry at birth; I should not worry a lot because if I do, I will not have the strength to push the baby during birth."

These statements reflect lack of knowledge coupled with misinformation.

Despite their confusion, none of the group members mentioned having had negative thoughts about their pregnancy. The emotional reactions experienced by focus group members support those experienced by the individual interviewees.

3.3.2.1.2 Parents' reaction to their daughter's pregnancy

Like in individual interviews, parents of the focus group members were initially angry and hurt, but later accepted and promised to send them to school again after the birth of the baby. The interesting thing, like in individual interviews, was that some fathers blamed mothers for not exercising control and discipline and for allowing the adolescent to fall pregnant. One group member said:

"When my parents discovered that I was pregnant, my mother got hurt like a mother would be. My father swore not to do anything for me again. He even blamed my mother for my pregnancy. But now he does everything for me like others in the family".

These findings support the findings of the individual interviews (present study) and previous studies on experiences of pregnant unmarried adolescents.

3.3.2.1.3 Boyfriend/sexual partner's reaction to pregnancy

Most of the group members stated that their boyfriends/sexual partners denied parentage from the beginning. Some mentioned that even though their boyfriends initially accepted parentage, as pregnancy advanced they disappeared. Only two group members mentioned that their boyfriends accepted parentage and proposed marriage. Consider the following extracts from the transcripts for these reactions:

> *"He agreed that he impregnated me and proposed marriage."*

> *"When I told my boyfriend he said he is not the one who impregnated me, I should leave him alone and I should not be telling people that he is the one because he is not."*

> *"My boyfriend initially accepted parentage. He accompanied me to the clinic (for prenatal care) for three successive months and on the fourth month he changed and disappeared."*

Group members described their boyfriends as "*untrustworthy*", because when they were dating their boyfriends they seemed to love them, but when they were pregnant and in need of their support they deserted them.

These results are consistent with those of the previous studies and the individual interviews (present study) that some boyfriends/sexual partners deny parentage to the child. Some accept it, although they may not be able to provide financial assistance to the child and the mother (Parekh & de la Rey, 1997:226).

3.3.2.2 Relationships

3.3.2.2.1 Parents' positive reaction

All group members reported to have been supported by their parents, especially their mothers. This reflects changing attitudes of parents toward pre-marital pregnancy. They mentioned that they were closer to their mothers than to their fathers, although they blamed their mothers for not being open enough to allow them to talk about their reproductive life.

> *"It is true that we are closer to our mothers than our fathers, but our mothers do not open the gates enough so that we could be able to ask them or talk to them about our reproductive life. If they did, maybe we would not be here now (pregnant). It is true that they are open now that we are pregnant, but it is too late because our future is spoiled."*

> *"I could not talk to my mother freely about my reproductive life before pregnancy, and even now I am still afraid to talk to her about my pregnancy. I would rather ask my aunt or friends."*

Available data reveals that pregnant adolescents usually report lower mother-daughter and father-daughter communication, lesser life satisfaction and happiness in general, and more school and economic difficulties. They are less likely to find support for their problems in the family. They also show higher levels of depression (Guijarro *et al*, 1999:169).

When explaining why they did not tell their fathers about their pregnancy group members said:

> *"Fathers do not accept the situation easily, so my father would not take it. Fathers do not keep secrets. Even when the mother is hurt, she does not stay in that mood for a long time, she soon forgives and accepts."*

> *"Fathers do not forgive."*

> *"My father is very strict. He would kill me."*

The parents, according to group members, provided material and social support. Parents also promised to send them to school after the birth of the baby and mothers have offered to look after the baby when the adolescent mother goes to school. This encouraged group members to move on with their lives and to accept themselves. McCullough and Scherman (1998:383) suggest that providing the teenager with an accepting and supportive atmosphere may assist her in building a positive identity as a mother.

3.3.2.2.2 Relatives and friends' supportive reaction

All group members mentioned that their relatives and friends were supportive during their pregnancy, especially in telling the parents about their pregnancy and calming down the angry parents. One group member said:

> *"My family has accepted me, supports me and treats me like everybody in the family. My friends have also not changed, they are still my friends. They support and encourage me."*

These findings support the findings of previous studies. However, the findings of the individual interviews in this study show that some relatives and friends were happy and unsympathetic to the pregnant adolescent.

3.3.2.2.3 Boyfriend/sexual partner's lack of support

All group members, except for two, were rejected by their boyfriends/sexual partners and did not get any form of support from them. Some of the boyfriends were initially supportive but as pregnancy advanced, they disappeared. One group member unhappily said:

> *"He does not do anything for me. He does not give me money or anything, the money that is being spent on everything concerning this pregnancy is from my family. But he hates me."*

These findings support those of the individual interviews and of the previous studies. Adolescent fathers deny parentage because they might doubt their ability to support their new family either financial or emotionally.

3.3.2.2.4 Community members' supportive reaction

In as much as premarital adolescent pregnancy is regarded as antisocial in Lesotho, community members were reported to have been supportive to group members in this study. This finding is consistent with the findings of the previous studies and of the individual interviews in this study.

3.3.2.3 Physical problems

3.3.2.3.1 Symptoms experienced by group members

Since group members reported to have suffered depression (see p.107 for definition) on confirmation of their pregnancy, they stated that they experienced weight loss, lack of appetite and sleeplessness. Earlier researchers had also found that adolescents who lacked parental or peer support were at high risk of psychosomatic symptoms (Yarcheski *et al.*, 1994:288).

Physical symptoms experienced by group members were similar to those experienced by individual interviewees and they included: nausea, vomiting, heartburn, dizziness, swollen painful legs and backache. These symptoms, according to Sweet and Tiran (1997:186, 497, 501, 507), are minor ailments of pregnancy. Those who experienced vaginal discharge and abdominal pains were advised by the researcher to consult the doctor.

Earlier researchers reported that pregnant adolescents who have high stress and low social network support are prone to more neonatal and obstetric problems when compared with adolescents who have equally high stress and high social network support. They also maintain that if lower levels of family functioning result in less network support and more stress, then physiological effects such as illnesses are likely for adolescent mothers and their infants (Kathryn, 1994:793).

3.4 FIELD NOTES

The researcher used field notes as a system for remembering the observations she made, and most importantly for retrieving and analysing them.

- ***Observational notes***

Observational notes are descritpions of events experienced through watching and listening. They contain the who, what, where and how of a situation and contain as little interpretation as possible (Wilson, 1989:343). Antenatal clinics were held twice a week, except in two clinics where they were held daily. In the clinics where they were held twice a week, one day was for the first visits and the other for re-visits. Most respondents were attending for the first time.

Staff members avoided interfering with the interview process. Patients' noise was minimal and did not interfere with the interview process. Nurses and doctors at the clinics were supportive and helpful to the researcher, especially in creating and maintaining a conducive environment for the interview, and in identifying the respondents. Respondents avoided direct eye contact with the researcher. Some respondents were reluctant at first to give a detailed description of their experiences. But with probes from the researcher, they eventually opened up to her. Some interviews had to be interrupted on and off to deal with the emotional reactions of respondents (like crying respondents).

- ***Theoretical notes***

According to Wilson (1989:435) theoretical notes are purposeful attempts to derive meaning from observational notes. Here the field worker interpretes, infers, conjectures and hypothesises to build his/her analytic scheme. In

Sesotho it is unrespectful to maintain continuous direct eye contact with a senior or an older person, therefore respondents avoided direct eye contact with the researcher. This behaviour supported their verbal statements when they said that they were ashamed of being pregnant at an early age. It seemed this was the first time respondents talked about their experiences with their pregnancy with the health care professional or somebody other than family members and friends. The fact that the antenatal clinics were held twice a week, could be the reason why health care professionals did not have time to talk to the respondents about their experiences as this needs time. After the interview, respondents appreciated that somebody other than their friends, family members or relatives listened to their experiences. One respondent told the researcher that she felt relieved after sharing her experiences with the researcher because at home she had no one to talk to about her pregnancy, and friends no longer associated with her. Some respondents seemed to be touched by the reaction of their parents, in that parents were angry and not forgiving even though respondents asked for forgiveness. Respondents cried when describing this experience.

- ***Methodological notes***

Methodological notes are instructions to oneself, critiques of one's tactics, and reminders about methodological approaches that might be fruitful (Wilson, 1989:435). The researcher made an appointment with staff members in the respective clinics to conduct the interviews. This was positive because it helped the researcher to gain the staff members' co-operation and assistance during both individual and focus group interviews. The researcher decided to spend some time with the respondents before the interviews by assuming the role of midwife on the day of the interview (did routine examination of a pregnant woman and conducted a health talk session) before assuming the role of the researcher. This was also positive, because it helped the researcher to gain their trust and to help them relax. This approach however

had some disadvantages for the few respondents who had to travel long distances or who had to catch a bus at fixed times, because they would be in a hurry to finish the interview. However, where possible such a respondent was made the first interviewee for the day. The researcher also decided to drop out the respondents who did not give much information on their experiences with their pregnancy as they would not assist the researcher to achieve the purpose of this study. The researcher remained responsible for making sure that the interview focused on or around the central question. She used the communication techniques (such as reflection, validation and summarising) and probes to elicit more information or to clarify responses.

- ***Personal notes***

Wilson (1989:435) describes personal notes as notes about one's own reactions, reflections and experiences. He maintains that field work relies on the investigator's ability to "*take the role of the other*" and be introspective. The researcher felt sad and frustrated by the fact that the health care professionals did not have time to talk to the respondents about their experiences. This could have resulted in missed opportunities for appropriate intervention strategies (like counseling).

3.5 CONCLUSION

Data presentation and literature control were discussed in this chapter. Discussion of the findings, study limitations, recommendations and conclusions will be discussed in the next chapter.

CHAPTER 4

Discussion, conclusions, study limitations and recommendations

4.1 INTRODUCTION

Data presentation and literature control were discussed in the previous chapter. In this chapter, discussion of the findings, conclusions, study limitations and recommendations will be made.

4.2 DISCUSSION OF THE FINDINGS

The findings of this study confirmed that the transition to motherhood is accompanied by a number of social and psychological consequences that place the pregnant adolescents at risk in terms of later life adjustment. The fact that all respondents met the confirmation of pregnancy with a mixture of disbelief, confusion and disappointment, suggests that they were far from being emotionally, cognitively and socially ready for the prospect of motherhood. The lack of preparedness for motherhood could be attributed in part to a breakdown in traditional Sesotho customs and practices in the areas of sexual instruction. Kimane *et al.* (1999:90), MOHSW/WHO/UNFPA (1994:14) and MOHSW (1993:93) indicate that in Sesotho, it was considered customary for the *"facts of life"* to be explained to teenage girls. This was done formally, through initiation schools (for example) and informally by older women through stories and tales. Traditionally parents, in groups or individually, also used to sit down with their children to tell them about the facts of life. From the interviews it was clear that the importance of these

traditional practices had decreased over time. The feeling was that parents (especially mothers) fail to make time for their children or feel intimidated by the subject. This finding was also reported by Kimane *et al.* (1999:102).

One negative aspect of rapid rural/urban migration, the media and modernisation in Lesotho, according to MOHSW/WHO/UNFPA (1994:14), has been the weakening of many traditional value systems. Modernisation and urbanisation have separated the youth from the elders, who were once responsible for conveying information on sexuality. In the absence of these, peers and mass media became the primary source of sexual knowledge for the respondents. Information and knowledge gained from these sources were however, often erroneous or distorted and accomplished little in the way of promoting informed attitudes to issues of human sexuality and reproductive health.

The results of this study confirmed the need for counseling and family life education in schools. Respondents still believed that they could not fall pregnant if they engaged in unprotected sexual intercourse. Only few pregnant adolescents mentioned that they would like to get married. One can therefore deduce that these adolescents plunged into sexual intercourse without actually stopping to think about the consequences. Their behaviour, however, conformed to the behaviour of other adolescents throughout the world.

Pregnant adolescents in this study showed concern about their maternal role attainment (defined by Lesser *et al.* (1998:8) as an interactional and developmental process during which the mother becomes attached to her infant, becomes competent in providing infant care and expresses pleasure and gratification in the role). Although respondents reported good relationships with their mothers during pregnancy, they still felt that their mothers did not prepare them enough for their future maternal role. They wished to give to their babies more than what they received from their

mothers. This uncertainty was due to the fact that they were not educated, not working and most importantly, they were still children themselves. From the respondents' descriptions, it is clear that the majority did not experience their pregnancy as good (positive). They felt robbed of their adolescence, their educational possibilities in the future and their chances for a good life socio-economically.

Most respondents in this study (both in individual and focus group interviews) reported to have dropped out of school early because of pregnancy. Ivey (1999:95), Kekesi and de Villiers (1999:44), Moore and Rosenthal (1993:159) and Stevenson, Maton and Teti (1998:379) confirm that pregnant adolescents usually drop out of school early. There is no question that this interruption to schooling or termination of education had implications for the economic well-being of these young women in their future. Most studies, according to Moore and Rosenthal (1993:159), show that adolescent mothers are less likely than older mothers to find stable and well-paid employment. One should however be wary of assuming a direct link between early motherhood and poor job prospects. Nevertheless, it is true that adolescents who begin child-rearing at an early age are economically disadvantaged. Because they left school at an earlier age, their ability to find employment in higher status jobs and earn high wages is diminished. Considering the unemployment rate in Lesotho (see 1.1.1.5 p.6), these adolescents are at great risk of poverty throughout their lifetime. However, the majority of respondents did not consider being pregnant as the end of their dreams. They expressed the desire to go back to school, to get a job and to work harder in life generally, to be able to support their babies.

Most respondents in this study reported to have received material and social support from their parents (especially mothers). This finding is reassuring because socially supportive networks have been determined to exert a favourable impact on the course and outcome of pregnancy, as well as on the individual's general health. Through its a significant predictor of prenatal

attachment in adolescents. Through its stress-buffering and direct effects, social support is believed to exert a mediating influence on psychological well-being and maternal behaviours that may beneficially affect the developing mother-child relationship (Lesser *et al.,* 1998:12; Ponirakis *et al.,* 1998:170).

The findings of this study suggest that pregnant adolescents perceived support from their mothers as having an important impact on their pregnancy, experiences of depression and future. This supports Lesser *et al.*'s (1998:12) findings on experiences of pregnant adolescents. Stevenson *et al.* (1999:119) also found that a high quality relationship with parents is associated with decreased depression and anxiety in pregnant adolescents.

One can therefore say that the success of adolescent single parent depends entirely on the physical, mental, social and financial support of parents, grandparents or other relatives. If this support is not forthcoming, the associated problems increase dramatically.

The fact that the parents of the respondents in this study were willing to play a supportive role in enabling the adolescent mothers-to-be to return to school after the birth of the baby, is also reassuring. Education *per se* has been found to play a significant role in influencing the well-being of adolescent mothers. Parekh and de la Rey (1997:228) for example, illustrate that black adolescent mothers with at least a high school diploma have on average fewer psychological distress symptoms, fewer symptoms of depression and higher self-esteem scores than adolescent mothers with few years of formal education.

The commitment to education on the part of parents needs to be contextualised. Maseru, the capital of Lesotho, carries 7.4% out of 16.8% of Lesotho's urban population and has a high concentration of job opportunities. However, the influx of population (especially females) to the capital in search of employment results in high competition for these jobs, leaving many

people unemployed (Ministry of Interior, 1990:5). Education therefore offers the only hope of families to improve their situation. Most parents of respondents in this study were unemployed and had minimal levels of formal education. Hence it is conceivable that for them a better future lay in their children's education. A child who is well educated is probably more likely to be employed and better placed to improve the financial well-being of the entire family. This probably explains why parents were prepared to make considerable sacrifices and endure hardship to support the adolescent mother-to-be in her desire and efforts to complete her formal education.

This effort also indicates a certain tolerance of adolescent pregnancies among family members. A reflection of changing norms and values.

Uncertainty over future interpersonal relationships, economic hardships and lack of peer and community support and understanding were also found to create a stressful environment surrounding the pregnant adolescents in this study. The loss of peer support and friendships is of concern particularly in the light of heightened importance of the peer group during adolescence. As Parekh and de la Rey (1997:228) state, the peer group is central to the manner in which adolescents find their way in the world. It both allows them to understand their predicament and provides them with the means to act accordingly. The loss of previously existing social networks (for example school friends), highlights the need for new sources of support. The preferable option would be for this support to be provided by similar others with whom pregnant and adolescent mothers could compare and evaluate their own performance and functioning as parents.

The majority of pregnant adolescents in this study reported to have been rejected by the fathers of their babies. This finding is also of concern because a close and satisfying relationship with the father of the baby has been found to have a positive influence on the maternal-fetal attachment and maternal distress (Bloom, 1998:428; Parekh & de la Rey, 1997:224). A high quality

relationship with the father of the baby, according to Alpers (1998:115), Henderson (1999:91), Smith and Grenyer (1999:31) and Stevenson *et al.* (1999:119) is associated with the pregnant adolescent's increased self-esteem and influences her decision to continue with her pregnancy.

It is common for young single Basotho men to deny parentage when a sexual partner becomes pregnant, due to fear to take responsibility. Traditionally a child born under such circumstances belongs to the parents of the girl (MOHSW/WHO/UNFPA, 1994:27). This may, however, cause problems for both the mother and the child (especially a boy) later in life. Basotho families are patrilineal and patrilocal, tracing lineage through men. Belonging to a family is important in a different way for men than it is for women in Lesotho. For men observance and adherence to rituals confirm their membership and family name (surname) which for them is permanent and unchanging. It also confirms their position in the hierarchy of the lineage. This means that their sons in turn will assume their family name, status and position through their fathers. It is therefore clear that when an unmarried woman bears a son, the position of such a child is uncertain, as membership to a family is usually through men rather than through women. The membership and position of a girl child would not present as many problems, because the expectation is that a girl's membership is not permanent in her natal family. She is expected to marry and assume the membership of her husband's family (Letuka, Mamashela, Matashane-Marite, Morolong & Motebang, 1998:49-50).

The fortunate child is accepted and integrated into her mother's family, but the unfortunate one is discriminated against and grows up with a stigma (MOHSW/WHO/UNFPA, 1994:27).

4.3 CONCLUSIONS

The purpose of this study was two-fold:

- to explore and describe the experiences of pregnant unmarried adolescents in Maseru; and

- based on the above experiences, to develop appropriate guidelines for an educational and counseling program for pregnant adolescents, if found necessary.

Pregnant unmarried adolescents were allowed to describe their experiences (positive and negative) with their first pregnancy, through individual phenomenological and focus group interviews. They were also allowed to describe the meanings that those experiences had for them. Respondents were asked to respond to the following research question:

> ***"Can you tell me more about your experiences with this pregnancy from the time you realised that you were pregnant until now?"***

Sixteen individual phenomenological and two focus group interviews were conducted. Focus group one consisted of five participants and group two had seven members. All respondents were interviewed once (either individually or in a focus group). They were between 16 and 19 years of age.

The findings indicate that respondents did not experience their pregnancy as positive. Their pregnancies were not planned. They reacted with fear, denial, confusion, anger, depression and shame when discovering that they were pregnant. Encouraging is the supportive relationship that respondents reported to have had with their parents and relatives. Fathers of the

respondents' babies were reported to have initially accepted parentage but as pregnancy advanced they denied it and deserted the pregnant adolescents. Some of the friends and community members were supportive while others were unsympathetic. Respondents also experienced minor ailments which are common in pregnancy in general.

It is clear from the above findings that much needs to be done to facilitate adolescents' adjustment to motherhood. It is in view of the above findings that appropriate guidelines are developed for an educational and counseling program. These guidelines are incorporated in the recommendations.

4.4 RECOMMENDATIONS

4.4.1 Educational programs

4.4.1.1 Before pregnancy

4.4.1.1.1 Family life education in homes and schools

- One suggestion is to re-enforce family life education (see p.7) in homes and schools, through use of educational video's followed by group discussions, peer education, role playing and others in the latter.

  - The findings of this study revealed that there is a breakdown in the traditional Sesotho customs of teaching the *"facts of life"* to the youths. The respondents felt that their parents (especially mothers) failed to make time to talk about the facts of life and/or felt intimidated by the subject. It is evident therefore that parents should be equipped with life skills to be able to teach the youth about family life, including contraception.

- The community could also be trained on teaching adolescents about family life, including contraception. This could be achieved through group discussions, role playing, peer education and youth associations (like girl guides, church associations, soccer teams and others).

- Despite the incorporation of family life education in schools, unplanned adolescent pregnancy still remains high in Lesotho. This indicates the need to evaluate the program. A high number of adolescents drop out of schools yearly due to pregnancy, although there are no statistics available to illustrate the magnitude of the problem (MOHSW/WHO/UNFPA, 1994:25). This statement is however supported, because all the respondents in this study, who conceived while still at school, had to drop out due to pregnancy. They reported to have been exposed to some form of family life education in subjects like biology and science at school.

- Respondents in this study suggested that male adolescents should also be educated because, more often than not, they are the ones who initiate sexual relations. Sometimes they even coerce the female into having sexual intercourse. It is therefore important that adolescent males should understand the consequences, for both themselves and their sex partners, before choosing to become sexually active. This could be achieved through sex counseling for male adolescents. The use of peer group discussions and educational video's (for example) could be of help in this case. By indicating the risks, and the consequences of adolescent pregnancy to boys, they might be discouraged from becoming sexually active, or may be motivated to take the necessary precautions to avoid the emotional trauma attached to unwanted pregnancy.

- Family life education should also be introduced to teachers training programs, because teachers are the ones who teach students at school.

- It is also important that adolescents should be taught life skills like problem-solving, communication and decision-making skills to empower them to make the correct decisions regarding their lives.

4.4.1.1.2 Introduction of adolescent friendly reproductive health services

- Health personnel in most health care services in Lesotho, according to MOHSW (1993:85), lack training on adolescent fertility management services. Adolescents also do not want to be seen or known to use contraceptives. Hence the recommendation is to have adolescent fertility management services available at schools, where they are presently not available. This would enable adolescents to use such services freely. Health personnel should be trained (for example, through in-service education) on providing adolescent fertility management services at clinics and in schools. Other people who work with adolescents should also be involved in the training (like social workers).

- Adolescents should be advised to go to the outpatient department or to the clinic for confirmation and counseling if they suspect that they are pregnant.

4.4.1.2 During pregnancy

The midwife has an important role to play in the prevention of psychological consequences associated with pregnancy and childbirth in adolescents.

- Respondents in this study showed concern over their ability to fulfil their future maternal role. Prenatal education should therefore provide anticipatory guidance related to maternal role issues and increase knowledge about effective mother-infant interactions. It should facilitate the adolescent's completion of Rubin's (1984) four maternal tasks of pregnancy:
  - identification of the complexities of motherhood;
  - development of attachment to the unborn infant;
  - gaining acceptance of the child by significant others; and
  - ensuring physical well-being of self and baby (Lesser *et al.,* 1998:10).

- Activities could include:
  - fetal awareness exercises (like noticing fetal movements. One of the respondents in this study said she felt happy when the baby moved);
  - discussions of feelings and expectations about the mothering role;
  - discussions regarding fetal development, nutrition, labour and birth;
  - peer group discussions could help pregnant adolescents to learn from and support each other; and
  - Colucciello (1998:16) suggests that midwives should develop visual aids that are attractive, bright in colour, contain more pictures than words and are kinesthetic in nature. These visual instructional processes regarding fetal characteristics including movement, heart beat, and developmental capabilities should be incorporated in pregnant adolescents educational programs.

- Midwives should identify pregnant adolescents who are already suffering from depression or other psychosocial problems and encourage them to seek counseling prior to the birth of their baby, before they experience the added stresses inherent in new motherhood. Quinlivan, Petersen and Gurrin (1999:865) maintain that failure of the midwife to identify psychosocial and other problems during the antenatal period could result in missed opportunities for positive intervention. They also state that these problems are common in adolescents. Therefore intervention is required to offer adolescent women alternative foundations upon which to base their mothering skills.

- Fathers of the babies of pregnant adolescents should be included, where possible, in the ongoing care of the mother and baby.

4.4.1.3 After delivery

- Role play and group discussions should be used to enhance attainment of maternal role by adolescent mothers.

4.4.2 Counseling program

The nurse is often the person who informs the adolescent that she is pregnant. It was also the case with respondents in this study. The nurse must not only disregard her own feelings and values about adolescents being sexually active; she must also not allow these to interfere with her role as a counselor.

Many adolescents become mothers not only before they have reached the legal age of consent for sexual intercourse (16 years) (MOHSW/WHO/UNFPA, 1994:15), but also while they are still children themselves.

4.4.2.1 Points to consider when counseling pregnant adolescents who

- Seek abortion
  - religion
  - guilt
  - age of adolescent
  - goals already set
  - educational level at present
  - length of pregnancy
  - own decision or forced
  - acceptance back into the family and society
  - effects on relationship
  - health risks
  - fertility risks
  - not legal in Lesotho
  - report to medical doctor or casualty (if she decides to perform an illegal abortion)

- Opt for marriage
  - length of relationship
  - age of both parties
  - present educational level
  - employment prospects
  - where to live once married
  - parents' support
  - financial implications
  - risk of divorce
  - loss of friends
  - goals already set
  - forced or mutual decision

- Want to remain a single parent
  - age
  - present educational level
  - job opportunities
  - parents' support
  - financial implications
  - where to live
  - child care while working/going to school
  - marriage prospects
  - risk of child abuse
  - goals already set
  - reaction of family and friends (Greathead, 1988:28)

- Many adolescents opt for abortion to *"save the family name"*, to protect the boyfriend, or in some cases even to keep the boyfriend. Some opt for abortion in the belief that nobody will know and therefore they are safe. Many adolescents also do not report to doctors or casualty departments after illegal abortions, for fear of prosecution. This fear needs to be allayed as the primary aim of medical personnel is preservation of life, and the incident will not be reported. It is imperative that adolescents be encouraged to report to a medical doctor after an abortion, to attempt to reduce the hazardous side-effects (Greathead, 1988:21; UNFPA, 1996:41).

- Too often, the adolescent father is ignored in decision-making. He is just made to face the blame for pregnancy attributed to him by the mother's angry parents. This might lead to the development of feelings of isolation and/or possible psychiatric problems. His feelings are seldom considered, nor are his wishes consulted, though he is a *"responsible"* party. Too often, he himself is so confused that he expresses the desire to do as the adolescent mother decides without actually thinking about matters (Moore & Rosenthal, 1993:162). Only by recognising that young fathers need

support in the same way that young mothers do, are health professionals in Lesotho likely to reduce the number of absent fathers in these young families. The same counseling guidelines for the adolescent mother should be used for the adolescent father. Ideally, counseling should include both adolescent parents, wherever possible. Whatever option that is eventually chosen, will affect both of them.

- Pregnant adolescents are often in conflict with their mothers, yet still value them as an important source of support. For this reason, it may be appropriate to involve the adolescent's mother directly in counseling sessions. When it is not possible, or desirable, to include the adolescent's mother, the nurse should still try to assist the adolescent in seeking support from her family or other members of her informal support network.

- Counseling services for pregnant adolescents should be provided by someone who has an interest in helping the youth. Not only skills matter here, but interest also. This will help the counselor not only to disregard her/his own feelings and values about adolescents being sexually active, but also not to allow these to interfere with her/his role as counselor.

- Every pregnant adolescent who comes to the clinic or outpatient department should receive or be referred for counseling.

4.4.3 Research

It is worth noting that the researcher could hardly recruit subjects for the study in the rural clinics of Maseru that were sampled for this study. Such clinics are Semonkong, Ramabanta and Likalaneng clinics. It is, however, also interesting to note that there were many pregnant adolescents aged (15 to 19) in the above-mentioned clinics, who were attending the antenatal clinic

during the data collection phase of this study (June to first week of August 2000). But they were married. This suggests that early marriages are common. Most of them were married for less than six months. The researcher therefore recommends that more research should be done on:

- The factors that influence the pregnant adolescent's decision to get married.

- The experiences of motherhood by unmarried adolescents in Lesotho.

- Evaluating family life education program in schools.

4.5 LIMITATIONS OF THE STUDY

- Since the data for this study were collected during winter, cold weather and snowfall hindered access to potential subjects in some clinics.

- Translation of the interview tapes from Sesotho to English may have resulted in loss of information, although the researcher (who was the translator) is fluent in both languages.

4.6 CONCLUSION

Based on the above information, it may be safely concluded that the purpose of this study has been achieved. Recommendations have been made.

ABSTRACT

The transition to motherhood is accompanied by a number of social and psychological consequences that place pregnant adolescents at risk in terms of later life adjustment. A qualitative study was undertaken to explore and describe the experiences of pregnant unmarried adolescents in Maseru district; and if necessary, to develop guidelines for an educational and counseling program for them. Pregnant unmarried adolescents, aged 13 to 19 years, from 10 randomly selected clinics in Maseru, were allowed to give detailed descriptions of their experiences with their first pregnancy. The meanings that those experiences had for them were also explored. Sixteen individual phenomenological and two focus group interviews were conducted. Tesch's (1990) method of analysis was used to analyse the data.

Results: The respondents reported to have met the confirmation of their pregnancy with a mixture of disbelief, confusion and shame. They also experienced fear to disclose the pregnancy to their next of kin. Emotionally they reacted with misery, depression and anger. They experienced rejection and scorn by their families and friends. Although most respondents' pregnancy was later accepted by parents, support granted was mainly material with minimal social support. The majority of their boyfriends were reported to have denied parentage. All respondents who were still in school had to drop out. Guidelines for an educational and counseling programs were made. Recommendations included: every pregnant adolescent who comes to the clinic or outpatient department should receive or be referred for counseling. Prenatal education should provide anticipatory guidance related to maternal role issues.

SAMEVATTING

Die oorskakeling na moederskap is vergesel deur verskeie sosiale en sielkundige gevolge wat swanger adolessente onder risiko plaas in terme van latere lewensaanpassing. 'n Kwalitatiewe studie is onderneem om die ervaringe van swanger ongetroude adolessente in Maseru te ondersoek en beskryf; en, indien nodig, om riglyne te ontwikkel vir 'n opvoedkundige en beradingsprogram vir hierdie adolessente. Swanger ongetroude adolessente, tussen die ouderdom van 13-19 jaar, is uit 10 klinieke in Maseru gekies en toegelaat om 'n gedetailleerde beskrywing van die ervaring met hulle eerste swangerskap te gee. Die betekenis wat hierdie ervaring vir hulle gehad het is ook ondersoek. Sestien individuele fenomenologiese en twee fokus groepe is ondervra. Tesch se metode van analise is gebruik om die data te analiseer.

Resultate: Die proefpersone het rapporteer dat hulle die bevestiging van hulle swangerskap met 'n kombinasie van ongeloof, verwarring en skaamte ontvang het. Hulle het ook vrees ervaar om hulle naasbestaandes in te lig oor die swangerskap; saam met gevoelens van ellende, depressie en woede. Meeste proefpersone is aanvaar deur hulle ouers en materiële en sosiale ondersteuning is voorsien deur familie en vriende. Die meerderheid van die mans het vaderskap ontken. Alle proefpersone wat nog op skool was, moes die instansie verlaat. Riglyne is voorsien vir opvoedkundige en beradingsprogramme is ontwikkel. Aanbevelings sluit in: Elke swanger adolessent wat na die kliniek of buitepasiënt departement kom, moet berading ontvang, of vir berading verwys word. Prenatale opvoeding moet vooruitlopende leiding bied ten opsigte van die moederlike rol.

KAKARETSO

Ho ba Motsoali, u sa rena, u sa nyaloa, ebile u sa le monyane lilemong, ho ka ama bophelo esita le kelello ea mocha 'me hoa tlisa litla-morao tse bosula bokamosong ba hae. Liphuputso li ile tsa etsoa litsing tse leshome tsa bophelo seterekeng sa Maseru tse khethiloeng ka lotho, 'me li etsoa holim'a baroetsana ba ithoetseng ba le banyane lilemong (13 ho isa ho 19). Sepheo e ne e le ho fuputsa ka mathata le manolo ao bakhachane bana ba kopaneng le oona bokhachaneng ba bona. Liphuputso tse tebileng li ile tsa etsoa ka bakhachane ba leshome le metso e tšeletseng e le ka bo-mong, ha ba bang e ne e le ka lihlopha tse peli. Mokhoa oa Tesch (1990) o ile oa sebelisoa ho manolla liphuputso. Sephetho: Bakhachane ba hlalositse ha ba ile ba apareloa ke tšoabo, mesarelo esita le ho koatela ketsahalo eo ea ho-ba bakhachane ba sa rera. Ho feta moo, ba ile ba eba le tšabo ea ho tsebahatsa bokhachane ba bona ho ba lelapa esita le metsoalle. Sethathong ha ba ea ka ba fumana tšehetso ho tsoa ho malapa a habo bona le metsoalle. Empa ha nako e ntse e e-ea batsoali ba bang ba ile ba amohela bokhachane ba barali ba bona, 'me ba ba thusa ka tse hlokahalang. Boholo ba bahlankana ba sentseng baroetsana bana, ba hanne ho nka boikarabello ketsahalong ena. Baroetsana ba neng ba ntse ba le sekolong nakong eo ba imang, ba ile ba tlameha ho se tlohela. Ho ipapisitsoe le sephetho sena ho entsoe likhothaletso tse kenyeletsang hore bakhachane ba ntseng ba le banyane lilemong ba fuoe likeletso, likhothaletso le tataiso e hlokahalang ho ba thusa ho iketsetsa liqeto malebana le bokhachane ba bona, esita le ho ba thusa hore e be bomme ba sebele.

REFERENCES

ALPERS, R.R. 1998. The changing self-concept of pregnant and parenting teens. *Journal of Professional Nursing*, Mar./Apr., 14(2):111-118.

AN ADVERTISING RRESEARCH FFOUNDATION. 1992. *Understanding qualitative research.* Research Reference Series Book. New York: Advertising Research Foundation.

ARTHUR, D. 1999. Assessing nursing student's basic communication and interviewing skills: The development and testing of a rating scale. *Journal of Advanced Nursing*, 29(3):658-665.

BECK, C.T. 1996. Postpartum depressed mothers' experiences interacting with their children. *Nursing Research*, Mar./Apr., 45(2):98-103.

BERG, B.L. 1995. *Qualitative research methods for the social sciences.* 2nd ed. London: Allyn & Bacon.

BLOOM, K.C. 1998. Perceived relationship with the father of the baby and maternal attachment in adolescents. *Journal of Obstetric, Gynaecologic and Neonatal Nursing*, July/Aug., 27(4):420-430.

BLOOM, K.C. & HALL, D.S. 1999. Pregnancy wantedness in adolescents presenting for pregnancy testing. *The American Journal of Maternal-Child Nursing*, Nov./Dec., 24(6):296-300.

BUREAU OF STATISTICS. 1996. *Population census.* Lesotho: Ministry of Central Planning.

BUREAU OF STATISTICS. 1998. *Health facilities in Lesotho.* Lesotho: Ministry of Central Planning.

BURNARD, P. & MORRISON, P. 1990. *Nursing research in action.* London: MacMillan.

BURNS, N. & GROVE, S.K. 1997. *The practice of nursing research. Conduct, critique and utilisation.* 2nd ed. Philadelphia: W.B. Saunders Co.

CLARKE, A. 1999. Qualitative research: Data analysis techniques. *Professional Nurse*, May, 14(8):531-533.

CLIFFORD, J. & BRYKCZYNSKI, K. 1999. Giving voice to childbearing teens: Views on sexuality and the reality of being a young parent. *The Journal of School Nursing*, Feb., 15(1):4-15.

COLUCCIELLO, M.L. 1998. Pregnant adolescents' perceptions of their babies before and after realtime ultrasound. *Journal of Psychosocial Nursing and Mental Health Services*, Nov., 36(11):12-19.

CONNELLY, C.D. 1998. Hopefulness, self-esteem and perceived social support among pregnant and non-pregnant adolescents. *Western Journal of Nursing Research*, Apr., 20(2):195-209.

CRESWELL, J.W. 1994. *Research design. Qualitative and quantitative approaches.* London: Sage Publications.

CUTCLIFFE, J.R. 1999. Qualified nurses' lived experience of violence perpetrated by individuals suffering from mental health problems: A hermeneutic study. *International Journal of Nursing Studies*, 36(1999):105-116.

DE VISSER, J.E. & LE ROUX, T. 1996. The experience of teenage pregnancy in Knoppieslaagte. *South African Journal of Sociology*, Aug., 27(3):98-105.

FICHARDT, A.E., VAN WYK, N.C. & WEICH, M. 1994. The needs of postpartum women. *Curationis*, 17(1):15-21.

GARRETT, S.C. & TIDWELL, R. 1999. Differences between adolescent mothers and non-mothers. An Interview Study. *Adolescence*, 34(133):91-105.

GREATHEAD, E. 1988. The dilemma of the pregnant teenager. *Nursing RSA*, Oct., 3(10):20-28.

GUIJARRO, S., NARANJO, J., PADILLA, M., GUTIEREZ, R., LAMMERS, C. & BLUM, R.W. 1999. The risk factors associated with adolescent pregnancy: Study of a group of adolescent girls and their families in Ecuador. *The Journal of Adolescent Health*, Aug., 25(2):166-172.

HENDERSON, L.R. 1999. A survey of teenage pregnant women and their male partners in the Grampian region. *The British Journal of Family Planning*, Oct., 25(3):90-92.

HOLSTEIN, J.A. & GUBRIUM, J.F. 1995. *The active interview. Qualitative research methods series 37.* London: Sage Publications.

HOPKINSON, J.B. 1999. A study of the perceptions of hospice day care patients: My phenomenological methodology. *International Journal of Nursing Studies*, 36(1999):203-207.

IVEY, J.B. 1999. "Good little girls": Reports of pregnant adolescents and those who know them best. *Issues in comprehensive Paediatric Nursing*, Apr.-Sept., 22(2-3):87-100.

JACOBSON, G. 1994. The meaning of stressful life experiences in nine to eleven year old children: A phenomenological study. *Nursing Research*, Mar./Apr., 43(2):95-99.

JOSEPH, D.H., GRIFFIN, M. & SULLIVAN, E.D. 2000. Video-taped focus groups: Transforming a therapeutic strategy into a research tool. *Nursing Forum*, Jan.-Mar., 35(1):15-20.

KAPLAN, H.I. & SADOCK, B.J. 1998. *Synopsis of psychiatry. Behavioural sciences/clinical psychiatry.* 8th ed. Philadelphia: Lippincott Williams & Wilkins.

KATHRYN, A. 1994. Adolescent mothers: Caregiving, approval and family functioning. *Journal of Obstetric, Gynaecologic and Neonatal Nursing*, Nov./Dec., 23(9):791-797.

KEKESI, J. & DE VILLIERS, F.P.R. 1999. Characteristics of teenage mothers delivering at Ga-Rankuwa Hospital. *The Medicine Journal*, Aug., 41(3):40-44.

KIMANE, I., MOLISE, N.M. & NTIMO-MAKARA, M. 1999. *Soicio-cultural phenomena related to population and development in Lesotho.* Unpublished study.

KLEIN, T.M. 1998. Adolescent pregnancy and loneliness. *Public Health Nursing*, Oct., 15(5):338-347.

KREFTING, L. 1991. Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, Mar., 45(3):214-222.

KRUGER, D. 1988. *An introduction to phenomenological psychology.* 2nd revised ed. Cape Town: Juta & Co., Ltd.

LEININGER, M.M. 1985. *Qualitative research methods in nursing.* London: B. Saunders Co.

LESSER, J., ANDERSON, N.L.R. & KONIAK-GRIFFIN, D. 1998. "Sometimes you do not feel ready to be an adult or a mon": The experience of adolescent pregnancy. *Journal of Child and Adolescent Psychiatry*, Apr., 11(1):7-15.

LESSER, J., KONIAK-GRIFFIN, D. & ANDERSON, N.L. 1999. Depressed adolecent mothers' perceptions of their own maternal role. *Issues in Mental Health Nursing*, Mar./Apr., 20(2):131-149.

LETUKA, P., MAMASHELA, M., MATASHANE-MARITE, K., MOROLONG, B.L. & MOTEBANG, M.S. 1998. *Family belonging for women in Lesotho.* Morija. Lesotho: Women and Law in Southern African Research Trust.

LI, Y.T., YIN, C.S. & CHAN, C.C. 1999. Psychosocial risk factors of teenage pregnancy in eastern Taiwan. *Chung hwa-I-hsueh Tsa Chih*, July, 62(7):425-430.

LINCOLN, Y.S. & GUBA, E.G. 1985. *Naturalistic inquiry.* London: Sage Publications.

MASSEY, V.H. 1995. *Nursing research. Springhouse notes.* 2nd ed. Pennsylvania: Spring House Corporation.

MATEO, M.A. & KIRCHHOFF, K.T. 1991. *Conducting and using nursing research in the clinical setting.* Baltimore: Williams & Wilkins.

MAXWELL, J.A. 1996. *Qualitative research design. An interactive approach. Applied social research methods series volume 41.* London: Sage Publications.

McCULLOUGH, M. & SCHERMAN, A. 1998. Family of origin interaction and adolescent mothers' potential for child abuse. *Adolescence* 33(130):375-384.

MINISTRY OF ECONOMIC PLANNING. 1997. *Sixth National Development Plan 1996/97-1998/99.* Maseru.

MINISTRY OF HEALTH AND SOCIAL WELFARE. 1993. *Rapid evaluation of maternal child health services in Lesotho.* In collaboration with WHO, UNICEF, UNFPA & UNDP, September.

MINISTRY OF HEALTH AND SOCIAL WELFARE. 1997. *National adolescent health promotion and development program for Lesotho.* In collaboration with WHO, October.

MINISTRY OF HEALTH AND SOCIAL WELFARE. 1994. *Young peoples health and development in Lesotho.* In collaboration with WHO & UNFPA, December.

MINISTRY OF INTERIOR. 1990. *Maseru development plan 2: Development proposals.* Lesotho: Physical Planing Division.

MOORE, S. & ROSENTHAL, D. 1993. *Sexuality in adolescence*. London: Routledge.

MORGAN, D.L. 1997. *Focus groups as qualitative research*. 2nd ed. New Delhi: Sage Publications.

MORSE, J.M. 1991. *Qualitative nursing research. A contemporary dialogue*. Revised ed. London: Sage Publications.

MORSE, J.M. 1995. *Critical issues in qualitative research*. California: Sage Publications Inc.

MUTUNGI, A.K., KARANJA, J.G., KIMANI, V.N., ROGO, K.O. & WANGO, E.O. 1999. Abortion: Knowledge and perceptions of adolescents in two districts in Kenya. *East African Medical Journal*, 76(10):556-561.

NEUMAN, W.L. 1997. *Social research methods. Qualitative and quantitative approaches*. 3rd ed. London: Allyn and Bacon.

PADGETT, D.K. 1998. *Qualitative methods in social work research. Challenges and rewards*. London: Sage Publications.

PAREKH, A. & DE LA REY, C. 1997. Intra-group accounts of teenage motherhood: A community based psychological perspective. *South African Journal of Psychology*, Dec., 27(4):223-229.

PARSE, R.R., COYNE, A.B. & SMITH, M.J. 1985. *Nursing research qualitative methods*. Maryland: Brady Communications Co.

PINTO, E. & SILVA, J.L. 1998. Pregnancy during adolescence: Wanted vs. unwanted. *Internatioinal Journal of Gynaecology and Obstetrics*, Dec., 63(suppl 1):5 for she 151-5156.

POLIT, D.F. & HUNGLER, B.P. 1991. *Nursing research. Principles and methods*. 4th ed. Philadelphia: J.B. Lippincott Co.

PONIRAKIS, A., SUSMAN, E.J. & STIFTER, C.A. 1998. Negative emotionality and cortisol during adolescent pregnancy and its effects on infant health and autonomic nervous system reactivity. *Developmental Psychology*, Sept., 33(2):163-174.

POWNEY, J. & WATTS, M. 1987. *Interviewing in educational research*. London: Routledge & Kegan Paul.

QUINLIVAN, J.A., PETERSEN, R.W. & GURRIN, L.C. 1999. Adolescent pregnancy: Psychopathology missed. *The Australian and New Zealand Journal of Psychiatry*, Dec., 33(6):864-868.

RENKER, P.R 1999. Physical abuse, social support, self-care and pregnancy outcomes of older adolescents. *Journal of Obstetric, Gynaecologic and Neonatal Nursing*, July-Aug., 28(4):377-388.

RIESSMAN, C.K. 1993. *Narrative analysis. Qualitative research methods series 30*. London: Sage Publications.

ROBERTSON-MALT, S. 1999. Listening to them and reading me: A hermeneutic approach to understanding the experience of illness. *Journal of Advanced Nursing*, 29(2):290-297.

ROBINSON, N. 1999. The use of focus group methodology with selected examples from sexual health research. *Journal of Advanced Nursing*, 29(4):905-911.

SEIDMAN, I.E. 1991. *Interviewing as qualitative research. A guide for researchers in educational and social sciences*. New York: Teachers College, Columbia University.

SKINNER, J.D., POPE, J.F. & CARRUTH, B.R. 1998. Alterations in adolescents' sensory taste preferences during and after pregnancy. *The Journal of Adolescent Health*, Jan., 22(1):43-49.

SMITH, M.M. & GRENYER, B.F. 1999. Psychosocial profile of pregnant adolescents in a large Australian regional area. *The Australian Journal of Rural Health*, Feb., 7(1):28-33.

SOUTH AFRICAN SOCIETY FOR NURSING RESEARCHERS. 1996. Ethical standards for nurse researchers. *Curationis*, Mar., 19(1):74-75.

STEVENSON, W., MATON, K.I. & TETI, D.M. 1998. School importance and dropout among pregnant adolescents. *The Journal of Adolescent Health*, May, 22(5):376-382.

STEVENSON, W., MATON, K.I. & TETI, M. 1999. Social support, relationship quality and well-being among pregnant adolescents. *Journal of Adolescence*, Feb., 22(1):109-121.

STEWARD, D.W. & SHAMDASANI, P.N. 1990. *Focus groups. Theory and practice*. New Delhi: Sage Publications.

SWEET, B.R. & TIRAN, D. 1997. *Maye's midwifery. A textbook for midwives.* 12th ed. London: Baillière Tindall.

TEAGLE, S.E. & BRINDIS, C.D. 1998. Perceptions of motivators and barriers to public prenatal care among first time and follow-up adolescent patient and their providers. *Journal of Maternal-Child Health*, Mar., 2(1):15-24.

TESCH, R. 1990. *Qualitative research analysis types and software tools.* New York: The Falmer Press.

THOMPSON, D. 1996. *The Oxford dictionary of current English.* Revised 2nd ed. Oxford: Oxford University Press.

UNITED NATIONS POPULATION FUND (UNFPA). 1996. *Programme review and strategy development report.* In collaboration with the Lesotho Government, October.

UYS, H.H.M. & BASSON, A.A. 1991. *Research methodology in nursing.* Pretoria: Kagiso Tertiary.

WAGNER, K.D., BERENSON, A., HARDING, O. & JOINER, T. 1998. Attributional style and depression in pregnant teenagers. *The American Journal of Psychiatry*, Sept., 155(9):1227-1233.

WANG, C.S. & CHOU, P. 1999. Characteristics and outcomes of adolescent pregnancies in Kaohsiung country, Taiwan. *Journal of the Formosan Medical Association*, Jun., 98(6):415-421.

WATT, J.H. & VANDENBERG, S.A. 1995. *Research methods for communication science.* London: Allyn & Bacon.

WILLIAM, C. & VINES, S.W. 1999. Broken past, fragile future: Personal stories of high risk adolescent mothers. *Journal of the Society of Paediatric Nurses*, Jan.-Mar., 4(1):15-23.

WILSON, H.S. 1989. *Research in nursing*. 2nd ed. California: Addison-Wesley Publishing Co.

WINCHESTER, H.P.M. 1996. Ethical issues in interviewing as a rsearch method in human geography. *Australian Geographer*, 27(1):117-131.

WORLD HEALTH ORGANISATION. 1998. *Safe motherhood*. Geneva: Reproductive Health Divison, April.

YARCHESKI, A., SCOLOVENO, M.A. & MAHON, N.E. 1994. Social support and well-being in adolescents: The mediating role of hopefulness. *Nursing Research*, Sept./Oct., 43(5):288-292.

ANNEXURE A

P.O. Box 1670
Maseru
100
LESOTHO

The Director of Health Services
Ministry of Health
P.O. Box 514
Maseru
100
LESOTHO

Dear sir/madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I kindly request permission to conduct research in the government clinics that are within the Maseru district. The research is on the *"Experiences of pregnant unmarried adolescents in Maseru"*. I am currently pursuing my masters degree in Nursing Science at the University of the Orange Free State and this research will be conducted in fulfillment of the above-mentioned degree.

A copy of the research proposal will be sent to you for review as soon as it has been approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Orange Free State.

Your usual co-operation and assistance will be appreciated.

Yours faithfully

.....

Tjoetso V. Lehana

ANNEXURE B

P.O. Box 1670
Maseru
100
LESOTHO

The Director
Christian Health Association of Lesotho
P.O. Box 1632
Maseru
100
LESOTHO

Dear sir/madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I kindly request permission to conduct research in the government clinics that fall under the Christian Health Association of Lesotho in the Maseru district. The research is on the *"Experiences of pregnant unmarried adolescents in Maseru"*. I am currently pursuing my masters degree in Nursing Science at the University of the Orange Free State. This research will be conducted in fulfillment of the above-mentioned degree.

A copy of the research proposal will be sent to you for review as soon as it has been approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Orange Free State.

Your usual co-operation and assistance will be appreciated.

Yours faithfully

.....

Tjoetso V. Lehana

ANNEXURE C

THE UNIVERSITY OF THE ORANGE FREE STATE

Office of the Director : Administration
Faculty of Health Sciences

✉ · 339 BLOEMFONTEIN 9300 REPUBLIC OF SOUTH AFRICA
☎ (051) 401-3013 / 401-2847 TELEFAX (051) 444 3103 SA

Enquiries:

Mrs Niemand Tel 4053004 18th April 2000

ME T V LEHANA
SCHOOL OF NURSING
UNIVERSITY OF THE ORANGE FREE STATE
BLOEMFONTEIN

Dear Me Lehana

ETOVS NR 75/00
RESEARCHER: ME T V LEHANA
PROJECT TITEL: EXPERIENCES OF PREGNANT UNMARRIED ADOLESCENTS IN MASERU, LESOTHO.

The abovementioned study was approved by the Ethics Committee during their meeting held on the 18th April 2000.

Your attention is kindly drawn to the requirement that a progress report be presented not later than one year after approval of the project.

Will you please quote the Etovs number as indicated above in subsequent correspondence, reports and enquiries.

Yours faithfully

For DIRECTOR: MEDICINE ADMINISTRATION

ANNEXURE D

LESOTHO

Ministry of Health
And Social Welfare,
P.O. Box 514,
Maseru - 100.
30 May 2000.

Ms. Tjoetso V. Lehana,

Re: Request for Permission for Conducting a Study on the Experience of Pregnant and Unmarried Adolescents in Maseru

Thank you for your letter requesting that you conduct the above-indicated study in fulfillment of your M. Soc. Sc Nursing degree research.

I am glad to inform you that you may go ahead with your research, observing the ethical issues as per your proposal, and in consultation with the relevant government and other authorities.

The ministry also requests that you avail the Family Health Division/Reproductive Health Programme of a copy of your report, at the end.

Thank you.

Yours Sincerely,

Dr. M. M. Moteetee
Director PHC

16/06/00
Please discuss with respective
HSAS and H/C

Cc: Dr. T. Ramatlapeng, DGHS
Mrs. Nchee, Executive Secretary CHAL
Ms. L. Makoae, Research Coordinator
Mr. B. Majara, Head FHD a.i

ANNEXURE E

INDIVIDUAL INTERVIEWS
Consent form

STUDY TITLE: **The experiences of pregnant unmarried adolescents in Maseru**

RESEARCHER: **T. Lehana (M.Soc.Sc. Nursing student)**

Mrs. Lehana is studying the experiences of pregnant unmarried adolescents in relation to their first pregnancy in order to develop guidelines for an educational and counseling program for pregnant adolescents if necessary. Although this study will not benefit you directly, it will provide information that will assist midwives to focus the objectives of the program towards helping the pregnant adolescents into becoming healthy mothers with healthy infants.

The study has been approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Orange Free State and the Director General of the Ministry of Health in Lesotho. The study procedure involves no foreseable risks or harm to you or your family, as it only involves responding to questions on your experiences of pregnancy in an interview that will take about 30 minutes. If you have any questions about the study or being the subject you are free to call Mrs. Lehana at 865116.

Your participation in this study is voluntary and you have the right to withdraw at any time and your antenatal care at the clinic will not be affected. The study data will be coded so they will not be linked to your name and your identity will not be revealed at any stage of the study. No unauthorised persons will have access to collected data.

I have read this consent form and I voluntarily consent to participate in this study.

Subject's signature	**Date**	**Parent/ Guardian (if appropriate)**	**Date**	**Relationship to subject**

I have explained this study to the above subject and have sought her understanding for informed consent.

Researcher's signature	**Date**

TUMELLANO EA HO NKA KAROLO LIPHUPUTSONG

SEHLOHO: **Mathata le manolo ao bakhachane ba lilemong tse lipakeng tsa l3 le 19 ba kopanang le oona ka bokhachane ba pele**

RALIPHUPUTSO: **'M'e TJOETSO LEHANA (Moithuti-Unifesiting ea Free State)**

'M'e Lehana o etsa liphuputso le boithuto ka mathata le manolo ao bakhachane ba ntseng ba le banyane lilemong (13-19) ba sa nyaloang ba kopanang le oona ka bokhachane ba pele. Sena se tla thusa hore ho thehoe lekalana le tla sebetsana le bacha ba bakhachane le ho matlafatsa litsebeletso tse fuoang bakhachane ho ba thusa hore e be bo'm'e ba kamoso ba phetseng hantle le masea a bona. Sephetho sa liphuputso tsena ha se na ho sebelisoa hona joale bokhachaneng ba hao, empa bakhachaneng ba tlang kaha ho tla nka nakoana ho theha lekalana lena.

Liphuputso tsena li etsoa tlasa botataisi ba unifesiti ea Free State moo Raliphuputso e leng moithuti teng 'me li amohetsoe ke lekala la Bophelo la 'muso oa Lesotho. Liphuputso tsena ha li na kotsi ea letho ho uena kapa ba lelapa la hao kaha u kopuoa ho fana ka mathata le manolo ao u kopaneng le oona bokhachaneng bona ba pele feela, lipuisanong tse tla nka metsotso e ka bang mashome a mararo le Raliphuputso. Ha u batla tlhakisetso ka liphuputso tsena u ka letsetsa 'm'e Lehana nomorong ena ea mohala 865116, 'me o tla araba lipotso tsohle.

U na le tokelo ea ho ikhethela ho nka karolo kapa ho se nke karolo kapa ho tlohela ha nka karolo liphuputsong tsena ka hara nako, 'me litsebeletso tsohle tseo o ntseng o li fumana setsing sa bophelo li keke tsa angoa ke qeto eo ea hao. Litaba tsohle tsa liphuputso tsena e tla ba pinyane 'me lebitso la hao le keke la sebelisoa kapa hona ho amahangoa le litaba tsa liphuputso tsena.

Ke balile litaba tsa tokomane ena 'me ke ikhethela ho nka karolo liphuputsong tsena.

Tekeno ea setho	**Let-satsi**	**Motsoali/ 'Maballi (ha ho hlokahala**	**Let-satsi**	**Kamano le setho**

Ke hlaloselitse setho se kaholimo litaba tsohle tsa liphuputso tsena 'me o utloisisitse.

Tekeno ea Raliphuputso	**Letsatsi**

ANNEXURE F

FOCUS GROUP INTERVIEWS
Consent form

STUDY TITLE: **The experiences of pregnant unmarried adolescents in Maseru**

RESEARCHER: **T. Lehana (M.Soc.Sc. Nursing student)**

Mrs. Lehana is studying the experiences of pregnant unmarried adolescents in relation to their first pregnancy in order to develop guidelines for an educational and counseling program for pregnant adolescents if necessary. Although this study will not benefit you directly, it will provide information that will assist midwives to focus the objectives of the program towards helping the pregnant adolescents into becoming healthy mothers with healthy infants.

The study has been approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Orange Free State and the Director General of the Ministry of Health in Lesotho. The study procedure involves no foreseable risks or harm to you or your family, as it only involves responding to questions on your experiences of pregnancy in an interview that will take about 30 minutes. If you have any questions about the study or being the subject you are free to call Mrs. Lehana at 865116.

Your participation in this study is voluntary and you have the right to withdraw at any time and your antenatal care at the clinic will not be affected. The study data will be coded so they will not be linked to your name and your identity will not be revealed at any stage of the study. No unauthorised persons will have access to collected data.

I have read this consent form and I voluntarily consent to participate in this study. I also affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this group interview. I agree not to talk about material relating to this study or interview with anyone outside of my fellow focus group members and the researcher.

_____ _____

Subject's signature **Date**

I have explained this study to the above subject and have sought her understanding for informed consent.

_____ _____

Researcher's signature **Date**

TUMELLANO EA HO NKA KAROLO LIPHUPUTSONG

SEHLOHO: **Mathata le manolo ao bakhachane ba lilemong tse lipakeng tsa l3 le 19 ba kopanang le oona ka bokhachane ba pele**

RALIPHUPUTSO: **'M'e TJOETSO LEHANA (Moithuti-Unifesiting ea Free State)**

'M'e Lehana o etsa liphuputso le boithuto ka mathata le manolo ao bakhachane ba ntseng ba le banyane lilemong (13-19) ba sa nyaloang ba kopanang le oona ka bokhachane ba pele. Sena se tla thusa hore ho theoe lekalana le tla sebetsana le bacha ba bakhachane le matlafatsa litsebeletso tse fuoang bakhachane hore e be bo'm'e ba kamoso ba phetseng hantle le masea a bona. Sephetho sa liphuputso tsena ha se na ho sebelisoa hona joale bokhachaneng ba hao, empa bakhachaneng ba tlang kaha ho tla nka nakoana hore lekalana lena le thooe.

Liphuputso tsena li etsoa tlasa botataisi ba Unifesiti ea Free State moo Raliphuputso e leng moithuti teng 'me li amohetsoe ke lekala la Bophelo la la 'muso oa Lesotho. Liphuputso tsena ha lina kotsi ea letho ho uena kapa ba lelapa la hao kaha u kopuoa ho fana ka mathata le manolo ao u kopaneng le oona bokhachaneng bona ba pele feela, lipuisanong tse tla nka metsotso e ka bang mashome a mararo le Raliphuputso. Ha u batla tlhakisetso ka lipatlisiso tsena u ka letsetsa 'm'e Lehana nomorong ena ea mohala 865116, 'me o tla araba lipotso tsohle.

U na le tokelo ea ho ikhethela ho nka karolo kapa ho se nke karolo kapa ho tlohela ha nka karolo liphuputsong tsena ka hara nako, 'me litsebeletso tsohle tseo o ntseng o li fumana setsing sa bophelo li ke ke tsa angoa ke qeto eo ea hao. Litaba tsohle tsa liphuputso tsena e tla ba pinyane 'me lebitso la hao le ke ke la sebelisoa kapa ho amahangoa le litaba tsa liphuputso tsena.

Ke balile litaba tsa tokomane ena 'me ke ikhethela ho nka karolo liphuputsong tsena. Ke boetse ke itlama ho boloka litaba tsohle tseo re tla li bua kopanong ena e le pinyane, ho se bue letho le amanang le liphuputso tsena le mang kapa mang eo e seng karolo ea liphuputso tsena.

_____ _____

Tekeno ea setho **Date**

Ke hlaloselitse setho se kaholimo litaba tsohle tsa liphuputso tsena 'me o utloisisitse.

_____ _____

Tekeno ea Raliphuputso **Date**

ANNEXURE G

PROTOCOL FOR DATA ANALYSIS

1. Get a sense of the whole. Read through all of the transcriptions carefully. Perhaps jot down some ideas as they come to mind.

2. Pick one document (one interview) – the most interesting, the shortest, the one on the top of the pile. Go through it, asking yourself, What is this about? Do not think about the "substance" of the information, but rather its underlying meaning. Write thoughts in the margin.

3. When you have completed this task for several informants, make a list of all topics. Cluster together similar topics. Form these topics into columns that might be arrayed as major topics, unique topics, and leftovers.

4. Now take this list and go back to your data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try out this preliminary organizing scheme to see whether new categories and codes emerge.

5. Find the most descriptive wording for your topics and turn them into categories. Look for reducing your total list of categories by grouping topics that relate to each other. Perhaps draw lines between your categories to show interrelationships.

6. Make a final decision on the abbreviation for each category and alphabetize these codes.

7. Assemble the data material belonging to each category in one place and perform a preliminary analysis.

8. If necessary, recode your existing data.

ANNEXURE H

TRANSCRIPTION OF INDIVIDUAL INTERVIEW 10 21/07/2000

Researcher: *"Good morning ausi." (Miss)*

Subject M10: *"Good morning 'm'e." (Mrs./mother)*

Researcher: *"How are you?*

Subject M10: *"I am fine and how are you?"*

Researcher: *"I am fine. I would like us to talk about your pregnancy. Could you tell me more about your experiences with this pregnancy from the time you realized that you were pregnant until now?"*

Subject M10: *"I suspect that I was pregnant when I missed a period. I went to the clinic to be checked. When I got there they checked my urine and it was positive. They asked me at the clinic what I am going to do now that I am pregnant. I said there is nothing I can do, I have to tell my parents. But I was afraid to tell my parents. My mother suspected something because I was uneasy. I went to my aunt's place and I told my aunt that I was pregnant and that I was afraid to tell my mother. She told her. That same day that my aunt told my mother, I did not go home. I stayed at my aunt's place, I was afraid of what my mother would say. When my aunt came back, she said that my mother*

was not happy but she said 'I have accepted it, because I already suspected it'."

"I went home. For about two days after that, my mother was still herself. She had not changed. But from the third day she changed. She did not talk to me when she came home from work, she looked angry. I told my aunt, who said that she thinks my mother is still trying to adjust to the situation, I should not take it to heart. I tried to take it easy but my mother has not changed until today. My mother does not forgive me (voice shaking) I think I have offended her (she cried. The researcher offered her a tissue to wipe off the tears, allowed her to cry and touched her. The situation was well managed)."

"I told my boyfriend that I am pregnant. At first he agreed that this was his child. But later he said the child was not his. I did not tell my mother that he said it was not his child. He said he did not want to hear that my parents have gone to his parents about this. If he could hear that, I would know how silly he is. Unfortunately he had a problem, he stole money and he was arrested. I told myself that I would go to see him in prison, I would forget what he told me about this baby because that day he was drunk."

"The surprising thing is because it is a long time now since my parents went to his parents and we still do not know what is happening. However I would not want him to marry me because of some reasons."

"At home, I am still fine. We are two children in the house. Me and my brother who cares for me and supports me very much. But my mother is angry and not happy and keeps telling me that she does not know what she is going to do with this baby. (she cried again) I sometimes ask myself why I did not abort this baby. Silence. At school I do not think that anyone knows about this pregnancy. Because it is till winter and we wear heavy clothes I do not know if they have realised already. But I intend to write the final examinations, as I have already paid the examination fee. Silence."

Researcher: *"You sometimes ask yourself why you did not abort this baby. Did it ever come to your mind?"*

Subject M10: *"Yes."*

Researcher: *"Can you tell me what happened then?"*

Subject M10: *"I went to someone whom I was told to consult if I want an abortion. But when it was my turn to go in my conscience would not allow me, I was afraid and I asked the next patient to go in, saying that I am going to the toilet, and I never came back. And from my conscience I learned that I have done a good thing by not aborting the baby. Even though it still comes to me that maybe if I could have aborted this baby, maybe my mother would not be like this to me. But I still believe that I have done the right thing. I do go to church and I pray a lot, so I believe that God will help me and this will pass."*

Researcher: *"Could you tell me more what your mother meant by 'she does not know what she is going to do with your baby'?"*

Subject M10: *"eh! I think if we were only three in the house (me, mother and my brother) things could still be okay with me. But I have a step-father who is staying with us. He gives my mother advice that I do not like, because they destroy us (me and my brother), they do not build a family."*

Researcher: *"What happens when you talk to your mother?"*

Subject M10: *"We have tried to talk to her with my brother trying to show her in a polite way what we do not like about the way she handles family matters. But these days if we request to talk to her, she does not like it, she does not even want to sit with us to talk about anything."*

Researcher: *"What do you think has caused your mother to be angry with you?"*

Subject M10: *"I think it is my pregnancy. But I could think that she should be the last one to be so angry with me, because she experienced the same thing that I am experiencing now (pregnancy outside marriage)."*

Researcher: *"Can you tell me what happened when your parents went to your boyfriend's parents."*

Subject M10: *"My brother was sent to deliver a letter to his parents. But until today there has not been any reply. But I have heard that my parents are preparing to go to his parents again."*

Researcher: *"You did say that your boyfriend did not want your parents to go to his parents. What happened when he discovered that they went?"*

Subject M10: *"He does not talk about that at all, he now has a problem that he caused himself. He is now in prison and we do not talk freely about everything there. So he has not said anything. But I think he has changed from his earlier statement when he said that he is not the father and my parents should not go to his parents."*

Researcher: *"From your observation or conversation, what can you say about your boyfriend's intention about you and the baby?"*

Subject M10: *"I really cannot say exactly what his intention is, because I am afraid to ask him certain things. I want him to initiate them and he never talks about his future and us. But in my family, I think their wish would be that he marries me but I do not want to marry him, because of what he said to me the first time and the fact that he said that baby is not his, it is mine and my mother's."*

Researcher: *"You said in the family they wish that you could marry him, who in the family is of that wish?"*

Subject M10: *"My grandmother and uncle, because I do not know where my mother stands, because she does not talk to me. As for my brother, he said it is up to me to make the correct choice, whether I do marry or do not marry him."*

Researcher: *"Can you tell me more about your brother?"*

Subject M10: *"He is the one whom I am free to talk to. He is the only one I told when my boyfriend said that this baby is not his, it is mine and my mother's. He promised to assist me even with baby's clothes if my mother hardened her heart forever."*

Researcher: *"You said you go to church. Can you tell me more about your going to church now that you are pregnant?"*

Subject M10: *"I do not go to church every Sunday, so that they would not be surprised when I do not go anymore because I think as this pregnancy advances I will no longer go to church. I will be afraid to mix with the church members in this condition. With my friends I have not told anyone, I do not know if they saw me."*

Researcher: *"Do you have any other experiences to tell me about?"*

Subject M10: *"My aunt is very close to me, she usually comes to check on me, how I am doing, but my mother does not like my closeness with my aunt. I think she believes that my aunt is going to take me away from her. So I do not bother my aunt a lot, because I do not want to cause clashes between her and my mother."*

Researcher: *"Can you tell me more about yourself before and after pregnancy?"*

Subject M10: *"At school, I have not changed, I am still brilliant. In fact I want to work harder because I will eventually have to raise my child and do everything for her. So I have to start now, working hard for her/him. At home I am trying to behave like a mature person."*

Researcher: *"What is the reason for trying to be mature at home?"*

Subject M10: *"There is one time when my mother talked to me and said I should know that I am no longer a child but a woman."*

Researcher: *"You said you do not want to marry your boyfriend because of some reasons. Could you tell me those reasons?"*

Subject M10: *"Yes, He is a type of person who wants to get whatever he wants without considering if the other person is going to be hurt or not. He makes sure he always gets what he wants. He is also rough. He does not work. He steals for a living. He is a thief."*

Researcher: *"Are there other things concerning this pregnancy that you can tell me about?"*

Subject M10: *"I wonder what they will say or do at school when they discover that I am pregnant. I think the teachers are not going to be that harsh because I am the best student in class. I am always in position one, even now. So I think the teachers will be able to help me. But as for other students, I wonder what they are going to say when they discover m pregnancy. Also my mother's attitude bothers me so much that I ask myself many questions, like will she really love my baby, will she end up buying clothes for my baby, will she help me after delivery and teach me how to care for the baby? I do not mind other people much."*

Researcher: *"Is there anything else that you still feel you can tell me about?"*

Subject M10: *"N-No."*

Researcher: *"Thank you very much for telling me about your experiences with this pregnancy. As I promised I will not use your name anywhere in this study and this information will be kept confidential. I realised that some of the experiences were painful. Would you like it if I referred you to someone whom you can talk to about your problems and see if you do not cope with them better?"*

Subject M10: *"I would like you to refer me to that person. (She was referred.)"*

ANNEXURE I

TRANSCRIPTION OF FOCUS GROUP 2

01/08/2000

Group of seven (7)

Facilitator: *"Today I would like us to talk more about your experiences with your pregnancy from the time you realised that you were pregnant until now."*

Group member: *"When I realised that I have missed a period I told my mother and she said I should go and tell my boyfriend. I told him and he said we should go to Queen E.II Hospital for confirmation. We went to Queen E.II Hospital and I was told that I am pregnant. He took my health card (Bukana) and said he was going to tell his parents. Time passed without him telling his parents. He did not tell them until I was seven months pregnant. My parents ended up going to his parents. But my mother was not rude to me and my friends kept visiting me. I was just like any other person in the family, until now nothing bad has happened to me."*

Group member: *"When I realised that I have stopped menstruating it was in December 1999, I did not observe my periods until the end of that month. I told my boyfriend about it. He took it as a joke. When he took it as a joke, I also kept quiet until I told my parents that I was pregnant. Time went by, oh, no, f-four days passed and after four days I told him that I would go to the clinic to confirm whether I am*

pregnant or I have just missed a month, because it could also happen that I have just missed a month without being pregnant."

"I went to the clinic where I was told to go to the hospital for a blood test. I went to the hospital and the blood test was done. When I came back I told him that I was told that I was pregnant and I should start attending the antenatal clinic. He accompanied me to the clinic for the successive three months and on the fourth month he changed. I told his cousin everything and his cousin told my boyfriend's aunt. The aunt told my boyfriend's father everything, but nothing happened."

"I ended up telling my parents that it looked like I was pregnant. My mother took me to the clinic for confirmation. We were told that I was pregnant and I should attend the clinic. When this happened my father was not there. When he came home he was furious and angry with me, but after some time things were well again with my father. They talk to me nicely and treat me like their child, not as someone who has done something very wrong against them. I asked them to forgive me. They are still in negotiations and preparing for that marriage of theirs. I told them that I do not want to get married now, I would still like to go to school again. That is all."

Group member: *"I did not menstruate for four months without telling anyone. On the fifth month I told my sister. She asked if it does happen that I sometimes miss so many months. I*

said no. She gave me money to come to the clinic for confirmation."

"I came to the clinic and I was told that I was pregnant. I went to tell my boyfriend. He did not reply when I told him. He did not deny anything, he agreed. My father was not there when these happened. They told my mother. My mother said she would rather tell my father in my absence because he would kill me. He was told. He did not get furious and angry with me (voice vibrated) he was told not to be rude to me because this is something that can happen to anyone. They have not gone to my boyfriend's parents, they are still preparing to go to them."

Group member: *"I missed my period in January. When I missed it I told my boyfriend that I have missed my period. He said we should wait and observe if it is not going to come in February. One of the lady teachers asked me at school whether I am still menstruating. I told her that I have missed two months. She tool me to the doctor where I was told that I was pregnant. When my mother knew, she was angry with me just like a mother would be with her daughter or child. My father swore not to do anything for me but now he does buy me those things he said he would not do for me. I have finished."*

Group member: *"I also missed my periods in the month of January. I passed standard seven last year (1999). I was sent to a dress making school. I did not know that I was pregnant. I had been dating my boyfriend for less than a month. When I told him that I have missed my periods, he said*

we should wait and watch, maybe it was just a delay. The next month it was just spotting, not my normal periods."

"My mother asked me if I was still menstruating. I told her that it was just spotting, not the normal menses. My younger sister said, it does happen sometimes without one being pregnant. I waited for the normal period, but it never came."

"Since my parents wanted me to go to a dressmaking school, my mother gave me five Rands for transport to go to school in town. But I did not go to school, I took the five Rands and came to the clinic here and related my story to the nurse here. The nurse said I should send the morning urine specimen to the hospital. I sent urine to Queen E.II hospital. I was told to go back to the clinic. I went to the dressmaking school, because I was already in town. The teacher asked where I was from. I told her I had gone for a medical check-up, she looked at my laboratory papers and realised that there was written "positive" on the results. She said 'positive' meant that I was pregnant."

"The next day we had to go on a trip to Katse Dam. The teacher said I should tell my mother to meet her before they left for Katse Dam to talk about the results. I did not believe this teacher, so I went to the clinic where the nurse told me that 'positive' meant that I was pregnant. My mother did go to my school and the teacher told her that I was pregnant, and asked whether my mother was aware of that. My mother said no. The teacher took her

privately and told her that I was pregnant. My mother asked me when we got home and I refused, saying that nothing was said to me at the Hospital. My mother took this laboratory form to ask people what 'positive' means. They told her that it meant that I was pregnant. I also told her that it was true I was pregnant and I was told to attend the antenatal clinic. My mother told my father. She took a week before telling my father, because my father is always in the shebeen. One Saturday morning she told my father. My father said I should go with my mother to my boyfriend who impregnated me. When we got to his sister's place where he stayed, we only found his sister and her husband who were already preparing to go to work. He was not there. My mother tabled the matter and I also said he is the one who impregnated me. His sister said she could not respond, she would wait for her mother when she came for Easter. Then they could respond. When his mother came, she was told everything as it was. She said she was waiting for my boyfriend's father. When his father came, his mother did not tell him anything. My father and uncle went to his father and when they got there they said 'we are here because of what your son has done, we believe you know what your son has done to our daughter'. His father said he did not know anything. When he asked his wife she said she was going to tell the relatives. My father used to take it all out on me when he was drunk. It is true he talked to me like a parent would do but every time he was drunk I would know that he would say all sorts of things. My uncle told my father to leave me alone because it had already happened, they should accept it. My mother said she had accepted already. So my father

has now stopped that behaviour, he is just a father. That is all."

Group member: *"I last menstruated in December, but I did not come to the clinic immediately. I was sick, when I was at home and when I was at school it was the same and I did not know why. My mother asked me what the matter was, I said I did not know, I was dizzy. My mother took me to the doctor where I was told that I was pregnant. I was asked who is the person who impregnated me. I told them. I was asked whether he was my boyfriend. I said "no, he was not my boyfriend". I was asked why if he was not my boyfriend that he impregnated me. I told them that he fetched me from school, he would take my school bag and my money for transport. So I would have no money for transport and was forced to go with him. I told them that he would take me to his place."*

"My father said I should tell this person that I am pregnant. I told him. When I told him he did not deny anything. He said if it is true it was him I should go and stay with him. I told him that I was told to tell him about this and not to stay with him. When I got home I told my mother that he agreed, but he said I should go and stay with him. My mother said I should not stay with him. I stayed at home. It was in February when I went to the doctor. H told me that I was pregnant. So I stayed at home. My mother said I should still go to school, I should not stay at home. When I went back to school he started fetching me from school again. My mother phoned my brother at work and asked him to go to this guy's place. When my brother got to this guy's home they said he

was not around and they told my brother to come back in the evening. In the evening when my brother went, this guy disappeared, because he knew my brother's vehicle, so when he saw it approach his home he disappeared . Until my brother said we should leave this guy, my brother would see what to do. So he left the guy alone. But the guy continued coming to my home to see how I was doing and I told him that I would no longer go to his place. My father and my mother have also left him like that."

Group member: *"I did not tell anyone until my mother observed that I might be pregnant. She asked me who was the person was who impregnated me. I told her, but no one has gone to this place until now. I said they should not go to his parents. I am just staying at home, not doing anything."*

Facilitator: *"Everyone has told us her experiences. Could we now elaborate on the bad experiences that we have had so far? We shall talk about good experiences afterwards."*

Group member: *"The bad experience that we had is that our boyfriends agreed when we told them for the first time, but as the pregnancy advanced they disappeared. So this really worries us. Sometimes they go out with someone else, so that also hurts us. Silence!!!"*

Facilitator: *"She has told us about her bad experiences. Could someone else tell us about hers also?"*

Group member: *"Ee! The problems that I have now are that I sometimes suffer from heartburn, lack of appetite and some abdominal pains."*

Group member: *"My problems are vaginal discharge, lack of appetite and sometimes vomiting. Also our boyfriends are not trustworthy, because when we are in trouble they leave us but, when we were dating they seemed to love us. Silence!!!"*

Facilitator: *"For those who do not talk, does it mean you do not have bad experiences? Do not be afraid of others, because each one of you has related her problems so you realise that you are not the only one with problems. Please do not be afraid, speak out those problems."*

Group member: *"My problem is swelling of the legs and they are also painful, I keep seeing the doctor because of this. Otherwise there is no other problem."*

Group member: *"My problem is backache and painful knees and abdominal pains, that is all."*

Facilitator: *"Besides physical problems, what about your relationships with other people, other than your boyfriend and parents?"*

Group member: *"My problem is that I am gaining weight and I am just getting round. Besides that, one of my relatives who attends the Zion Church came to my place one morning and said that in her vision, it was revealed to her that my boyfriend's family did not wish me and this baby to live.*

She said these people have put some Sesotho medicines in the road where I usually pass especially on my way to and from the clinic and if I step on them I would be hurt somehow and I would die with my baby. This shows how much they hate me."

"Initially my boyfriend agreed to marry me and his aunt said she would see how she could help us if my parents took this matter to court. But now they have completely changed, because they are no longer on my side. It is like I annoy them in other words. This relative said my boyfriend's family has bewitched me because I had pain in the breasts, although the pain went away after sometime. She said these things showed that my boyfriend's family is not happy that I am still alive. I also annoyed them because I was always at home. I did not go to different places."

Facilitator: *"Could I just ask for more explanation? After your relative has said these things to you, how did you feel?"*

Group member: *"It affected me a lot, I was afraid and annoyed because they do not do anything for me. They do not give me money or anything. The money that is being spent on everything is from my family, but they hate me. I hated everybody from that family including his sister who used to come to my home to see me and his aunt. I hate them all. Silence!!!!"*

Facilitator: *"You remember that the researcher said if there are bad experiences with your pregnancy she is going to use them to help other adolescents who find themselves in your situation in the future."*

Group members: *"Yes 'M'e."*

Facilitator: *"So please if there are still some more experiences, do not hide them, speak them out so that they could be used to help others."*

Group member: *"My parents and everybody I knew have not changed, they still love me."*

Group member: *"All my friends still love me, even the one who is also pregnant still visits me and I visit her."*

Group member: *"They all still love me."*

Facilitator: *"Some of you said you were attending school before pregnancy, although some of you did not touch on that. Could you tell us what happened with school?"*

Group member: *"I had to discontinue school because I am pregnant, but I would still like to continue after the baby is born."*

Group member: *"I do not have much of a problem, because I failed form C and I am supplementing English language, which is the subject I did not do well in. So my brother is assisting me with whatever I need to learn in that subject. I think I will be able to write the examinations."*

Group member: *"I still want to go back to school after the pregnancy."*

Group member: *"I still like school. Once my baby has grown older and my parents are still prepared to send me back to school, I will go back. I do not even want to get married to my boyfriend, because his mother is cruel. Why didn't she tell her husband about my pregnancy and his son" (laughter from group members)"*

Group member: *"As for me, I would like to get married. I love my boyfriend and I can't afford to lose him. (More laughter from group member)"*

Facilitator: *"That's her feelings. What do you have to say? (To other quiet group members"*

Group member: *"I still want to go back to school."*

Facilitator: *Which of your experiences are similar?"*

Group members: *"They are all the same except one."*

Facilitator: *(To one group member) Could you explain a bit more why you said your parents should not go to your boyfriend's home?"*

Group member: *"I never really loved my boyfriend, even though we ended up making a baby. That is why I asked my parents to leave him, and they agreed."*

Facilitator: *"Could you now tell me about your good experiences with your pregnancy?"*

Group member: *"My mother supports me and encourages me. At least I feel good about that."*

Group member: *"The nice thing for me is that my mother buys fruit and she has already bought the baby's clothes."*

Facilitator: *"Let us talk about nice experiences."*

Group member: *"Because I am naughty, when I do some of the things, I am told not to do them because I will have problems on the day of delivery."*

Group member: *"My family has accepted me. No problems."*

Group member: *"My family does everything for me now, they are no longer angry with me."*

Facilitator: *"So you are just waiting to see the baby."*

Group member: *"Yes. Now everybody talks to us nicely, but after the baby is born they are not that nice. You have to see to your baby. (Group members laugh)"*

Facilitator: *"How do you know that?"*

Group members: *"We know, it happens."*

Facilitator: *"So you wish you could stay pregnant forever?"*

Group member: *"No , I want to have a baby, I cannot even sleep because of this tummy. (Group members laugh) It is like I could put a pillow under it. It is like it gets bigger at night."*

Facilitator: *(To one group member) "You said you are told that if you do some of the things, something will happen when you are in labour. Could you tell us more about that."*

Group member: *"I liked to sleep, so they said the baby would sleep during birth, and would not be born on time; I liked to stand on the door entrance, and they said the baby would be stuck at the pelvic outlet; I liked eating eggs and they said the membranes would not rupture and I would roam about like a chicken when it wants to lay an egg (group members laugh). So I was told not to eat eggs, and that if I feel sleepy during the day, I must do something to avoid sleeping most of time. So I do that."*

Facilitator: *"I think this is interesting. Is there anyone else who has had a same or similar experience?"*

Group member: *"Yes, I was told that the baby would sleep during birth if I sleep a lot. It would not cry at birth. I should not worry a lot because I will not have strength to push the baby during delivery."*

Group member: *"I have heard that it is very painful to give birth, so I wonder how I am going to stand the pain."*

Facilitator: *"Who do they say suffers more pain, the youth or the elderly?"*

Group member: *"Everybody. The nurses also ill-treat us. They pinch us if we do not open our legs."*

Facilitator: *"How do you know that?"*

Group member: *"I have experienced it when I was admitted on 28-07-2000. I had abdominal pains and I was discharged on 31-07-2000."*

Facilitator: *"You all said you told your mothers, could you tell me why you did not think of telling your fathers first?"*

Group member: *"My father would kill me."*

Group member: *"Fathers do not accept the situation easily, so mine would not take it, and fathers do not keep secrets. Mothers do keep secrets until the right moment has come for them to reveal the secrets. Even when the mother is hurt, she does not stay in that mood for a long time, she soon forgives and accepts."*

Group member: *"The mother is able to present the matter in a way that will calm the father and that will make him accept. But If I told my father, he would say, 'this is what I was expecting from you'."*

Group member: *"Fathers do not have the heart to forgive because even now my mother suffered as he told her that she contributed to my pregnancy, whereas my mother did not know anything."*

Group member: *"My father would get angry with me. He lied and said that my mother knew that I am pregnant. Whereas she did not know, because she was told by my teacher, not even by me."*

Group member: *"I knew very well that my father is very, is very strict and would kill me."*

Group member: *"My father was not there when this happened. I think I could still have told him because even when I started menstruating I told him first and he told my mother. But this time I was afraid, I did not know how to approach him when he came."*

Facilitator: *"If there are no more experiences, thank you very much for sharing your experiences with us and for your time that you spent talking to us. Remember to keep this information confidential. Remember you are soon going to be mothers and you have just said that mothers are able to keep secrets. Thank you."*