Variables influencing delay in antenatal clinic attendance among teenagers in Lesotho

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Abstract

Background

A delay in deciding to seek antenatal care is predominant among pregnant teenagers in Lesotho. This subsequently leads to delay in reaching treatment and in receiving adequate treatment. Early antenatal care attendance plays a major role in detecting and treating complications of pregnancy and forms a good basis for appropriate management during delivery and after childbirth.

Although antenatal care is provided at different levels, Lesotho still has a high maternal mortality rate, estimated at 762 per 100 000 live births, and an infant mortality rate of 72 per 1 000 live births.[1] Lesotho has a chronic shortage of doctors and nurses. According to the Lesotho Population Data Sheet of 2000, the doctor-patient ratio for this country for the year 1999 was 1:13 041 and the nurse ratio was 1:2 035. About 31% of the adult population between the ages of 15 to 49 years is infected with HIV/Aids.[1]

This shortage of health care personnel and the impact of HIV/Aids result in insufficient focus on health promotion in reproductive health, especially birth preparedness, and lack of community participation and male involvement in reproductive health care issues. Early sexual activities with consequent early pregnancy lead to high maternal and neonatal morbidity and mortality. As a result, the National Adolescent and Development Programme was started in 1998 by the Ministry of Health and Social Welfare to address the needs of teenagers. This led to the establishment of adolescent health clinics (referred to as *teenage corners*) that focus on teenagers in three districts of Lesotho, namely Mafeteng, Maseru and Leribe.

Despite the establishment of these teenage corners, delay in antenatal attendance is still prevalent in Lesotho. Out of 632 pregnant teenagers in 2003 who attended the clinic at Queen II Teenage Corner, the majority (43%) visited the antenatal clinic for the first time during the third trimester and only 14.9% attended in the first trimester. This late antenatal clinic attendance provides little or no time for appropriate screening, management of risk factors, if detected, and timely referral.

The aim of this study was to identify variables that contribute to delay in antenatal clinic attendance among pregnant teenagers and to make recommendations based on the research findings for the development of policies that will ensure early attendance.

Methods

An exploratory, descriptive research design was used to acquire understanding of the variables that contribute to the delay in antenatal clinic attendance among teenagers in Lesotho. The population composed of all pregnant teenagers who have started their antenatal clinic attendance at the three teenage corners after the thirteenth week of gestation. Purposive sampling was used and the sample was considered adequate when saturation of data was reached. A total of 21 pregnant teenagers and 21 parents/guardians participated. Data was gathered through observation of records and activities undertaken at the teenage corners and through in-depth interviews with the teenagers and their parents/guardians. A semi-structured interview schedule was used.

Results and conclusions

Twenty-one pregnant adolescents were interviewed, of which 71.3% started antenatal clinic attendance during the second trimester, while 28 (57%) started during the third trimester. Variables that contributed to the delay in early antenatal attendance included lack of knowledge regarding the importance of early attendance, denial of the pregnancy by the boyfriend, the fact that sex outside of marriage in Lesotho is still taboo and structural variables related to service provision.

The interviews with the pregnant teenagers and their parents/guardians highlighted the need to empower teenagers through education and counselling and the need for the Minister of Education and Training to review policy regarding the expulsion of pregnant teenagers from school. Community awareness campaigns should be held annually to sensitise the public about the increasing rates of teenage pregnancies in Lesotho and the consequences thereof. Life skills education and teenage pregnancy issues should be included in the health courses for primary school learners as early as grade 6 and 7.

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Introduction and problem statement

The World Health Organization (WHO) estimates that there are approximately 585 000 women who die each year of pregnancy-related causes.[2,3] Ninety-nine per cent of these deaths occur in developing countries, while in developed countries the range is between 10 to 15 deaths per 100 000 births. The greatest risk of maternal deaths, which is now compounded by the HIV/Aids pandemic, is faced by women in Sub-Saharan Africa.[11]

Research has shown that most causes of maternal deaths are avoidable.[4] According to Maine, Akalin, Ward, and Kamara accessible and effective emergency obstetric (EmOC) services are a necessity to reduce maternal mortality,[5] Although EmOC services are necessary to reduce maternal morbidity and mortality, women with obstetric complications still face a variety of barriers in using them. These barriers have been grouped into three major delays, namely delay in:

- deciding to seek care;
- reaching the treatment facility; and
- receiving adequate treatment at the facility.[4,5,6]

Maternal mortality is a result of a combination of biological, medical and social factors, often inextricably intertwined. The immediate medical causes of maternal deaths are similar for all women all over the world. These causes include haemorrhages, infections, toxaemia, obstructed labour and complications of unsafe abortion. Pregnancy during adolescence is further complicated by physiological and psychological immaturity of the individual and delay in deciding to seek care. Delay in deciding to seek care results in women missing the opportunity to receive lifesaving care, because they are unable to recognise the signs of life-threatening complications of pregnancy and childbirth. Educating women and the community at large about signs of life-threatening complications during pregnancy and about when and where to seek care is key to reducing this delay.[4,6]

Delay in deciding to seek care is predominant among pregnant teenagers, and this delay subsequently leads to delay in reaching treatment and in receiving adequate treatment.[7,8,9] Adolescent mothers are a group with special needs, because they are children themselves and their bodies are not yet sufficiently developed to handle pregnancy and delivery. It is therefore necessary to encourage them to attend antenatal clinics where they will be equipped with health information on how to care for themselves during pregnancy, delivery and after childbirth. Delayed antenatal clinic attendance provides little or no time for appropriate screening, management of risk factors, if detected, and timely referral. The situation is worse for teenage mothers, as they are also experiencing physical and psychological changes of adolescence, which may have a negative effect on both the mother and her unborn child.

Effective health care systems make obstetric care available to all women during pregnancy, delivery and after childbirth. Early antenatal care attendance, that is, during the first three months of gestation, plays a major role in detecting and treating some complications of pregnancy and forms a good basis for appropriate management during delivery and after childbirth. Failure to attend antenatal care early results in the potential for complications during pregnancy, delivery and puerperium.[6]

Early sexual activities with consequent early pregnancy lead to high maternal and neonatal morbidity and mortality.[3]The epidemiological profile of Lesotho reflects a high incidence of teenage pregnancy, namely 52.1%.[3] The majority of these young pregnant women tend to report late for antenatal care services, as evidenced in Table 1 below. The table shows the total number of teenagers (antenatal care first visits) who attended antenatal care services at the Maseru teenage corner during the year 2003, and the trimester at which the pregnant teenagers started their antenatal visit.

Out of the indicated 632 pregnant teenagers, 43% visited the antenatal clinic for the first time during the third trimester and only 14.9% attended in the first trimester. Seventy-eight per cent of those who attended the clinic during the first trimester were married teenagers. Table 1 indicates delayed antenatal clinic attendance among pregnant teenagers in Lesotho.

In 1998 the National Adolescent and Development Programme was established by the Ministry of Health and Social Welfare to address the needs of teenagers. The National Adolescent and Development Programme led to the establishment of antenatal clinics that focus specifically on pregnant adolescents. The clinics (referred to as ***teenage corners***) are based in three districts, namely Mafeteng, Maseru and Leribe. These districts are referred to as pilot districts, as the teenage corner concept was first implemented there. The districts were selected on the basis that they were the largest urban areas, and already had established youth projects. Despite the establishment of these teenage corners, delay in antenatal clinic attendance among pregnant adolescents is still prevalent in Lesotho.

Objectives for the study were to:

- identify variables that influence delay in antenatal clinic attendance among teenagers in Lesotho; and
- determine the pregnant teenagers' support systems.

Review of related literature

Several authors have identified a number of variables that influence delay in antenatal clinic attendance among women. These factors include:

SOCIO-DEMOGRAPHIC FACTORS

Low socio-economic status

Several authors state financial problems as the major constraint to antenatal clinic attendance.[9,10,11] While having a medical aid or a health care insurance policy is key to attending antenatal clinics in the USA and other Western countries, this is not the case in Lesotho, because women are not required to have any insurance in order to receive antenatal care services. In fact, antenatal services as well as contraceptive services are among the cheapest health services offered in this country. For instance, in Lesotho M10.00 (or R10.00 in South African currency) is required for the first antenatal visit; subsequent visits are free of charge. One would therefore ex-

Table 1: Antenatal service utilisation by pregnant adolescents in Lesotho (First visits only) (Adapted from in-patient records for first visits to Queen II Teenage Corner, 2003)

Attendants during first trimester	Attendants during second trimester	Attendants during third trimester	Total number of pregnant teenagers for the year 2003
94	268	270	632

pect that the pregnant teenagers would attend these services more often.

Educational attainment
Compared to illiterate women, educated women bear fewer children and achieve better child survival, because they avoid early marriage, teenage pregnancy, high parity and because they attend antenatal and postnatal services more frequently. These are all important aspects in the prevention of maternal deaths.[11,12,13,14]

Education about sex, pregnancy and contraceptives should commence at primary level when students are at the age of ten years, and not later than at twelve years. This early education will enable adolescents to acquire the necessary knowledge to make informed decisions about issues regarding sex, pregnancy and contraceptives.[15,16]

Age and marital status
The use of antenatal care services can also be limited by the woman's attitude towards her pregnancy and other psychological factors. Single women with unplanned pregnancies, like most pregnant teenagers, may have a negative attitude towards their pregnancy and, due to this, may be less aware of the signs of pregnancy and as a result seek care much later than would older women.[17]

The majority of Health Service Area (HSA) hospitals in Lesotho offer antenatal services without regard to the age of the pregnant woman. While this might be good for the health care professionals, it might be a drawback to the pregnant teenagers to find themselves in the company of older women who are most probably married, while they might be pregnant out of wedlock.

Ethnicity
Inadequate antenatal care has been associated with low income and ethnicity. While the issue of low income might be significant, ethnicity may not be an influencing factor in Lesotho, because 99.7% of the population are Basotho, only a small percentage (0.3%) comprise of other ethnic groups (Europeans, Asians, Xhosas and Zulus) and antenatal care services are offered to all without regard to ethnicity.[14]

Lack of support for pregnant teenagers
Social support has been reported to affect attitudes and behaviours, including satisfaction with pregnancy and parenting.[16] Pregnant adolescents who have high stress and low social support networks have been found to have more neonatal and obstetric problems than those who have high stress and high social support networks.[6,9,10,16,18] Attending antenatal clinics early will assist in the identification of such stress and/or depression, resulting in appropriate management of the identified problems.[18]

PERSONAL BARRIERS
Unintended versus intended adolescent pregnancy
There are two major types of teenage pregnancy, namely intended or unintended pregnancy. Intended teenage pregnancy occurs when the teenager is consciously motivated to fall pregnant. This usually occurs where there is lack of educational and vocational goals other than motherhood. Pregnant teenagers falling in this group might notice early that they are pregnant and, because they might be supported by their parents and/or friends, may seek early antenatal clinic services.[19]

Unintended pregnancy, on the other hand, results when the adolescent engages in sexual intercourse without the knowledge of the cause and effect relationship of this activity and pregnancy. Due to denial, these adolescents may fail to recognise that they are pregnant and therefore seek antenatal care services late.[11,19]

Lack of value attached to the antenatal clinic services
It is important that antenatal services, especially those meant for pregnant adolescents, are planned with input from adolescents and that the services are made as meaningful and as interesting as possible – otherwise the pregnant adolescents will not view the services as valuable to them.[8]

SYSTEM BARRIERS
Negative attitudes of providers
According to Dennis, Flynn and Martin, some women stated that the reasons influencing their delay in or lack of antenatal clinic attendance were the long waiting hours, inconvenient service hours and that they were not treated well by the service providers.[6] This may also not be tolerated by pregnant teenagers, as they can be very impatient.[20] The judgmental nature of some staff members towards pregnant adolescents may negatively influence pregnant teenagers' efforts to attend antenatal services.[19]

Accessibility of antenatal care services
Adolescents' health services should be financially, functionally and geographically accessible, and should be adolescent-friendly and confidential.[18,21] Smart states that the environment in which services are provided for young people should be appealing to them, probably by avoiding the 'clinical' atmosphere often associated with hospitals or hospital-based care.[21] At the moment, health services provided for pregnant teenagers in Lesotho are still located at the hospitals, and are offered between 08:00 and 16:00 on weekdays only. This means, therefore, that they are not accessible to be utilised effectively.

Distance to the health centre should also be reasonable. According to the WHO, as cited by Dennill, King, and Swanepoel,[22] a distance of about five to ten kilometres to the health care facility is recommended. The health workers providing services for pregnant adolescents must be committed, friendly and have a non-judgmental approach. Obstacles such as an unsuitable name for the health centre must be avoided. Names like "Family Planning Clinic", for example, when one is not planning a family, are said to be off-setting to the youth.[22]

STUDY SETTING
The study was conducted in Lesotho from July 2003 to April 2004 among pregnant teenagers using the teenage corners located in the three districts of the country, namely Maseru (Queen II), Leribe (Motebang Government Hospital), and Mafeteng (Mafeteng Government Hospital). These teenage corners were used for the study because they are well established, and they serve the larger population of adolescents in Lesotho.

POPULATION
The population composed of all pregnant teenagers who have visited their antenatal clinic after the 13th week of gestation.

SAMPLE AND SAMPLING TECHNIQUE
Purposive sampling was seen as appropriate for this study as it enabled the selection of unique cases, which enabled the researchers to gain a deeper understanding of the phenom-

enon under investigation. Observation of records at the clinics (three teenage corners) was the first step in identifying pregnant teenagers appropriate for the study. Their parents or guardians were then identified. For inclusion, the teenager had to:

- be pregnant and be 19 years of age or younger;
- have started antenatal clinic attendance after the 13th week of gestation;
- have attended the clinic in one of the three teenage corners before; and
- be willing to participate in the study.

The biological mother/father or guardian of the pregnant teenager participating in the study had to be willing to participate in the study.

The sample was considered adequate when saturation of data was reached. Saturation was reached after 42 participants were interviewed, that is 21 pregnant teenagers and 21 parents/guardians.

ETHICAL CONSIDERATIONS

The proposal was first sent to the Research, Ethics and Publications Management Committee at the University of Limpopo (Medunsa Campus) for review and approval. Permission was also sought from the Director General of Health Services and the Research Department of the Ministry of Health in Lesotho, and administrators of the three teenage corners. At the time of the study, the process was fully explained to the participants with a view to obtaining their informed consent. Participants were asked to sign informed consent forms. Voluntary participation was emphasised, and the participants were given a chance to ask questions. They were assured of confidentiality of the information provided. Their permission was sought first before the interview was tape-recorded. They were informed that they were free to withdraw from the study at any time if they so wished and that their withdrawal would not affect their antenatal care in any way.

DATA COLLECTION

Data was gathered through observation of records and activities undertaken in each of the clinics (teenage corners) and through in-depth interviews with the pregnant teenagers themselves and their parents/guardians. A semi-structured interviews schedule was used. Each interview took about 30 to 60 minutes. Interviews were tape-recorded, and transcribed verbatim immediately after each interview session.

Figure 1: Trimester of first antenatal clinic attendance (N=21)

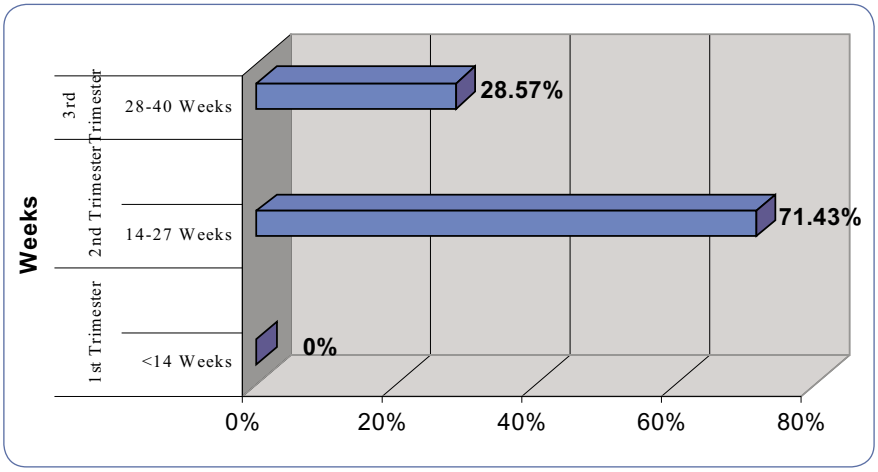


Figure 2: Age distribution of pregnant teenagers (N=21)

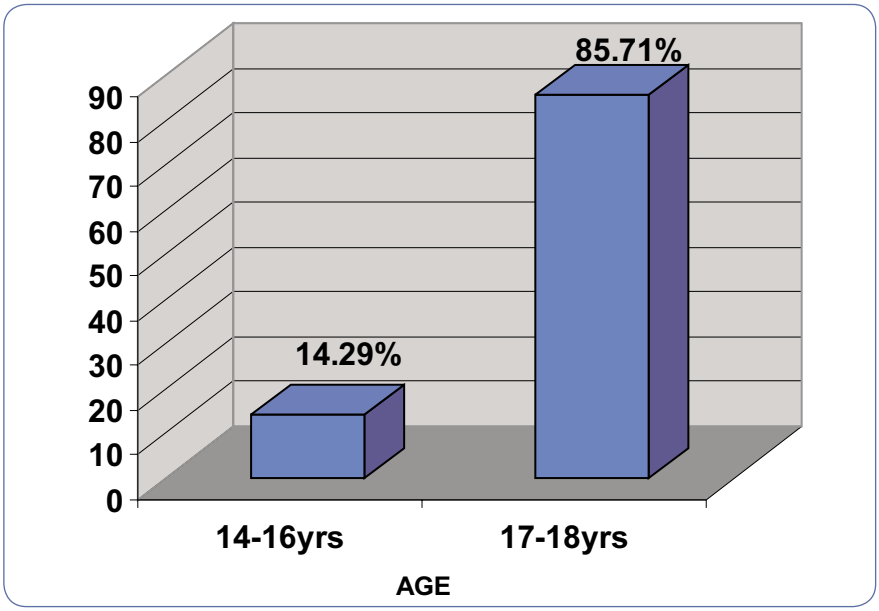
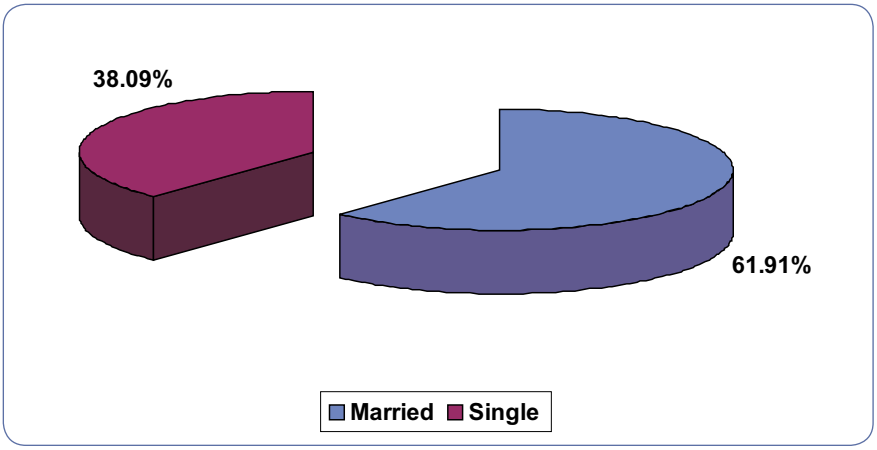


Figure 3: Pregnant teenagers' marital status (N=21)



DATA ANALYSIS

Data from observation of records and activities carried out in the clinics and from socio-demographic information of participants were summarised by

Figure 4: Pregnant teenagers' aspirations for further education (N=21)

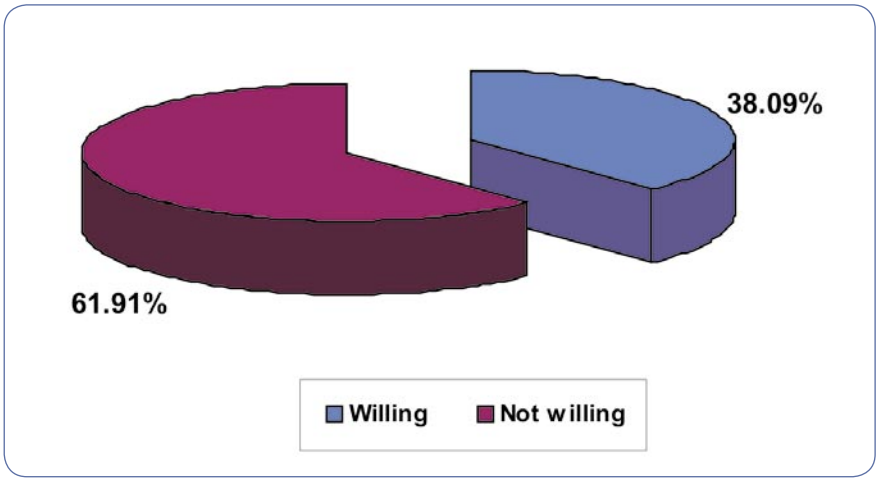


Figure 5: Pregnant teenagers' financial support (N=21)

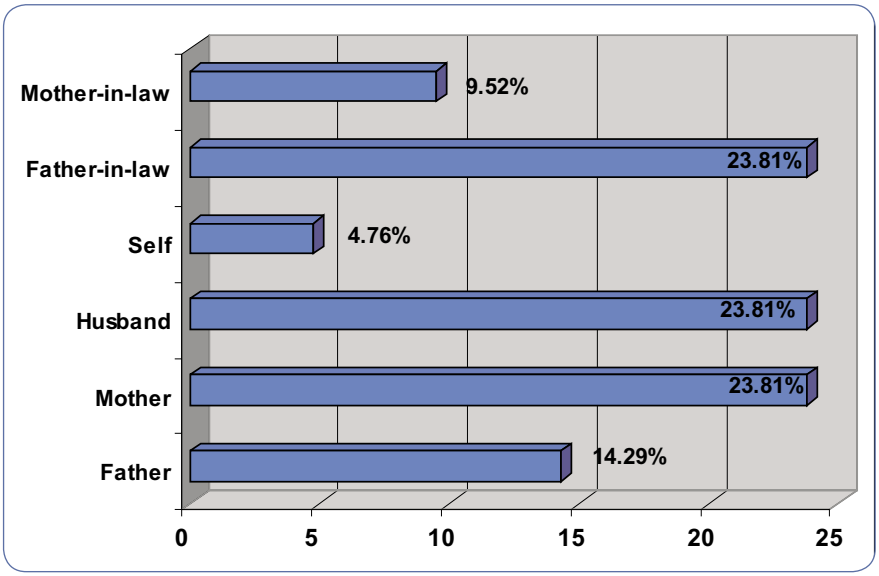
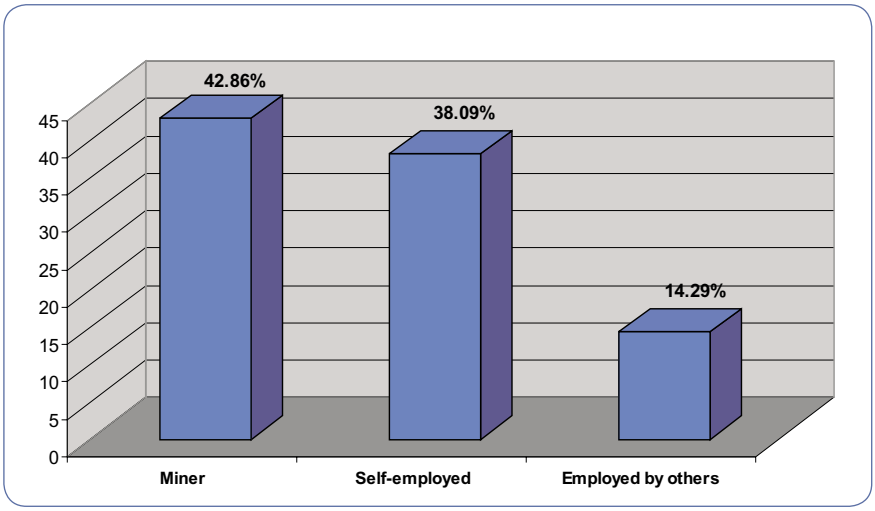


Figure 6: Breadwinners' employment status (N=21)



descriptive statistics. For descriptive data analysis, the researcher adapted the logical and systematic approach of Maxwell and Maxwell (1989) as cited by Buckeldee and McMahon, [23] with some modifications from Neuman.[24]

PRESENTATION OF RESULTS

Pregnant teenagers and their parents/guardians: Socio-economic and socio-demographic data

Trimester of first antenatal care visit

A total of 21 pregnant adolescents were interviewed. The majority (71.43%) started visiting the antenatal clinic during the second trimester, while 28.57% started antenatal care during the third trimester. This phenomenon, reflected in Figure 1, supports what most researchers have noted, namely that delay in deciding to seek care is predominant among pregnant teenagers.[8,18,21]

Ages of pregnant teenagers

Figure 2 denotes ages of pregnant teenagers interviewed for the study. The figure reflects that 14.29% (N=3) of the pregnant teenagers' ages ranged between 14 to 16 years, and 85.71% (N=18) ranged from 17 to 19 years. This supports the notion by Lehana[25] that teenage pregnancy is more prevalent in later adolescence than in early adolescence.

Pregnant teenagers' marital status

Thirteen (61.91%) of the pregnant teenagers were married, although seven (33.33%) got married when they were already pregnant, and eight (38.09%) were single (see Figure 3). This indicates that the majority (71.43%) of pregnant teenagers fell pregnant out of wedlock.

In Lesotho, pregnancy out of wedlock is regarded as a disgrace to the girl as well as her parents.[26] The solution is usually to arrange for marriage if the boyfriend accepts the pregnancy. Therefore, delay in attending antenatal care may be due to negotiations taking place between families of the pregnant teenager and her boyfriend. The pregnant teenager will probably not go to the clinic until the parents know whether she is going to get married or not.

Pregnant teenagers' educational level

The majority (47.62%) (N=9) of pregnant teenagers' educational level was low, ranging between grades 5 and 7, while 33.33% (N=7) of teenagers had educational levels ranging between grades 8 and 10, and 19.05% (N=5) had educational levels ranging between grades 11 and 12. Although 61.91% indicated that they would like to go further with their education (see Figure 4), this does not normally happen, since they tend get married to husbands who also have low educations and might therefore not allow them to go back to school. Alternatively, the pregnant teenagers often

Figure 7: Parents/guardians' marital status (N=21)

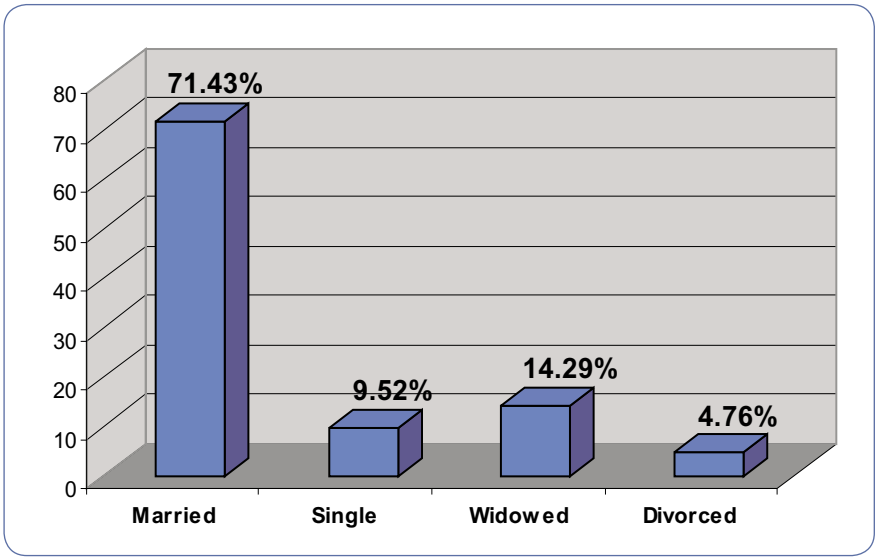
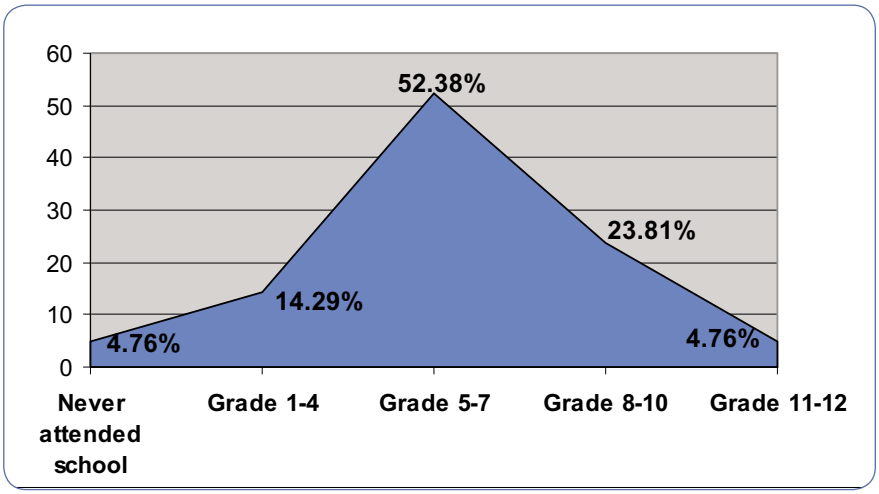


Figure 8: Parents/guardians' educational level (N=21)



simply feel too ashamed to go back to school as married women.

This denotes that there is an association between early childbearing and lower educational attainment[27] and proves the notion that women with higher educational levels are more likely to attend antenatal services early, as they know what the ideal gestational age for booking is.[28] This also indicates the need for education about sex and sexuality at primary level, preferably among grade 4 students. Since most teenagers are expelled from school when pregnant, this means that their educational levels will remain low – affecting their future socio-economic status.

Pregnant teenagers' financial support

Figure 5 reflects the breadwinners, or individuals responsible for supporting the pregnant teenagers financially. Only one (4.76%) of the teenagers indicated that she was working. The high unemployment rate among teenagers may be because they are still too young to get any employment, and because they have a low educational level. If pregnant teenage girls are also expelled from school, this will further perpetuate poverty among this group of people.

Breadwinners' employment status

Nine (42.86%) participants work as miners in the Republic of South Africa and do not earn much. The self-employed group (38.09%) (N=9) included vendors, housewives and subsistent farmers, who in most cases are earning very little or nothing at all. Those employed by others include people working in cafés as waiters or working as baby sitters, and they also earn very little. All this signifies low socio-economic status for the pregnant teenagers and their families (see Figure 6).

Parents/guardians' marital status

In total, 71.43% (N=15) of the participants were married, 14.29% (N=3) were widowed, 9.52% (N=2) were single and 4.76% (N=1) were divorced (see Figure 7).

Parents/guardians' educational level

As seen in Figure 8, 52.38% (N=11) of the participants' educational levels ranged between grades 5 to 7; 23.81% ranged between grades 8 to 11; and 14.29% fell within grades 1 to 4. Only 4.76% obtained grades 11 to 12. The other 4.76% did not attend school at all. The data indicates that the educational level of parents/guardians was also low.

The low educational attainment makes it difficult to get well-paid jobs. This results in low socio-economic status. This may also make it difficult for the parents/guardians to encourage these teenagers to continue with their studies.

Qualitative data analysis

Data obtained through in-depth interviews with the pregnant teenagers and their parents/guardians was analysed using the logical and systematic approach of Maxwell and Maxwell (1989) as cited by Buckeldee and McMahon.[23]

In order to determine the reasons for their delayed visits to the clinics the following question was asked: "**Can you tell me why you did not (or why your daughter/wife did not) come to the clinic during the first three months of pregnancy**?" A discussion of some of the themes deduced from their responses is given below:

- **Lack of knowledge** regarding the importance of early antenatal clinic attendance, as indicated in the following excerpts:

"I did not know the right time to start prenatal care."; "I was not aware that it was important to start that early."; "I realised late."; "I did not know on time about her pregnancy. She delayed informing me." "She was afraid to let us know that she was pregnant . . . she was hiding the pregnancy."; "I thought if she was not complaining about anything, it was fine and that she will go if she is not feeling well."

- **Denial of the pregnancy** by the boyfriend. This usually led to long negotiations between the concerned parties, as could be noted from the following excerpts:

"My parents were still negotiating with my boyfriend's parents regarding the pregnancy."; The first three months she concealed the pregnancy. Thereafter, we were also busy looking for the man who impregnated her."; "We had to negotiate with the boyfriend so that she could get married prior to prenatal clinic attendance. She had to be married before starting her prenatal care."

- **Economic/financial constraints**. Five (23.8%) of the parents/guardians stated financial constraints as one of the reasons for late antenatal clinic attendance. This is how some of the parents/guardians responded to the question:

"I was waiting to inform her father because I did not have money."; "She had to work first to pay the M10.00."; "I had financial problems, and I was waiting to inform her brother and sister as I depend on them financially."; "Poverty, we did not have the means to send her to the clinic."

- **Structural variables related to the service provision.** Although all the pregnant teenagers (N=21) indicated that they were satisfied with the services provided, the following excerpts indicate that delay in antenatal attendance may be the result of the attitude/conduct of the service providers:

"*I was afraid since I heard that the nurses ill-treat single pregnant teenagers."; "We went to the clinic but they would not assist us, they told us that we should come during the fifth month, they even gave us the date. Some of the nurses even said we are too much in a hurry because this is a first baby."*

The participants were asked about their feelings regarding the pregnancy: **"How do you feel about this pregnancy?"**

- **Sex outside marriage is still taboo in Lesotho.**

"Ache, I was not pleased really. I did not accept the pregnancy."; "I was not happy at all to realise that she was pregnant."; "I am feeling so hurt, but although I am hurting, I told myself that this is what our children live like these days."; "I had a problem to pass on the news to her elder siblings, especially her brother."; "I was still hoping she is a virgin and she will get married in a decent manner one day. Yeah I was badly hurt."; "I feel hurt. He refused that he is the one who impregnated me … I was then afraid of telling my mother, until she realised by herself."

Denial of the pregnancy by the boyfriend does not only bring pain to the pregnant teenager, but also exacerbates feelings of pain and confusion among the parents, as one of the parents stated:

"The pain would have been better quickly if he agreed … And now he is going around in circles, but he doesn't want to accept that he is the one who impregnated my daughter … I don't want him to marry her because he might end up making her life very miserable. He will torture her. He will own her, claiming that he has paid monies towards her marriage … No, I just want him to pay for the damage he did and leave (name of the pregnant girl) alone, she will find somebody who will love her one day, after completing her studies. Let her go to school because there is nothing she can do with Form 1."

Support during pregnancy has been associated with positive pregnancy outcome. Pregnant teenagers were therefore asked ***what*** **type of support they have to take care of themselves and their coming babies.** People who provided support were the biological mothers and sisters of the single pregnant teenagers and the mothers-in-law and husbands of the married pregnant teenagers. This coincides with the statement by Stevens-Simon and McAnarney[28] that the most important support pregnant teenagers get is from their mothers, friends and the father of the baby. Adolescents who have adequate coping resources, a supportive family and peer environment, a stable, sympathetic partner or partner substitute, and access to well designed intervention programmes that teach parenting skills and help solve their problems adjust better and provide higher quality parenting skills.[29]

It was interesting to note that among the support systems mentioned, the biological fathers of the teenagers were not mentioned. According to the Basotho culture,[26] everything that deals with pregnancy and childbearing is considered a woman's concern. That is why a pregnant girl will generally tell her mother and/or sister about the pregnancy and not her father or the father of the baby. Again, in most cases the men are working in the mines or in the cities and do not stay at home. Therefore, in this study the closest person to be informed was the mother. However, it would be interesting to conduct research to determine the attitudes and/or experiences of the biological fathers regarding their daughters' pregnancy, particularly if pregnancy occurred out of wedlock.

It was deduced from their responses that the mothers and sisters provided psychological support while fathers and husbands mainly provided for material needs in the form of money and food. Most of the teenagers indicated that they required support for their children rather than themselves. This is how some of them responded to the above-mentioned question:

"I think I will need my child to grow up well, to have adequate nutrition."; "I will need food and clothing for the baby."; "I would need things like baby's clothes and food."

It is indeed surprising that they would be concerned about their unborn babies, particularly the single pregnant teenagers who stated that they were unhappy about the pregnancy. Some showed concern for themselves as well as their babies, as can be noted from the following citations:

"I need things that I would use for myself and my child when going to deliver such as cotton wool and the baby's blanket. I will also need the baby's diapers. Even though those (diapers) for my sister's child are still there, but they are few and old."; "I think I will need food for the baby, and things that I will use to wash myself."

The pregnant teenagers and their parents/guardians were further asked the following question **"What do you think we (nurses) can do to ensure or to encourage early prenatal clinic attendance among teenagers?"** The purpose of this question was to get suggestions from them as to what should be done in order to facilitate early antenatal clinic attendance. The following are themes deduced from their responses:

- **Empower teenagers through education and counselling:** The majority of participants indicated

the need for the education of adolescents about issues, which include abstinence, the importance of attending antenatal clinics and being open to their parents. In this regard the participants said:

"*Nurses should hold public gatherings to explain the importance of early prenatal attendance.";* *"Teenagers should be encouraged to abstain and to remain virgins.";* *"Nurses should convince the community that prenatal care is important, as most of them do not see it as important unless they see a malformed child.";* *"Peer education is important. Hold workshops for both pregnant and non-pregnant teenagers and teach them about the importance of early prenatal attendance. These workshops should then be facilitated by the trained teenagers themselves.";* "*Nurses should do home visits to counsel and support pregnant teenagers. Pregnancy outside marriage is painful."*

Discussion of findings

In this study both qualitative and quantitative data were collected, which necessitated utilisation of both qualitative and quantitative data-analysis methods. The teenagers' socio-demographic data, which was analysed quantitatively, revealed that delay in antenatal clinic attendance was predominant among pregnant teenagers in Lesotho and that teenage pregnancy was more prevalent among low educated single teenagers. The study further revealed that teenage pregnancy was more prevalent in later adolescence than in early adolescence. Socio-demographic information from parents/guardians revealed that 42% of participants were also teenagers when they had their first children; that the parents/guardians occupied low paying jobs, which indicates poor socio-economic status, and that, in general, their educational level was also low, ranging between grades 5 to 7.

These findings denote that in order to prevent teenage pregnancy, education regarding sex and sexuality should resume at primary level, preferably among grade 4 students. Since most of them are expelled from school when pregnant, this means that educational levels for women will remain low – affecting their future socio-economic status, that of their offspring and the country as a whole. There is therefore a need for the government to put in place policies that would discourage expulsion of pregnant teenagers from schools, because such expulsion denies them their right to education.

The qualitative analysis revealed that unplanned pregnancy resulted in denial of the pregnancy by the teenagers and parental disbelief, particularly if the boyfriend denies the pregnancy. Most single pregnant teenagers, particularly those whose sex partner in the resulting pregnancy refused responsibility for the pregnancy, reported that they felt **unhappy/hurt or irritated** about the pregnancy. The decision taken by the sex partner in the resulting pregnancy seems a major variable that influenced both the feelings of the pregnant teenagers and their parents/guardians. Denial of the pregnancy by sex partner resulted in unhappiness, while acceptance, even if the couple does not get married, eased the feelings of hurtfulness of both the pregnant teenager and the parents/guardians.

People who provided support were the biological mothers and sisters of the single pregnant teenagers, and for the married pregnant teenagers, the mothers-in-law and the husbands seemed the major sources of support. The type of support provided was mainly psychological, which was provided by the women (biological mothers, mothers-in-law, aunts and sisters). The males, that is, husbands, brothers, fathers and fathers-in-law, mainly provided material support in the form of money and food.

Support during pregnancy has been associated with positive pregnancy outcome. Adolescents who have adequate coping resources, a supportive family and peer environment, a stable, sympathetic partner or partner substitute, and access to well designed intervention programmes that teach parenting skills and help solve their problems adjust better and provide higher quality parenting skills.[30] It is therefore very important that the healthcare system also provide support to these pregnant teenagers by offering adolescent-friendly health services, where teenagers will be cared for by **well trained and caring healthcare workers** who will provide them with education and counselling, which are necessary weapons to ease their pain and embarrassment.

Recommendations

The following is recommended:

- There should be yearly community awareness campaigns to sensitise the public about the increasing rates of teenage pregnancies in Lesotho and to the consequences thereof.
- The Ministry of Education and Training should review its policy regarding expulsion of pregnant teenagers from school.
- The National Curriculum Development Centre should include life skills education and teenage pregnancy issues in the health courses for primary school (grade 6 and 7) learners.
- The Ministry of Health and Social welfare should provide free antenatal care services for pregnant teenagers.
- The Ministry of Health and Social welfare should refurbish the present adolescent health corners to meet the needs of pregnant teenagers:
- The staffing pattern needs to be improved: The healthcare workers should be well educated regarding issues related to adolescents, they should be motivated and interested in working with adolescents, and they should have a non-judgmental approach towards those who are pregnant.
- Evaluation research should be done to assess service utilisation of the existing adolescent corners and the problems experienced.
- Supportive programmes for young fathers should be developed and implemented.
- There is a need for all the teenage corners to employ the same antenatal return date's schedule, preferably to use the Adequacy of Prenatal Care Utilisation (APNCU) scale,[17] since it emphasises both the adequacy of initiation of antenatal care and adequacy of received services once antenatal care has commenced.

Conclusion

The study was undertaken to explore variables that influenced delay in antenatal clinic attendance among teenagers in Lesotho, since the delayed antenatal clinic attendance provides little or no time for appropriate screening, management of risk factors, if detected, and timely referral. The pregnant teenagers also require close monitoring, as they are also experiencing physical and psychological changes of adolescence,[31] which may have a negative pregnancy outcome for both the mother and her baby. There are also a number of factors that can adversely affect a pregnant teenager's ability to come to terms with

her pregnancy, which include among others life crises during pregnancy, e.g. bereavement, denial of the pregnancy by the boyfriend, and going through a transitional period. All these may have a negative impact on the pregnancy and its outcome, hence the need for early antenatal clinic attendance to enable recognition of such factors and the appropriate management thereof.

Generally, the findings from this study indicate that there are several variables/factors leading to delay in antenatal clinic attendance in Lesotho. However, repudiation of the pregnancy by the boyfriend seems to be the key to the delay in visiting antenatal clinics among single pregnant teenagers, while financial constraints is the main factor among married pregnant teenagers. It could also be deduced from this study that low educational levels contributes to delays in antenatal clinic attendance, since most of these pregnant teenagers and their parents/guardians have an educational level of grade 7 or below and therefore do not know about the value of early antenatal clinic attendance.

Having identified these factors, it would be possible to correct the situation through the development and implementation of programmes aimed at enhancing early antenatal clinic attendance and to provide adolescent-friendly health services, which do not exist in this country at present. The knowledge generated from this study could also be utilised by all health care workers to develop appropriate programmes to assist in the prevention of teenage pregnancy.

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