A PHENOMENOLOGICAL INVESTIGATION OF EXPERIENCES OF PREGNANCY BY UNMARRIED ADOLESCENTS IN MASERU

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OPSOMMING

Verskeie sosiale en sielkundige gevolge gaan gepaard met swanger adolessente se oorgang na moederskap en kan latere aanpassing by die lewe bemoeilik. 'n Kwalitatiewe studie is onderneem met die doel om die belewenisse van swanger ongetroude adolessente in Maseru te ondersoek en te beskryf en om, indien nodig, riglyne te ontwikkel vir 'n opvoedkundige- en beradingsprogram vir hierdie adolessente. Swanger, ongetroude adolessente, tussen die ouderdomme van 13-19 jaar, is uit 10 klinieke in Maseru gekies en versoek om 'n gedetailleerde beskrywing van die belewenis van hulle eerste swangerskap te gee. Die betekenis wat hierdie belewenis vir hulle gehad het is ook ondersoek. Sestien individuele fenomenologiese onderhoude en twee fokusgroeponderhoude het plaasgevind. Tesch (1990) se metode van analise is gebruik om die data te analiseer.
Resultate: Die proefpersone het gerapporteer dat hulle die bevestiging van hulle swangerskap met 'n kombinasie van ongeloof, verwarring en skaamte beleef het. Die data is in vier hoofkategorieë gegroepeer naamlik emosies, verhoudings, fisieke probleme en geloof. Positiewe en negatiewe ervaringe is beskryf. Al die respondente wat nog op skool was, moes die skool verlaat. Aanbevelings sluit in: elke swanger adolessent wat na die kliniek of afdeling vir buitepasiënte kom moet berading ontvang of vir berading verwys word. Prenatale opvoeding moet voorbereidende leiding ten opsigte van die moederlike rol bied.

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. The purpose of this qualitative study was to explore and describe the experiences of pregnant unmarried adolescents in the Maseru district and, if necessary, to develop guidelines for an educational and counselling 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. Data were grouped into four main categories namely emotions, relationships, physical problems and religion. Positive and negative experiences were described. All respondents who were still in school had to drop out. Recommendations included: every pregnant adolescent who comes to the clinic or outpatient department should receive or be referred for counselling. Prenatal education should provide anticipatory guidance related to maternal role issues.

INTRODUCTION

Talking about sex before marriage is a taboo in Lesotho. This tends to determine the extent to which adolescents (13-19 years of age) can be taught about sexuality. However, many adolescents are sexually active at an early age with the mean age at first sexual intercourse of 17.5 years (Ministry of Health and Social Welfare [MOHSW], 1993:58) and fail to use any measures to avoid conception (Moore & Rosenthal, 1993:145). When sexual activity begins, most adolescents lack accurate knowledge about reproduction and sexuality.

Pregnancy outside marriage is regarded as antisocial in Lesotho and carries a stigma. This may put unmarried adolescent mothers at risk of developing adverse psychological and behavioural problems that could affect their lives, as well as the infants' health and development (Lesser, Anderson & Koniak-Griffin, 1998:7).

PROBLEM STATEMENT

In Lesotho, like in many developing countries, there is an alarming increase in adolescent pregnancy. The epidemiological profile of adolescents in Lesotho shows a high incidence of adolescent pregnancy (as a proportion of first pregnancies among antenatal clients) of 52.1% (Ministry of Health and Social Welfare in collaboration with the World Health Organisation [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.

The researcher has also noticed that the experiences of pregnant unmarried adolescents have not been explored in Lesotho. It was therefore important to explore their experiences, in order to modify the nursing care provided to pregnant adolescents by implementing appropriate strategies that would help pregnant adolescents to become healthy mothers with healthy infants.

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 counselling program for pregnant adolescents, if necessary.

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 utilised. A phenomenological approach was used to explore and describe the experiences of pregnancy as lived by pregnant unmarried adolescents in the Maseru district in Lesotho.

The focus of phenomenological philosophy is understanding the response of the whole human being, not just understanding specific parts or behaviours. Phenomenological research is based on the philosophy that espouses the idea that there is not a single reality – each individual has his/her own reality. Reality is considered subjective, thus an experience is considered unique to the individual (Burns & Grove, 1997:39; 81).

POPULATION AND SAMPLING

Population refers to all elements that meet certain criteria for inclusion in a given universe (Burns & Grove, 1997:58). In this study the population refers to all pregnant unmarried adolescents in the Maseru district.

The inclusion criteria into the sample were that the subjects should:

- be able to speak and understand Sesotho;
- be between 13 and 19 years of age;
- be pregnant for the first time at the gestational age of 28 weeks and above (according to Neagle's rule and McDonald's method of measurement);
- be unmarried;
- be from the district of Maseru; and

- express a willingness to participate in the research.

SAMPLING TECHNIQUE

A sampling frame of the clinics that offer antenatal services in the Maseru district was made and eight clinics out of 24 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.

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. Phenomenological interviews were conducted with the subjects. Saturation of data was reached after 16 individual phenomenological interviews.

The simple random sampling method as described in the individual phenomenological interviews was also used to select two other clinics for the focus group interviews. These two clinics were not the ones used in the pilot study or in conducting individual phenomenological interviews. The convenience (accidental) sampling method was used to obtain group members. Focus group interviews were held with the group members. The data obtained was utilised to confirm and verify the data obtained from the phenomenological interviews.

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). Sixteen in-depth individual phenomenological and two focus group interviews were used to collect data. The research question asked was: *"Can you tell me in detail about your experiences with this pregnancy from the time you realised that you were pregnant until now?"*

At this stage it is important to remember that data obtained from focus group interviews are not identical to individual phenomenological interview data. Focus group data are group data. It reflects the collective notions shared and negotiated by the group. Individual phenomenological interview data reflects the views and opinions of the individual shaped by the social process of living in a culture (Berg, 1995:78).

In accordance with the phenomenological method, the researcher, prior to data collection, suspended 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 judgment 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).

Permission was sought from each subject to tape-record the conversation in order to ensure accurate transcriptions. The researcher explained the rationale for tape-recording to each subject and also indicated that the tapes would not be made available to anyone except the researcher. The interviews were begun with the researcher introducing herself and asking subjects about their biographical data. This was to comfort and help the 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). The interviews were done in a private room at the clinic.

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 subject. According to these authors continued eye contact also improves communication with the subject. Therefore the researcher maintained continued eye contact with the subjects throughout the interview.

The researcher believes that to work 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. Tape-recording also benefits the subjects. 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 (Seidman, 1991:87).

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. Subjects were allowed to give a narrative description of their experiences with their 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. Facilitative communication skills, for example, reflection, clarifying and validation were employed to encourage subjects to talk about their experiences.

The researcher also used field notes as a system for remembering the observations that were made, and most importantly for retrieving and analysing them. These included:

- Observational notes, which dealt with the descriptions of events, experienced through watching and listening. They contained the *who, what, where* and *how* of a situation.
- Theoretical notes which were used to derive meaning from observational notes. They were used to interpret or infer in order to build analytic scheme.
- Methodological notes were instructions or reminders of the researcher's tactics concerning methodological approaches.
- Personal notes contained the researcher's reactions, reflections and experiences.

MEASURES FOR ENSURING TRUSTWORTHINESS

In research terms it is not enough to merely have the research results. These results must be accepted by all members of the scientific community as authentic without reasonable doubt. This was achieved by applying Guba's (1981) model of assessing trustworthiness as presented *in* Krefting (1991:214-222) and Lincoln and Guba (1985:290-331). The four criteria to assess trustworthiness are credibility, transferability, dependability and confirmability. See Table 1 for the application of the trustworthiness. (Table 1 is on the next page.)

ETHICAL CONSIDERATIONS

The permission to conduct this research was obtained from the Ethics Committee of the Faculty of Health Sciences, University of the Free State, Director of Health Sciences, Ministry of Health Lesotho, and Director of Christian Health Services Lesotho.

Additional permission was obtained from the participants in the form of written consent for the interviews (Polit & Hungler, 1991; Burns & Grove, 1997). This consent contained all the rights to which subjects were entitled, which included the following: anonymity and confidentiality, the right to privacy and the right to protection from any discomfort or harm (Burns & Grove, 1997:197-206). This was ensured by not requesting any personal detail from subjects and to refer the respondents for counselling where emotional discomfort was caused by the interview.

DATA ANALYSIS

The transcribed interviews and field notes were analysed by using Tesch's method (1990) of analysis. 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 con

Table 1: Application of trustworthiness

STRATEGY	MEASURE	APPLICABILITY
Credibility	♦ Prolonged engagement	- The researcher first conducted the antenatal clinic (did routine examination of pregnant woman and conducted a health talk session). - Thereafter the researcher spent about 15-20 minutes with each of the subjects – to-be alone or with their parents building rapport; explaining the topic and purpose of study and ethical issues involved. - The researcher spent 45-60 minutes in conversation with the subject.
	♦ Persistent observation	- The researcher constantly observed the non-verbal communication of the subjects (like laughter, silence, cry and tone of voice) and other elements in the context of the conversation. Explanation or clarification was sought where necessary.
	♦ Triangulation - Data triangulation	- Only teenagers used here. - Subjects were from different families, different places in four Health Service Areas in the Maseru district and had different backgrounds.
	- Method triangulation	- Individual phenomenological and focus group interviews were used to collect data.
	♦ Peer debriefing	- The researcher's supervisor who is an experienced qualitative researcher and has a PhD in nursing served as a researcher's debriefer.
	♦ Member-checking	- After each interview, the interview was played back to the subject(s) who provided it, for reaction. - A copy of the analysed data was given to three of the subjects to confirm if they were a true reflection of their experiences.
Transferability	♦ Sampling	- Simple random sampling was used for selecting the clinics. - Convenience sample of pregnant adolescents was used. - Subjects in focus group signed a statement of confidentiality.

	♦ Data collection	- Individual phenomenological and focus group interviews were conducted until saturation was reached.
	♦ Dense description	- Comprehensive description of methods was given, including illustrative direct codes.
Dependability	♦ Dependability audit	- Data analysis protocol developed. - Use of an independent expert who has a PhD in Nursing for coding data. - Use of researcher's supervisor as a debriefer.
	♦ Dense description	- As discussed under transferability.
	♦ Code-recode procedure	- After coding a segment of data, the researcher waited for two weeks and then returned and recoded the same data and compared the results.
	♦ Method triangulation	- As discussed under credibility.
	♦ Independent expert	- A consensus discussion between the researcher and the independent expert was held to identify themes and categories.
Confirmability	♦ Triangulation	- As discussed under credibility.
	♦ Reflexive analysis	- 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 collection and analysis phases.

stituent parts (Clarke, 1999:532; Creswell, 1994:155). The analysis of data was done by the researcher as well as an independent co-coder.

The framework for content analysis (Figure 1) was 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 (Figure 1).

(Figure 1 is on the next page)

Figure 1 groups data from the interview transcripts into four main categories (emotions, relationships, physical problems and religion) and subcategories. Comprehensive themes were developed to support each category and subcategory.

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 researcher there

Figure 1: Framework for content analysis

CATEGORY	SUBCATEGORY	THEME
Emotions	Self/respondent	♦ Fear ♦ Denial/disbelief ♦ Confusion ♦ Worry ♦ Misery ♦ Shame ♦ Anger ♦ Bad feelings ♦ Hope ♦ Depression ♦ Acceptance
	Parents/Guardian	♦ Confusion ♦ Denial/disbelief ♦ Disappointment ♦ Hurt ♦ Anger ♦ Love ♦ Acceptance
	Relatives	♦ Anger ♦ Hurt ♦ Acceptance
	Boyfriend/Sexual partner	♦ Fear ♦ Surprise ♦ Denial ♦ Acceptance
Relationships	Parents/guardians	♦ Supportive ♦ Silence
	Relatives	♦ Silence ♦ Care ♦ Discrimination ♦ Rejection ♦ Supportive
	Boyfriend/Sexual partner	♦ Care ♦ Supportive ♦ Rejection ♦ New girlfriend

	Community Members	♦ Supportive ♦ Change (negative)
	Friends	♦ Supportive ♦ Change (negative)
Physical problems	Symptoms	♦ Nausea ♦ Vomiting ♦ Lower abdominal pain ♦ Cramps ♦ Pain left side of abdomen ♦ Increased epileptic attacks ♦ Backache ♦ Weight gain ♦ Tiredness ♦ Cough ♦ Weight loss ♦ Dizziness ♦ Heart burn ♦ Lack of appetite ♦ Increased vaginal discharge ♦ Swollen painful feet ♦ Sleeplessness
	Activities	♦ Unable to: – swim – play netball – wash heavy clothes – run (athletics)
Religion	Self/respondent	♦ Religious acceptance ♦ Still attends church ♦ No longer attends church
	Parents/guardians	♦ Religious acceptance

fore used a frequency table (Table 2) to present the experiences of pregnant unmarried adolescents from the highest to the lowest frequencies. However, these frequencies were not interpreted in the same way as frequencies generated in survey studies because of the imprecision in the sampling of cases and the enumeration of the themes (Polit & Hungler, 1991:505). (Table 2 is on the next page.)

Table 2 shows that some of the experiences of pregnant unmarried adolescents in the study were positive (like acceptance of pregnancy by parents/guardians, boyfriend/sexual partner and support from parents/guardians, relatives, friends and community members) while others were negative (like being rejected by parents, boyfriend/sexual partners, friends and community members).

Table 2: Experiences of pregnant unmarried adolescents in order of their frequency (n=16)

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 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 relative	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	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
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
Afraid to tell boyfriend	2	12.5

Afraid to tell boyfriend	2	12.5
Underwent counselling	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 by parent	1	6.3
Parent took this matter up to the local court	1	6.3
Relatives terrified	1	6.3

DISCUSSION OF RESULTS

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. 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, Molise and Ntimo-Makara (1999:90), the Ministry of Health and Social Welfare in collaboration with the World Health Organisation and the United Nations Population Fund [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, for example through initiation schools 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 overtime. 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).

The results also confirmed the need for counselling and family life education in schools. Respondents still believed that they could not fall pregnant if they engaged in unprotected sexual intercourse. Only few respondents 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.

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. Their uncertainty was due to the fact that they were not educated, not working and, most importantly, they were still children themselves. From the respondent's descriptions, it was 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. However, parents, especially mothers, were reported to have provided material and social support for most respondents. This finding its 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 stress buffering and direct effects, social support is believed to ex

ert 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, Susman & Stifter, 1998:170).

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

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

Respondents also reported to have dropped out of school early because of pregnancy. The same finding was reported by Ivey (1999:95), Kekesi and De Villiers (1999:44), Moore and Rosenthal (1993:159) and Stevenson, Maton and Teti (1998:379). 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. The fact that their parents were willing to play a supportive role in enabling them 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 only a few years of formal education.

The commitment 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 for families to improve their situation. Most parents of respondents were unemployed and had minimal levels of formal education. Hence it is conceivable that for them a better future lies 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 hardships to support the respondents in their desire and efforts to complete their 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 friends and community support and understanding were also found to create a stressful environment surrounding the respondents in this study. The loss of peer support and friendships are of concern particularly in the light of heightened importance of the peer group during adolescence. Parekh and De la Rey (1997:228) state that the peer group is central to the manner in which adolescents find themselves 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.

Respondents also 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). According to Alpers (1998:1150, Henderson (1999:91), Smith and Grenyer (1999:31) and Stevenson *et al.* (1999:119) a high quality relationship with the father of the baby 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 patricocal, 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. 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).

RECOMMENDATIONS

Some of the guidelines for an educational and counselling program are:

- Every pregnant adolescent who comes to the clinic or outpatient department should receive or be referred for counselling.
- Every father-to-be should be counselled (where possible).
- Adolescent friendly reproductive health services should be introduced.
- Education that is given to adolescent mothers pre- and post-natally should prepare them for the motherhood role.
- More research is recommended on:
  - The factors that influence the pregnant adolescent's decision to get married.
  - The experiences of motherhood by unmarried adolescents in Lesotho.

LIMITATIONS OF THE STUDY

Since data for this research was collected during winter, cold weather and snowfall may have hindered access to potential subjects in some clinics.

CONCLUSION

It is clear that much needs to be done to facilitate the teenager's adjustment to motherhood. Parents should be encouraged to send adolescent mothers to school again to finish their formal education as well as to provide not only material and social support but also emotional and spiritual support.

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