EXPERIENCES OF ANTENATAL CARE AMONG PREGNANT ADOLESCENTS AT KANYAMA AND MATERO REFERENCE CLINIC IN LUSAKA DISTRICT

BY

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DEDICATION

I dedicate this work to my late mother, Violet Chikoya Bwalya, who has been my source of inspiration in everything l do. She is behind the woman lam today.

Secondly, l would like to thank my father, George Mwimba Bwalya, for the encouragement and love that you always render to me. My heartfelt appreciations also goes to my husband, Kelvin Sinyangwe and my daughter, Chitambo Suwilanji Nanyangwe and other family members, for their love, patience and encouragement throughout my study.

My gratitude also goes to my sister, Chimfwembe Bwalya who gave me all the motivation and support to pursue my masters' programme. I thank you so much.

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STATEMENT

I hereby state that this dissertation is entirely the result of my own personal effort. The various sources to which I am indebted have been clearly indicated in the references and acknowledgements.

Signed……. Date:…….

Bwalya Chisoso Bwalya

DECLARATION

I hereby declare that this dissertation herein presented for the degree of Masters of Public Health has not been previously submitted either wholly or in part for any other degree at this or any other university nor is it being or currently submitted for any other degree.

Signed……. Date:…….

Bwalya Chososo Bwalya

ABSTRACT

Introduction: Adolescent pregnancy is among the many public health concerns not only in Zambia but also in other parts of the world. Access to skilled health providers is essential for the health and wellbeing of both the mother and the unborn child. Exploring pregnant adolescent's experiences of antenatal care provides an important approach to identify specific problems that may require re-evaluation of existing policies and programs in health care systems in Zambia. However, there is limited documentation on the experiences of antenatal care among pregnant adolescents in Zambia.

Methodology: A qualitative, phenomenological research design was adopted, using semi structured in-depth interviews to collect data. The interviews with the research participants were audio recorded. Maximum variation sampling technique was used to select 12 pregnant adolescents (12-19 years) that attended antenatal care from both Kanyama and Matero Reference clinic in Lusaka District. The participants were identified through observation of antenatal cards at the clinics. Consent was sought from adolescents who were 17years old and above. Parental consent/assent was also sought from the biological mother/father or guardian from participants below 17 years old. Data was analyzed thematically with the help of Nvivo software version 10.

Results: The findings of this study indicate that pregnant adolescents had both positive and negative experiences with the health care providers. They complained that the health care providers were rude in the way they communicated with them. However other participants reported that the health providers were friendly and welcoming. The participants also described their experiences of antenatal care with older pregnant women. Some participants reported being judged and discriminated against by older women, while others (older women) were reported to be unfriendly towards the adolescents. On the other hand, some participants revealed that older women offered them good advice on how to take good care of their pregnancy. In addition, a number of learning outcomes from antenatal classes were also noted by the participants with specific reference to antenatal education. Furthermore, the participants also raised a number of other issues with regards to their experiences with the antenatal care services. These included long waiting period to receive care, issues of privacy and confidentiality during counselling and physical examinations of pregnancy, and lack of adolescent specific spaces.

Conclusion: Therefore there is a need to establish an adolescent friendly antenatal care that would address some of the issues facing pregnant adolescents at the antenatal clinic.

Key Words: Pregnant Adolescents, Experiences, Antenatal Care

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Adolescent pregnancy is one of the Sexual and Reproductive Health (SRH) problems facing several Low Middle Income Countries (LMICs) (Morris and Rushwan, 2015). It accounts for about 11 percent of all births worldwide (WHO, 2014) and 95% of these births occur in LMICs (Morris and Rushwan, 2015). However, adolescent pregnancy is associated with various maternal health related complication and death (Pogoy et al, 2014). For instance, it has been documented worldwide that pregnancy and childbirth related complications are among the leading causes of death for adolescent girls aged 15-19 years(Gross et al, 2012). A study done in Latin America showed that girls who give birth before the age of 16 are three to four times more likely to suffer maternal death than women in their twenties. (ZADH-SP-2011-2015).

In Zambia, 27% of the total population are adolescents. Approximately 3 in 10 young women aged 15 to 19 years have either given birth or carrying a pregnancy. (ZADH-SP-2011-2015). However, early pregnancy can cause severe health problems not only for the mother but also for a child (2013-2014 ZDHS, 2015). For example, adolescent pregnancy is said to be associated with various pregnant related complications such as obstructed labor (Pienaar, 2011), toxemia, hemorrhage, hypertension and anaemia (James, Rall and Strumpher, 2012) among others.

Research has shown that most of the maternal related complications mentioned above are avoidable through timely access to antenatal care services as it presents an opportunity to prevent or manage pregnant related risks (Banda, Michelo and Hazemba, 2012; Fernanda et al, 2015). These studies have also indicated an association between antenatal care attendance and a reduction of premature births, low birth weights, congenital malformations, congenital infections, neonatal tetanus, pre-eclampsia and anaemia (Alemayehu, Haidar and Habte,2010; Banda, Michelo and Hazemba 2012) as well as reducing fetal and neonatal deaths related to obstetric complications.

Despite the effectiveness of antenatal care services in reducing some of the negative outcomes associated with adolescent pregnancy, existing health data on pregnant adolescents implies that

this group under use the available antenatal care services, thereby compromising its effectiveness (Peterson, 2010). This has also been proven from several studies around the world. It has been claimed that adolescents are less likely than adult women to access and initiate antenatal care due to a number of reasons (Lenters et al, 2015) such as judgmental health workers (Atuyambe et al., 2008, Geary et al, 2014) and a lack of training in and understanding of adolescent reproductive needs as well as restrictive laws and policies (Atuyambe et al., 2008). There is also fear of humiliation or having to respond to unpleasant questions and procedures during antenatal care. Furthermore, there is also lack of respect, privacy and confidentiality within the health care system (Atuyatumbe, Mirembe, Johansson, Kirumira, & Faxelid, 2015 cited in Munywoki, 2015).

In Zambia, pregnant adolescents utilize the same antenatal care services as adults as there are no specific services for the adolescents. In order to encourage uptake of these service, the Zambian government provides these services at no charge and are provided every working day of the week (Kapeta, 2012). If at all pregnant adolescents utilize antenatal care services, it would provide an opportunity to educate teenaged women on how to recognize and respond to the signs of obstetric complications as they may have little knowledge and experience in reproductive health (Alemayehu, Haidar and Habte, 2010). The other added values obtained from ANC services are provision of tetanus toxoid immunization which is lifesaving both for the mother and infant; treatment of malaria, anemia and STIs; and an entry point for prevention of mother to child transmission of HIV. Provision of health advices on birth spacing and use of institutional delivery which would significantly improve both maternal and fetal outcomes are the other important services obtained in the process and health education on health promoting activities, like exercises, diet (Alemayehu, Haidar and Habte, 2010).

Policies for these young women may fail to take into account their unique situation, resulting in less effective medical care. The patient's perspective is invaluable in the design and evaluation of health policy, yet teens' voices are usually missing from the debate (Michels, 2000). This report is aimed to bring those voices to the foreground by exploring and understanding the lived experiences of antenatal care among pregnant adolescents within the existing non-targeted antenatal care services.

1.2 STATEMENT OF THE PROBLEM

In Zambia approximately 3 in 10 young women aged 15 to 19 years have either given birth or carrying a pregnancy (ZADH-SP-2011-2015). However, early pregnancy can cause severe health problems not only for the mother but also for a child (2013-2014 ZDHS, 2015). For example, adolescent pregnancy is said to be associated with various pregnant related complications such as obstructed labor (Pienaar, 2011), toxemia, hemorrhage, hypertension and anaemia (James, Rall and Strumpher 2012) among others.

Pregnant adolescents are not only vulnerable to pregnancy complications but are also often met with judgmental attitudes and pushed into isolation by society as well as health professionals (Baddiley, 1997; Kiddy, 2002; Patterson, 2003; Beckinsale, 2003 in Martis, 2005). As a result they are either reluctant to initiate antenatal care, refuse to go back for antenatal checks or do not want to share antenatal classes with older pregnant married women, as teenagers perceive married women to be another judgmental group (Condon and Corkindale,2002).

Several maternal related studies have been undertaken in Zambia such as factors contributing to non-utilization of antenatal care among pregnant women (Banda, Michelo and Hazemba, 2012). However, most of these studies used quantitative research design. The reasons for lack of uptake of antenatal care can be too complex for a quantitative design. In addition, few studies have used qualitative approaches to describe specific aspects of adolescent pregnancy including adolescent's experiences of antenatal care (Kingston et al, 2012). It is against this background that inspired me to conduct a qualitative phenomenological study in order to explore, describe and provide a much deeper understanding of adolescent's experiences of antenatal care from the antenatal clinic environment.

1.3 SIGNIFICANCE OF THE STUDY

Pregnant adolescents face unique challenges (Kingston et al, 2012). Understanding the experiences of adolescents with regards to antenatal care may contribute to an increase in the utilization of antenatal care. Thus a deeper understanding of the lived experiences of pregnant adolescents with regards to the antenatal clinic environment will add to the existing body of knowledge on issues surrounding maternal and child health in Zambia. The findings of this study are therefore important to policymakers and programme implementers in designing

appropriate strategies and interventions for an adolescent-friendly maternal and child health care services.

1.4 RESEARCH QUESTIONS

What are the positive and negative experiences of antenatal care among pregnant adolescents?

1.5 OBJECTIVES

1.5.1 MAIN OBJECTIVE

- To explore and understand the lived experiences of antenatal care among the pregnant adolescents.

1.5.2 SPECIFIC OBJECTIVES

- To explore and describe the experiences of pregnant adolescents with the healthcare providers at the antenatal care clinic.
- To explore and describe the experiences of pregnant adolescents with older pregnant women within the antenatal care clinic.
- To describe the experiences of pregnant adolescents with the antenatal education

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Antenatal care is one of the most effective ways to identify, prevent and manage pregnancy related complications in adolescents. Pregnant adolescents require special care as they present unique challenges compared to older pregnant women due to their physiological immaturity (Pienaar, 2011). Pregnant adolescents are less likely than older women to utilize antenatal care services and are less likely to keep antenatal care appointments (Lenter et al, 2015). It is for this reason that several studies have been undertaken to identify factors that contribute to non-utilization of antenatal care among pregnant adolescents. However, this study specifically focused on the experiences of antenatal care among pregnant adolescents.

2.2 ATTITUDES AND BEHAVIORS OF HEALTH CARE PROVIDERS

Health care provider's attitudes and behaviors can either be positive or negative (Kapeta, 2012). The negative attitudes and behaviors of health care providers are some of the concerns that have been cited by pregnant adolescents as the reasons for not attending antenatal care. In a study conducted in South Africa by Pienaar, 2011, participants reported that the midwives shouted and screamed at them. Similar findings were reported in a study conducted by Michels, 2000, at Riley High School, located in the Watts neighborhood of Los Angeles. Her findings revealed that there were some adolescents that saw their doctors as inexcusably rude and disrespectful.

Another similar study conducted by Alemayehu, Haidar and Habte, 2010, in Ethopia demonstrated that the health workers were un-friendly towards pregnant adolescents. Such negative attitudes and behaviors of health care providers, according to Pienaar, have the potential to delay or avoid care among adolescents because they feel embarrassed, sad, hurt, and afraid of midwives.

Although negative attitudes and behaviors of health care providers were reported by Pianaar and Michels, some participants in these studies also reported that the health care providers were friendly and caring. Positive attitudes and behaviors of health care providers were also revealed in studies conducted in Ontario, Canada by Peterson, 2007; Daggan and Adejumo, 2011 of South Africa and Phafoli, Aswegen and Alberts, 2007 of Lesotho. These studies revealed that health care providers were friendly, in the way they spoke to the adolescents. In addition, the attitudes and behaviors were also seen as positive when the health care providers were perceived to be patient, respectful and gentle, smiled, laughed, and joked with them, as well as provided comfort when in fear. Therefore, health care providers who provide antenatal care services for pregnant adolescents must be committed, friendly and have a non-judgmental approach.

2.3 STIGMA AND DISCRIMINATION

Stigma and discrimination in a health setting has also been identified as one of the factors in influencing delay or non-utilization of antenatal care among adolescents. Studies have revealed that pregnant adolescents are stigmatized and discriminated upon not only by other service users (older pregnant women) but also by health care providers. Participants in Michels study reported that doctors stigmatized them and looked down on them for being pregnant. It is worthy to note that pregnant adolescents are acutely aware of the stigma that is attached to adolescent pregnancy and thus they become sensitive with how they are treated by others. For instance in studies carried out by Pienaar 2011, James, Rall and Strumpher 2012; Peterson et al, 2007, Daggan and Adejumo 2011, health care providers were perceived as discriminatory when they behaved differently around pregnant adolescent from how they did with older pregnant women receiving the same antenatal care service as them. The participants argued that the needs of older women were met before theirs despite reporting to the antenatal clinic much earlier than them. One participant in Peterson's study described overhearing nurses talking to her older roommate. This adolescent perceived a difference in the health care providers' tone of voice and the content of their conversations, depending on whom they were speaking to. She interpreted this difference as meaning that the nurses were negatively judging her.

Moreover, another form of discrimination may be in relation to policy and practices in the health care system. For example, in a study conducted in Ghana by Lenters et al, 2015, the participants study clearly understood the value of being tested for STIs such as HIV, but many disliked that tests were administered only when husbands/partners were present. A number of Tanzanian participants were reportedly told that they would not be tested or cared for if a partner did not accompany them to receive STI testing at the same time. However, participants with supportive husbands had less trouble bringing them to the facility, but some young women were unable to bring a partner or the father of their child (i.e. if paternity was unknown or the man "refused to take responsibility for the pregnancy"). While male involvement in antenatal care is encouraged and valued, requiring all pregnant women to bring their partners to antenatal leaves out some vulnerable adolescents without access to care.

On the contrary, participants in Lenters et al's study did not raise the same concerns, presumably due to less emphasis on partner accompaniment to antenatal care visits in this context.

Stigmatization against pregnant adolescent by older women attending antenatal care was also reported by Pienaar. The experiences of stigma by pregnant adolescents in this case was reported in Pienaars study when participants accused pregnant older women of pointing at them at the clinic. There were also instances where the participants felt unpleasant and embarrassed when the older women did not want to engage in any conversation with the adolescents or were unfriendly as it was perceived to have been related to the misconception of adolescent pregnancy among older women. Individuals would feel lonely when they feel that their relationships with others are less satisfying than they would like it to be (Taylor, Peplau and Sears; 2003:234 cited in Pienaar).

Findings from the studies conducted by Sally and Mitchel, 2009; and Cremona 2009, also reveal that pregnant teenagers experienced stigma not only from families, friends and society at large but also from the health care providers. Some participants in these studies revealed that the nurses considered them to be too young to be pregnant, useless and called them prostitutes. Other participants were preached to by the nurses.

2.4 OPERATING HOURS

Service hours for antenatal care may also pose as a major challenge in seeking care by adolescents. In Zambia, these services are provided during working days (08:00-16:00 hours) and usually in the morning implying that those who are free after school or during weekends may not be able to access the services. (Kapeta, 2012). Clearly, this may affect accessibility because it may only be appropriate for teenagers who are not in school. Pregnant teenagers who are still in school may not be able to access the services due to the inflexible time the antenatal care services are provided.

Length of time spent at the clinic was another issue that came out from the peer reviewed studies conducted by Daggan and Adejumo, Michels, Pienaar, Peterson et al; and Phafoli, Aswegen and Alberts. The pregnant adolescents that participated in these studies claimed that they spent long periods of time waiting in queues to receive care at the clinic and yet they arrived at the clinic as early as 06:00 am. Pienaar; and James Rall,and Strumpher further argued that although the participants went to the trouble of arriving early at the clinic, they felt that they were treated unfairly as the needs of the older women were seen before their own. Some participants also attributed long waiting time to shortage of health care providers at the clinic, while others observed that health care providers would just sit, talk, laugh with each other or take long breaks while keeping the participants waiting. However, Michels presented slightly different findings that were in relation to the time the adolescents spent with the doctor. He argued that some adolescents were not happy with the doctors that spent too little time or attention on them. The participants complained that the doctors were too quick and this made it impossible to ask them any questions.

2.5 PRIVACY AND CONFIDENTIALITY

Lack of privacy and confidentiality at health centres is another concern for adolescents. Lack of privacy towards teenagers was reported by Phafoli, Aswegen and Alberts, 2007 and Mlilo-Chaibvu, Roos, and Ehlers (2007). Issues of privacy and confidentiality in a health care setting have also been a source of concern among pregnant adolescents in studies carried out by Daggan, James, Pienaar and Michels. Privacy and confidentiality in Pienaars and James study were directly linked to congestion, consulting rooms were situated too close to one another and as such the participants felt they were exposed to other patients especially when the midwives were

taking their history or explaining their treatment. Participants in Pienaars study also felt that their confidentiality was breached when the health care providers screamed at or were racially discriminated against in full view of everyone as there were no private rooms where the health care provider could question them, give information or comment on them being late for antenatal care.

On the contrary, lack of privacy and confidentiality was presented in a different context in Michels study were participants reported that the clinic staff left their files carelessly and that anyone could easily go through them. However, others reported that the doctors respected their privacy in the sense that the doctors were not loud when talking to them.

2.6 NON-TARGETED ANTENATAL CLINIC CLASSES

Generally, antenatal classes for pregnant women are group sessions involving instructions, discussions and exercises for labour and delivery (Lena et al, 1993). According to Alemayehu, Haidar and Habte 2010, antenatal classes provide an important opportunity for discussion between a pregnant woman and the health care provider about recognising complications that may arise during pregnancy. However, it has been argued that within non-targeted classes, young, single unmarried mothers perceived the classes most negatively and were less likely to attend due to fear of stigmatizations and humiliation when attending the classes alongside older pregnant women (Kaufman, , Wet and stadler, 2001; Rozette, Clemmey,and Sullivan 2000; Howie and Carlisle, 2008). Lena et al, 1993, conducted a study at Ottawa General Hospital that focused on the experiences of prenatal care, prenatal classes and birthing among adolescents. The findings revealed that 26% of the adolescents attend such classes as compared with 91% of the adults. The reason for not attending included fear, feeling uncomfortable with couples and older women, people asking the whereabouts of their husbands and staring at them. Other participants reported that they did not feel prepared for labour and delivery. This was attributed to not knowing what to expect and being poorly prepared thus triggering fear. The fear of what to expect during delivery was inversely proportional to the number of visits to antenatal clinics and classes.

In addition, the participants in Lenas' et al study revealed that they felt out of place, and uncomfortable in adult-oriented clinics and classes. The adolescents were also uneasy at insensitive comments and attitudes of some of the staff during the admission procedures. Consequently, more of the adults than the adolescents participated in these prenatal classes.

Similar findings were found in studies conducted by Pienaar, 2011 and James, Rall and Strumpher, 2012 due to the age difference between pregnant adolescents and the older pregnant women. The age difference made the adolescents uncomfortable because they were the young ones in the group. Others were unable to ask questions freely in adult oriented classes. These findings are also consistent with the findings by Killoran, 2010. He noted that young parents reported feeling judged, intimidated, and dissatisfied with their treatment from older women. He pointed out that they are unable to ask questions as they felt stigmatized and lacked confidence. Additionally, participants from Lenters et al, reported about feeling shy or embarrassment when waiting for their antenatal appointment in the general waiting area at the facilities. The reason why some of the adolescents may have felt uncomfortable was because of the fact that adolescents are aware that society frowns on young people participating in unsafe sex, resulting in teenage pregnancies (James et al. 2010:4 cited in James, Rall and Strumpher 2012). The participants were also very aware of the fact that they were the youngest of the women attending the clinic, and that they were being forced to sit amongst women who were all older than them, thus making them feel uncomfortable.

From the reviewed literature, it is evident that pregnant adolescent go through numerous challenges. There are similarities with the literature that has been reviewed in this study. The methodology used for all the studies was purely qualitative in nature. Pienaar; James, Rall, and Strumpher; Daggan and Adejumo; Peterson et al used semi-structured interviews to gather information from adolescents while Lenters et al used focused group discussion. However, Michels 2000, do not only explicitly explain the methodology of her study as well as the technique she used to collect data from young mothers. Additionally some of the findings in a study conducted by Pienaar 2011 are synonymous with the findings in studies conducted by James, Rall and Strumpher; Peterson et al; Daggan and Adejumo as well as Michels. The reviewed studies indicate that the teenagers were uncomfortable with the clinic environment and this was due to a number of issues such as lack of privacy, confidentiality and the age difference between the teenagers and other older pregnant women that attended antenatal care. Other issues that came out were in relation to time management as well as the attitude and behaviours of health providers towards pregnant adolescents. Some participants described health care providers as caring and supportive, while others described them as harsh and discriminatory.

To add on the challenges they face, in Zambia, there are no antenatal care services specifically for adolescents as they utilize the same antenatal care services as adults. There are several studies which have been done on antenatal care but little has been done spacifically on the experiences of antenatal care among pregnant adolescents in Zambia.

Therefore, this study provided an opportunity to add on to the body of knowledge on the experiences of antenatal care among Pregnant adolescent, a typically underrepresented population within existing antenatal care literature in Zambia.

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY DESIGN

This study was a qualitative phenomenological study. 'A phenomenological study describes the meaning for several individuals of their lived experiences of a phenomenon. Phenomenologists focus on describing what all participants have in common as they experience a phenomenon (Creswell, 2007, p58). Phenomenology provides a deep understanding of a phenomenon as experienced by several individuals. Data is collected from people who have experienced the phenomenon, and develops a composite description of the experience for all the individuals. This description consists of "what" they experienced and "how" they experienced it (Moustakas, 1994, cited in Creswell, 2007)**.**

This design and approach enabled me to collect data that allowed me to explore and develop an in-depth understanding of the experiences and perceptions of pregnant adolescents attending antenatal clinic at Kanyama and Matero Ref clinic. In particular, this design and approach enabled me to uncover details about experiences of pregnant adolescents within the antenatal clinic environment.

3.2 STUDY SETTING

This study was conducted at Kanyama and Matero Reference health care centres that offer antenatal care services in Lusaka, Zambia. These two health centres are first level hospitals run and owned by the Republic of Zambia. They are located in densely populated residential areas of Lusaka (Kanyama and Matero).

Kanyama clinic is located in Kanyama Compound, which is part of Kanyama Constituency North-west of Lusaka, whereas Matero Reference clinic is located in Matero Constituency with a catchment population of 109,776(CSO, 2010).

Purposive sampling technique was used to select these two clinics based on their potential to provide a sufficient number of variations in the demographic characteristics of eligible research

participants. In addition, the health centres needed to be physically/geographically accessible to the researcher.

3.3 STUDY POPULATION

The research participants were pregnant adolescents who ranged between the ages of 15-19 years old. They received antenatal care from Kanyama and Matero Referral health centres. All the participants were not in school at the time when this study was being conducted as most of them were school drop outs due to pregnancy.

3.4 INCLUSION AND EXCLUSION CRITERIA

The research study included pregnant adolescents who attended antenatal care at Kanyama and Matero Referral clinics between the ages of twelve to nineteen years old. These participants had to at atleast have two or more antenatal care visits and were willing to participate in the study. In addition to the inclusion criteria, the mother/father or guardian of the pregnant adolescent had to give parental consent for the adolescents below 17 years to participate in the study.

The exclusion criteria for this study were pregnant adolescents that came for registration because they were unable to relate to any experience when responding to the research interview and those that did not give consent to participate in the research study.

3.5 SAMPLING AND SAMPLE SIZE

The sample was chosen from the targeted population by means of purposive sampling. In purposive sampling, participants are selected because they are believed to be able to give the researcher access to a special experience that she wishes to understand, and are seen as a good representative of the target population (Yegidis and Weinbach, 1996: 122). As a researcher I used the inclusion and exclusion criteria as a guide to choose and pick only those who best met the purpose of the research (Polite and Hungler, 1993: 444).

Twelve pregnant adolescents from the ages of 15 to19 years were purposively selected to take part in the study from Kanyama and Matero Referral antenatal health care clinics. Sampling was drawn from the antenatal care clinic records. All the names that met the inclusion criteria were identified through the observation of antenatal records (antenatal cards) at the two respective

clinics. Subsequently, for those adolescents that were below 17 years, their parent's/guardians were then contacted for parental consent.

Maximum variation sampling frame was used as a guide to determine the sample size for this study. This type of purposive sampling was applied so as to capture maximum variation in terms of age. The aim was to increase representation of pregnant adolescent's lived experiences of antenatal care. Eight age categories of pregnant adolescents were identified (12-19 years old). Two participants (one per site) from each of the eight categories were to be sampled, bringing the total of the initial targeted sample size to 16 pregnant adolescents. However, only 12 (7 from Matero Ref. and 5 Kanyama clinic) participants were interviewed due to the fact that no new information was coming out from the interviews. In addition, participants from 12-14 years old were an available at the time the study.

According to Burns and Grove (2009:361), the focus in qualitative research is on the quality of information obtained from the person, situation, event, or documents sampled versus the size of the sample. The sample size used in qualitative research methods is often smaller than that used in quantitative research methods. This is because qualitative research methods are often concerned with getting or acquiring an in-depth understanding of the phenomenon under study. The concept of saturation is the most important factor to think about when mulling over sample size decisions in qualitative research (Creswel, 2007). Saturation is the point at which the data collection process no longer offer any new or relevant information. In this current study saturation of information was reached after 12 participants were interviewed.

DATA COLLECTION METHOD

As stated above, the study was a qualitative study using a phenomenological method. The duration for data collection for this study was one month. I used semi-structured interviews questions to collect data on the experiences of antenatal care among pregnant adolescents. Each interview lasted approximately thirty minutes. There was a set of only thirteen pre-determined questions which served as a guide to the interview and kept it focused on the topic. Additional probing questions were asked when the response to the main question seemed not to have come out very clear or incomplete, or when participants brought out an interesting topic that I had not previously considered in the main interview guide (for a list of the thirteen questions see Appendix E). The interviews were conducted in a private room within the clinic. All the thirteen interviews were audio-recorded and then transcribed on the same day the interviews

were conducted. Three interviews were scheduled first as a pre-test. In these three interviews, the appropriateness and effectiveness of the research questions, structure and technique were assessed. After the pre-test, the questions, or the order of the questions, were revised accordingly before the thirteen main interviews took place. Phenomenological framework for in-depth interviews was chosen for this research because it was the most appropriate methodology to answer my research questions. The goal of this study was to gain a depth of knowledge through the personal stories of what pregnant adolescents like about antenatal care, what they dislike.

3.6 DATA ANALYSIS

The analysis of interview transcripts largely followed a combination of deductive and inductive reasoning. Inductively, themes were generated by following the procedures recommended by Moustakas (Creswell, p.89 2007): All in-depth interviews were recorded and transcribed in English. The process of transcription involved listening and writing down the verbatim of the audio recorded interviews several times, back and forth so as to ensure that no details were left out. All details that happened in the background such as laughter or any disruption were also taken note of. After I finished transcribing each interview, I listened to the whole recording again and again whilst following along with the transcribed text in order to check for any error or omissions. The personal details for the participants were replaced with numbers before the transcripts were imported into Nvivo10 software. Secondly, I Read through all the written transcripts several times to obtain an overall feeling of the contents; After I familiarized myself with the content of each interview transcripts in Nvivo, I then identified and took note of significant phrases or sentences that pertained directly to the experience of antenatal care by the adolescents. The list below shows some of the words from the preliminary list of significant phrases:-

- Adolescent's relationship with the provider
- Stigma and discrimination
- Relationship with older women
- Positive impact of antenatal education
- Unfriendly older women

The third stage was to compress the preliminary list by formulating meanings and clustering them into parent and child themes common to all of the participants' transcripts as shown in the

table below. The last stage involved coding the text into their respective subthemes and thereafter integrated the results into an in-depth, exhaustive description of the phenomenon (Creswell, p89, 2007). Below is a table of major themes and sub-themes that emerged during data analysis.

Table 1: Summary of Major-themes and Sub-themes

Major-themes	**Sub-themes**
Experiences with the health care providers	• Good reception from service providers • Bad attitude of health workers towards adolescents • Discrimination by the health workers
Experiences with other service users	• Positive advice from adult service users • Unfriendly interactions with adult mothers • Stigmatization by other users
Experiences of antenatal care procedures	• Positive lessons learnt from antenatal education • Fears or insecurity
Operating hours	• Too early at the health facility and yet being attended to late • Long waiting time
Venue for delivering antenatal services	• Clean environment • Lack of adolescent specific spaces • Privacy and confidentiality • Overcrowded environment
Suggestions for service improvements	• The demand for Antenatal care services for adolescents only • Preferred time to receive antenatal care

3.7 ETHICAL CONSIDERATION

This research study involved research on humans and it was a requirement to seek approval from the University Of Zambia Biomedical Research Ethics Committee (UNZABREC). The application to conduct research from UNZABREC can be found in Appendix F. The information sheet was shown to all participants, informing them about the nature of the research as well as their rights. A copy of the information sheet can be seen in Appendix A. A copy of the consent, which was signed by all participants, can be found in Appendix B. Permission to conduct on-site research was also sought from the clinics where interviews took place, and a copy of the letter requesting this permission can be seen in Appendix G. Finally, a sample interview guide can be seen in Appendix E. The ethical principles that guided this study included privacy and confidentiality. The participants were assured that the information gathered from the interviews would be kept confidential and that no names would be attached to it. In addition, the interviews were also conducted privately within the research sites. Audio recording were to be kept under lock and key. The participants were informed of their rights for both voluntary participation and termination of participation at any stage of the research. Informed consent (see appendix B) was an important step that was taken to ensure that the rights of research participants were respected and this was obtained in writing from adolescents above 16 years. Assent (see appendix D) and parental consent (see appendix C) was obtained from adolescents below 16 years. All participants were informed about the nature and duration of the study. This information was needed the participants make an informed decision of whether to take part in the study or not. Audio recording was under lock and key.

The other ethical principle that guided the study was justice. All the participants were equally treated regardless of their age and economic background. Because of the condition under which the research participants were in, fatigue was likely to occur during the interview session. The participants were therefore allowed to take short breaks during the interview and would resume the interview at the time that was convenient for the participant.

3.8 DISSEMINATION PLAN

The findings of this study will be presented at the Graduate Forum at the University of Zambia. The results will also be published in an academic journal. Other copies of this study will be submitted to UNZA Public Health Library as well as Ministry of Health. The results of this study will be useful for the midwives as they are the ones that deal directly with the pregnant teenagers.

CHAPTER FOUR

4.0 FINDINGS

4.1 INTRODUCTION

In the last chapter, I discussed the qualitative method of this study and its appropriateness for eliciting information from pregnant adolescents about their antenatal care experiences at Kanyama and Matero Referral Clinics. This chapter starts by first presenting the demographic profile of the research participants. Thereafter, the main themes and their sub-themes will be presented. Direct quotations from the raw data will be provided to support the description of the experiences and the findings of the study. The true identities of participants were replaced with Pseudonyms (the first number represents the age of the participants and the last number on the left represents the I.D number for the participants whereas letters represents the study site-K for Kanyama clinic and M for Matero Ref clinic). The results have been organized as follows:

- Experiences with service providers
- Experiences with other service users
- Experiences of antenatal education
- Operating hours
- Venue for delivering antenatal services
- Recommendations for service improvement

4.2 PARTICIPANT'S DEMOGRAPHIC PROFILE

Table 2: Participants Demographic Profile

Age	Number of participants	Marital status
15	1	Single
16	2	Single
17	2	Single
18	4	Single
19	3	Single

Participants ranged in ages from 15–19 years old. Two of the 12 participants were 16 years old, two were 17 years old, four were 18 years old, three were 19 years old and one was 15 years old. All participants were pupils before they became pregnant but most have since withdrawn from school due to pregnancy. Pseudonyms were substituted for the names of participants in order to protect their privacy and maintain confidentiality. Each participant's name was replaced with a number.

4.3 EXPERIENCES WITH SERVICE PROVIDERS

There were variations with regard to the experiences of pregnant adolescents with health care providers at the clinic. While some had positive experiences, others did not have. Below are the detailed explanations of their experiences with the health care providers

4.3.1 Good reception from service providers

Most participants (from both Kanyama and Matero Ref. Clinic) in this study revealed that their relationship with the service provider was good. This good relationship was attributed to the good reception they received from the health care provider and just the general care they received from them. Some participants made the following comments:

> "*I have a good relationship with the nurses. They welcomed me very well the first time l came here with my husband and they are very educative" 18-K10.*
>
> *"They are good because they attend to us pregnant women quickly when we come to the clinic" 16-M1.*

4.3.2 Bad attitude of health workers towards adolescents

Although some pregnant adolescents had good experiences with the health care providers, other participants had also encountered negative attitudes and behaviors of health care providers during the antenatal care service. Some adolescents complained that the nurses were sometimes rude in the way they communicated to them. One participant reported that the nurse was rude in the way she spoke to her.

> *.. "The first time the nurse was rude because I dint understand her instructions clearly" 15-K8.*

Another research participant had echoed a similar negative experience with regards to the attitudes and behaviour of health care providers at Matero reference clinic. The doctor shouted at her for not waiting for two years before she could conceive the second time. Below is how the adolescent explained her situation.

> *"I lost my child last year..I had a pregnancy that ended up in an operation but I lost the baby. When I came back for antenatal this year, I requested for a referral to go to*

another hospital from the Sister-In-Charge.. Instead, she started scolding at me for having not waited for 2 years before getting pregnant again.. I was hurt with the words she used as if I did it deliberately to have lost the child with the first pregnancy,'' 19-M12.

4.3.3 Discrimination by the Health Care Provider

The participants also felt that they were being discriminated upon by the health care providers because of their marital status. The reasons cited for this was that health workers gave first priority to those that went with their partners for antenatal care. They complained that the nurses first attended to the couples before they were attended to despite reporting to the clinic much earlier than them.

"I don't like the way this clinic operates because they give first priority to those women who come with their husbands…even when they come late for antenatal care" 16-K11.

4.4 EXPERIENCES WITH OTHER SERVICE USER

The participants narrated different experiences with older pregnant women with whom they shared the same antenatal classes at their respective clinics. Some adolescents had positive experiences, while others experienced stigma and unfriendly interactions with older women.

4.4.1 Positive Advice from Adult Service Users

Kanyama and Matero Referral Clinic both provide general antenatal care for all ages. This means that there is no separation between adolescents and the older women's antenatal classes. The participants in this study expressed different views on how they related with older women during antenatal care. Generally, most of the research participants reported that they had a healthy relationship with older expectant mothers. Some adolescents reported that older women provided them with good advice on how to take care of their pregnancy and that they got along very well during antenatal care visits:

"I ask them pregnancy related questions… they teach me on how to take care of my pregnancy such as, what to eat, not to sleep too much and carry heavy things and preparations for my delivery…..They also teach me other things that I don't know" 19-M2.

4.4.2 Unfriendly Interactions with Adult Mothers

The pregnant adolescents in this study provided a deeper insight into their relationship with older women. During their interaction with older women some girls encountered negative experiences such as unfriendly interactions with older pregnant women. Older women were perceived to be unfriendly when they did not initiate or engage themselves in any conversations with the adolescents. Others were perceived to be uninterested in the adolescents as they minded their own business. Such unfriendly encounters with older women at the clinic made the adolescents feel out of place, uncomfortable, ashamed and discouraged to attend antenatal care:

"There are a few who l get along with but others usually just mind their own business and I usually feel shy to interact with them" 19-M3.

"Others are not friendly and this makes me to feel lonely and out of place and get discouraged to even come for antenatal..... l think maybe it's because l am young and pregnant" 17-K7.

Others don't really want to be talked to but others are very interesting and welcoming....l feel lonely because some women are not friendly. They spend most of their time on the phones" 19-M9.

Others adolescents also felt that older women were stereotyping them and this made them uncomfortable.

"Other women where Stereotyping and this made me feel uncomfortable at the clinic'' 18-M4.

4.4.3 Stigmatization by other Users

Experiences of stigma were also indicated as additional challenges faced by the adolescents at the clinic. Some adolescents complained of lack of respect by older women. These experiences of lack of respect often arose through their contact with older women who come for the same service. According to the adolescents, this lack of respect made them feel ashamed and uncomfortable thereby triggering a feeling of stigmatization:

"I respect the older women but others are not respectful to us pregnant adolescents, they like talking all sorts of things may be because of their pregnancy'' 18-M12.

"I overheard some pregnant women talking in a mocking manner when I went to call my husband.. This made me to feel uncomfortable and ashamed of myself. They were even laughing at me" 15-K8.

4.5 EXPERIENCES OF ANTENATAL EDUCATION

There were different views on the usefulness of antenatal education by the participants. Overall, the participants highlighted their positive learning outcomes and fears of antenatal education. These positive outcomes mainly focused on prevention, treatment as well as management of diseases.

4.5.1 Positive Lessons Learnt From Antenatal Education

When the issue of what was learnt was explored with the research participants, the main learning points identified focused on HIV prevention and management, prevention of malaria and a healthy diet for both the mother and the unborn child. The majority of the participants felt they had learnt a lot on how to take good care of themselves during pregnancy.

"I have learnt on how to take care of my pregnancy like what to eat so that I may have a healthy baby. I have also learnt that we should cut tall grass on our yard to avoid breeding places for mosquitos that cause malaria… A pregnant woman should not smoke or drink" 17-K6.

Some participants had also mentioned the benefits they had gained from antenatal education, in particular the measures taken in the prevention of HIV. It was reported that they had learnt how to take care of themselves whether one is found to be HIV positive or negative.

.. "It has helped me to learn how to take precautionary measures when taking care of people with HIV/AIDS without getting myself infected'' 19-M2.

"They teach us about HIV.. how one can get HIV… and how to take care of ourselves when you are pregnant. I share with others what l learn here" 16-M1.

A number of other learning outcomes from the interviews were identified and these revolved around facts concerning appropriate dress code for pregnant women, the effect of drinking or

smoking on the baby and the mother, Preparations for delivery, sleeping positions and healthy dietary choices. These components of antenatal care are very vital for both the mother and the unborn child.

"I have learnt about proper sleeping positions in order to protect my baby" 19-M9.

"A pregnant woman should not smoke or drink alcohol"17-K6.

"I have also learnt on the dress code for pregnant women and how to have a good diet for the baby" 18-M4.

4.5.2 Fears or Insecurity

Contrary to the positive learning outcomes of antenatal education, some participants experienced fear of certain information on labour that was presented in class. This fear stems from the uncertainty of what actually happens during the period of labour.

"They are times when they raise up a topic that l don't know about labour ….. It's very scary…it brings fear in us'' 19-M9.

4.6 OPERATING HOURS

Several concerns regarding the operating hours of the antenatal clinic were expressed by the participants of this study. Long waiting hours in the queue for consultation as well as long periods of time spent at the clinic were among the many concerns raised by the adolescents.

4.6.1 Time for Antenatal Care

There are specific services that are routinely provided at Kanyama and Matero Referral antenatal clinics such as weight measurement, physical assessment of pregnancy, laboratory tests and immunizations. The standard operating hours for antenatal care for both Kanyama and Matero Referral clinics is between 08:00-13:00 hours. When asked what time they arrive at the clinic for antenatal care, the participants gave different responses. Majority of the participants arrive at the clinic before 07:30 hours, while others come at exactly 08:00 hours.

"I have to come as early as 06:00 hours" 17-K6.

"We are supposed to arrive here at this clinic at 7:30 so that we start the class at exactly 08:00" 19-M2.

4.6.2 Too Early at the Health Facility and yet being Attended to Late

There were some issues that were raised with regard to the opening and closing of antenatal care. Some participants complained that sometimes they could wait for about 2 to 3 hours after the official antenatal clinic operating hours. This was attributed to health care providers performing other tasks before attending to them.

"I wait for long hours before they begin antenatal class…. about 2 to 3 hours" 15-K8.

"During my first pregnancy the nurse took long to see us. She said she was going to cook beans before she could attend to us because we arrived late…..She finally attended to us at around 12:00 after her beans was cooked" 19-M2.

Other research participants also complained about knocking off as late as 16:00 hours in the afternoon despite them coming very early in the morning. As a result of this they got hungry.

"Sometimes they knock off at 16:00 hours despite us coming early'' 18-M4.

"I don't like the knocking off time because usually when I come around 06:00 hours I sometimes have to go home at 16:00 hours and I usually get very hungry ''17-K7.

4.7 VENUE FOR DELIVERING ANTENATAL SERVICES

Pregnant adolescents expressed different views with regards to the organisation of the clinic. These views mainly focused on issues of privacy and confidentiality, adolescent's specific spaces, as well as overcrowding of the antenatal classes.

4.7.1 Clean Environment

All the participants were happy with the environment at the clinic. They reported that the toilet and the surroundings were clean. They appreciated a clean environment as it made them feel safe and comfortable.

"I like the way they take care of the toilets and surrounding" 15-K8.

4.7.2 Lack of Adolescent Specific Spaces

All the participants interviewed for this study reported that the clinics do not provide a separate space for antenatal care specifically for adolescents nor does it provide a waiting room for adolescents only. This means that pregnant adolescents use the same antenatal care services as older women.

"No, the clinic has no separate waiting room for adolescents" 17-K6.

"No, the clinic has no separate space to provide services for adolescents" 18-M5.

What is currently obtaining on the ground is that the pregnant adolescents are put in the same antenatal class as older pregnant women. When the research question was probed further, the respondents brought out divergent views and opinions. Some participants felt uncomfortable sharing the same antenatal class with older women, while others felt out of place for they were the only young ones amongst the group of older pregnant women. Others also viewed it as a sign of lack of respect for older women due to lack of privacy during physical assessments of pregnancy.

"No there is no separate room for adolescents that come for antenatal care. We are mixed together with the older pregnant women...l don't like this arrangement because people lose respect. There are times were you see an older woman undressing when the nurse is conducting physical assessments of pregnancies or during delivery in the labour

ward…this happens in full view of us young ones..Such is not a good thing to experience because she is like my mother"19-M2.

"l feel shy when am with older women because am the only one who is young"18-K10.

Some participants also described how they experienced a feeling of uneasiness. This feeling was aggravated by the fact that they did not feel free to participate in a class discussion due to the sensitive nature of certain sexual topics in the midst of adults.

"This kind of arrangement does not show respect because there are sensitive questions that we fail to answer… because there are older women present" 18-M4.

"Am not free to ask questions during antenatal class because older women are around" 18-K10.

Another reason that may limit the adolescents to freely participate in class discussion is fear of embarrassment because some topic may be too sensitive for them. Discussing sexual issues in the presence of adults made the adolescents not to ask questions because they felt shy.

"There are always embarrassing topics especially when you come with your partner….about private parts. I do not ask questions during class because I feel shy. I would only ask questions privately" 19-M9.

4.7.3 Privacy and Confidentiality

Issues of privacy and confidentiality were also brought out by the adolescents. Some participants reported that the counseling and screening sessions were conducted in a private and confidential environment. The participants felt confident that their important and sensitive information that they discussed with the health care providers were not overheard or retold to other persons.

"Yes there is privacy when we come for HIV counseling and testing. No one hears what we discuss during pre-testing and post-testing''19-M3.

"It's just for the two of us…No one hears what we talk about during counselling'' 18-K10

"The doctor always has to wait for you to dress up before someone else can come in for the same service'' 17-K6.

Others participants however, reported that the counselling and examinations rooms at the clinic do not guarantee privacy and confidentiality. She reported that one could hear from outside what the patient and the counsellor were talking about. Lack of privacy was also raised by another participant when she reported that nurses kept on interrupting the counselling session.

"The rooms are not very private because the people outside are able to hear what is being discussed between the counsellor and the patient''18-M4.

"They nurses kept on interrupting"19-M9.

4.7.4 Overcrowded Environment

The main concern that was raised by one of the participants was overcrowding of the antenatal class. They are overcrowded because antenatal classes and under five clinics are conducted in the same room and at the same time. She argues that she could not pay attention to what was being discussed because of the noise that was coming from mothers and children that were being attended to for under-five.

"We are in the same room with new recruits, the old ones and those that come for under five. This is not good because there is a lot of noise and l can't really hear what we are learning….So they need to find another place so that we learn more. It is crowded" 19-M9.

4.8 SUGGESTIONS FOR SERVICE IMPROVEMENT

Suggestions for service improvement were also highlighted by the participants. The participants made suggestions on their preferred time at which they could receive antenatal care. They also gave reasons for demanding an adolescent only antenatal care clinic.

4.8.1 The Demand for Antenatal Care Services for Adolescents Only

There were some participants that preferred to have antenatal classes just for adolescents. The reasons why they preferred to have adolescent only antenatal classes included fear of being judged by older pregnant women, to have freedom to freely express themselves and to feel comfortable because they will be with their fellow age mates with the same situation.

"l would like to have a separate class specifically for adolescents because such an arrangement can make me feel because l will be with my age mates……I am not free to ask questions because l feel shy" 17-K7.

Others reported that older women had the tendency of dominating the class discussions and would pass derogatory comments against pregnant adolescents. Having a specific class for adolescents was perceived as an opportunity to learn more on pregnancy and its related outcome.

> *"It would be a good idea to have a separate class for adolescents because that's when we are starting to learn…We will learn more. They will specifically tell us what to do and expect… Older women have a tendency of dominating the class discussions. They also pass derogatory comments against us especially when you come with a partner" 19-M9.*

However, there were also other participants who felt that there was no need for them to have a separate class specifically for adolescents because they were also learning something from the older ones.

> *"l have no problem with mixing with older women" 18-M 5.*

> *"They make me feel comfortable… they give advice on how to take care of the pregnancy" 18-M12.*

4.8.2 Preferred time to receive antenatal service

Pregnant adolescents also had different opinions regarding their preferred time frame to spend at the antenatal care clinic. Some participants suggested 08:00-12:00 hours as their most convenient time to spend at the clinic so that they could have enough time to do other things at home.

> *"08:30 – 12:00 or14:00 is okey with me so that l can go home and sleep because the fansidar we take make us drowsy* ''19-M2.

CHAPTER FIVE

5.0 RESEARCH DISCUSSION

5.1 INTRODUCTION

The purpose of this study was to explore and describe antenatal care experiences among pregnant adolescents at Kanyama and Matero Referral clinics in Lusaka. Five major themes emerged during data analysis: Experience with service providers; experiences with other service user; Experiences of antenatal education; Operating hours; and venue for delivering antenatal services. These themes showed that the experiences of antenatal care among pregnant adolescents occurred at various levels of the clinic environment namely individual, relationship, community and societal levels (Svanemyr et al, 2015). The learning outcomes of antenatal education were identified as experiences at individual levels, while positive and negative experiences with the health care providers were experienced at relationship level. In addition, the relationship between the adolescents and other service users were experiences at the community level, while operating hours and lack of adolescent spaces were experiences at the societal level. According to Rimer and Glanz, 2005, an ecological perspective emphasizes the interaction between, and interdependence of factors within and across all levels of a health problem.

5.2 INDIVIDUAL RELATED EXPERIENCES

At an individual level, individual characteristics such as knowledge, attitudes, beliefs, and personality traits can influence behaviour (Rimer & Glanz, 2005).

The participants highlighted their positive learning outcomes of antenatal education. These positive outcomes mainly focused on prevention, treatment as well as management of diseases and complications. In particular, these adolescents learnt about making healthy choices, the effects of alcohol or smoking on the mother and the baby, the ideal dress code for pregnant women as well as the appropriate sleeping positions for pregnant women.

However, despite the positive learning outcomes of antenatal education some participants expressed fear relating to child birth. This fear was attributed to alarming information on what was going to happen during childbirth. Similar findings were also reported in a study conducted by Lena et al, 1993. The experiences of fear in Lenas' et al study were attributed to lack of

adequate preparation for labour and not knowing what to expect during delivery. It is therefore important that health care providers should be made aware of the anxiety related to labour among adolescents so that they could tailor antenatal education in a manner that could help them cope with such fears.

This study has demonstrated the important role of antenatal education. For instance, these adolescents have gained sufficient knowledge on pregnancy and its related problems. As the result of this, they would be able protect themselves and their unborn babies by leading a healthy lifestyle. Furthermore, having knowledge about the importance of antenatal care through antenatal education will help enhance adolescent's health seeking behaviour when need arises, as well as increase confidence in adolescent's ability to give birth.

5.3 RELATIONSHIP RELATED EXPERIENCE

Attitudes and behaviours of health care providers are likely to influence adolescent's access to antenatal care. These attitudes and behaviours of health care workers may include the way in which adolescents are attended to, welcomed and the concern shown to their special needs (Mannva et al, 2015). The results of this study indicated that pregnant adolescents had both positive and negative experiences with the health care providers. For those that had a negative encounter with the health care provider in this current study complained that nurses were sometimes rude in the way they spoke to them. In Particular, one participant reported that the Doctor shouted at her for becoming pregnant too soon after her previous delivery. This finding is consistent with the results presented in a study that was conducted in South Africa by Pienaar (2011). The adolescents reported that the midwives shouted and screamed at them, thus evoking fear, despair and embarrassment. This finding is also supported by Michels, 2000 and Atuyambe et al, 2005 (cited in Duggan & Adejumo, 2011) where health professionals attitudes were perceived as inexcusably rude and disrespectful. Similar findings were also observed in a study conducted by Alemayehu, Haidar and Habte 2010, in Ethiopia. The study revealed that health workers were un-friendly towards pregnant adolescents.

It is worth mentioning that these negative attitudes and behaviours of health care providers that have been described above can be attributed to several interrelated factors. According to Holmes and Goldstein, 2012 attitudes and behaviours are a complex phenomenon shaped by macro and micro level interrelated factors such as the broader cultural context, work conditions and the

work environment. In addition, Mannva et al 2015, also suggests that providers' beliefs and characteristics, client's attitudes and behaviours and the overall provider- client relationship all have an influence on the attitude and behaviour of health care providers. For example, the perceived abusive attitudes of health care providers as reported by Mannva et al can be caused by the patients' attitudes and behaviours. He goes on to argue that doctors, nurses and midwives complained about women and their families presenting late for antenatal care, not complying with medical advice or falsely accusing providers' mistreatment. Other specific examples which might trigger verbal abuse among health care providers include the patient's failure to follow instructions regarding attendance at antenatal care, not possessing an antenatal card, had many previous pregnancies or are pregnant adolescents. Moreover, Holmes and Goldstein also claimed that some maternal health care providers believe that treating patients rudely can enable them feel more powerful.

However, there is clear evidence that poor provider's attitudes and behaviours have a variety of adverse impact on a patient (Holmes and Goldstein, 2012). Mannva asserted that lack of respectful care from providers may not only lead to dissatisfaction with the health care system but also diminish the likelihood of seeking antenatal care. In addition, maternal health care provider's attitudes and behaviours might directly affect the emotional wellbeing of patients and clients, and the relationship between patients and providers.

Contrary to the negative attitudes and behaviours of health care providers, positive attitudes and behaviours were also noted in this study. Most of the participants revealed that they had a good relationship with the health care providers. This good relationship was attributed to the good reception they received from the health care providers. Duggen & Adejumo, 2011, Peterson et al, Michels, Lenters et al, Phafoli Aswegen and Alberts, and Mannava's et al reported similar findings. The participants from these studies described health care providers as being caring, respectful, friendly and welcoming. Several factors that can influence positive attitudes and behaviours of health care providers have also been documented in literature. The understanding and caring nature of providers in Bangladesh (as cited in Mannva et al) in private facilities was attributed to provider's familiarity with the patient's cultural practice and communities where they come from, or if the patient was known by the health care provider.

Furthermore, results of this study indicated that participants felt that they were being discriminated upon by the health care providers because of their age and marital status. The participants argued that health workers gave first priority to women who attended antenatal care with their partners despite reporting at the clinic before them. Pianaar 2011, Peterson, James, Rall, and Strumpher; Duggen & Adejumo, 2011; Rozette, Clemmey and Sullivan, reported similar findings. The participants in Pianaar research study argued that going early to the clinic was a waste of time because the needs of older women were attended to before their own. Similarly, studies conducted by Rozette Clemmey, and Sullivan; Perterson et al, 2007 and Duggen & Adejumo, 2011, indicated that pregnant adolescents felt that the health care providers treated them differently because of their age.

However, in a Tanzanian study undertaken by Lenters et al 2015, reported that many adolescents did not like that the tests were being administered only when husbands/partners were present. The participants were reportedly told that they would only be tested or cared for if their partner had accompanied them to test for STIs. Young women as suggested by Lenters et al (2015), were unable to bring the person who impregnated them. This was either because paternity was unknown, or the man refused to take responsibility for the pregnancy. On the contrary participants in the current study did not raise the exact concern, presumably due to the fact that adolescents had access to care and other laboratory tests such as HIV with or without their partners. It may also be due to less emphasis on partner accompaniment to antenatal care visits in this context.

This perceived discrimination of service by the health care providers may probably have a valid justification that has not been adequately communicated to, and understood by the participants (Lenters et al, 2015). Both participants from Tanzania and this current study were probably not aware of the policy and practice of attending the first antenatal care visit with their partners or did not fully understand the purpose of bringing their partners at the clinic. It is therefore, important to revise policies and practices that may be viewed as discriminatory towards adolescents. Adolescent's negative experiences with the health care providers could also serve as a barrier to the future use of antenatal care services.

5.4 COMMUNITY RELATED EXPERIENCES

In the Zambian society pregnant adolescents are often met with judgmental attitudes and pushed into isolation by the community as well as by society at large. Therefore, they are either reluctant to initiate antenatal care, refuse to go back for antenatal checks or do not want to share antenatal classes with married couples, as adolescents perceive married couples to be another judgmental group (Condon & Corkindale, 2002). The participants in this study described their antenatal care experiences with other service users (older pregnant women). Some of the participants in this study experienced stigma and discrimination from older pregnant women with whom they shared the same antenatal class with. Research has shown that pregnant adolescents are more likely to experience stigma from strangers or health care providers as compared to older women (Lenters et al, 2015, Weed & Nicholason, 2015). Stigma was typically expressed verbally and non-verbally through facial expressions, attitudes and behaviours by older women during antenatal service. One of the participants in this current study encountered stigma and discrimination through her interaction with older women. She overheard them pass derogatory comments about herself and her partner.

Older women were also described as unfriendly. Some participants reported that they failed to initiate or engage themselves in any conversation with older women due to their unfriendly behaviour. Such negative encounters with older women brought out feelings of loneliness and discomfort. Individuals may experience loneliness when they feel that their relationships with others are less satisfying than they would like them to be (Taylor, Peplau & Sears 2003:234 cited in James, Rall and Strumpher). In addition, other participants in this study felt out of place, ashamed and discouraged to attend antenatal care. Similar findings have also been noted by Pienaar and James et al, Weed & Nicholason (2015), and James, Rall and Strumpher 2012, claimed that adolescents are fully aware that society tends to judge and discriminate women who appear to violet perceived social or moral conventions such as having sex at a tender age. These social and moral conventions often stem from various societal, cultural and religious belief systems that are deeply embedded in our communities.

On the other hand some participants in this current study reported that they had a healthy relationship with the older expectant mothers. Some older women were perceived to be friendly because they offered some advice to the adolescents on how to take care of their pregnancy and

such gesture made them feel comfortable during antenatal care. In this case there was some level of acceptability of adolescent pregnancy by some older women.

The other concern that was voiced out in this study was the problem with the age difference between them (pregnant adolescents) and older women attending the same antenatal class. The participants were uncomfortable with the age gap and several views were expressed about it. One of the concerns raised was that the participants felt uncomfortable being in the same class as older women because they were the only young ones amongst the group. Others felt that they were unable to freely express themselves or ask questions due to the presence of adults. Some participants felt that sharing the same antenatal class with older women was a sign of luck of respect for elders. This was because of the fact that they would sometimes discuss sensitive sexual topics. As a result they felt uncomfortable. According to Svanemyr et al, 2015, adolescent girls are less likely than older women to ask, obtain information, discuss and express their worries about SRH issues due the culture of silence which is deeply embedded in the social norms and taboos related to sexuality in family or the communities. This is particularly the case when it comes to communication with adults either at the clinic or at home.

The issue of the age difference between them and older women was also raised in a study conducted by Pianaar (2011). The participants argued that they were unable to hold any conversation with the older women. Some adolescents went with friends or family members along so as to have someone to talk to. Others opted to go with their mothers to ask the necessary questions on their behalf or as a social support. Similar concerns were also voiced in a study conducted by James, Rall and Strumpher (2012). The age difference made them feel uncomfortable because they shared the antenatal classes with older women. This was confirmed when participants failed to ask questions when opportunity to do so was presented. Similarly, the participants in Lenters' et al, study spoke about feeling shy or embarrassed when waiting for their antenatal care appointment in the general waiting room at the clinic.

However, these experiences of stigma and discrimination from other service users (older pregnant women) may have short or long term effect on their personal well-being and that of their children (Weed & Nicholason, 2015). Apart from that, adolescents' health seeking behaviour may be restrictived because of fear of loneliness, discomfort, embarrassment, stigma,

and unfriendly behaviours of older women. These may have the potential to contribute to the low uptake or non-utilization of sexual and reproductive health services among adolescents.

5.5 SOCIETAL RELATED EXPERIENCE

Concerns about the clinics operating hours were also raised by the participants in this study. Some participants complained they received care late despite arriving as early as 06:00 am at the clinic. Others complained about the number of long hours spent at the health facility. On average they spent 9 hours at the clinic. The adolescents also made suggestions on the actual time that would best suit them to spend at the clinic. A considerate number reported that the best time would be from 07:00-12:00 hours. The same concerns were also expressed in studies undertaken by Pienaar 2011, James, Rall and Strumpher 2012, Michels, 2000 and Duggan & Adejumo, 2015. The adolescents in these studies spent long periods of time booking, as well as receiving care at the antenatal clinics. This happened despite them arriving very early at the clinic. This was partially attributed to shortage of health care providers.

Issues related to lack of spaces for pregnant adolescents at the antenatal clinic were also reported in this study. Majority of participants demanded for antenatal care specifically for adolescents. The need for an adolescent antenatal care was generated as a result of the negative experiences some participants had with the traditional antenatal classes. Some of the reasons cited included fear of being judged by older pregnant women, wanting freedom to freely express themselves and to feel comfortable because they would be with their fellow age mates with the same situation. This finding corresponds with the findings of Pienaar and James. The participants felt that it would be less embarrassing for them to attend a special clinic with only pregnant teenagers or that if they would be allowed to wait in another room and be separated from adult women. They also argued that not being amongst older women would grant them an opportunity to ask questions related to issues that matter to them most. Santrock, 1996, Mills 1997, Lesser et al. 1998 and Coddington, 2001 (all cited in Martis, 2005) identified that pregnant adolescents relate best with their own peer group and therefore are more willing to listen, questions provided information and identified their needs through antenatal care education that is focused on them. On the contrary, others in this current study opted not to separate them from older women because they had learnt valuable lessons regarding pregnancy care from them.

Lack of adolescent friendly environment in relation to inconvenient service hours and lack of adolescent spaces could be a barrier to adolescent girls obtaining SRH information, learn skills, and feel supported in expressing their concerns related to their lives and SRH issues (Svanemyr et al, 2015). This is more likely to also contribute to increased rates of preterm delivery, Low–Birth Weight (LBW) infants, and infant mortality among others (Chen et al, 2008). All of these can be addressed if the Ministry of Health could set up adolescents friendly antenatal clinic environments.

5.6 LIMITATIONS OF THE STUDY

- The results for this study cannot be generalised to the entire population of pregnant adolescent's experiences of antenatal care because a non-probability sampling method was used.
- The sample size was reduced from 16 pregnant adolescents to 12 participants because that's where point data saturation was reached.
- This study was unable to find pregnant adolescents that represented adolescents from 12-14 years old. Only older adolescents (18-19 years olds) were the majority participants. Therefore, this study was deprived of insights from the experiences of pregnant adolescents between the ages of 12-14 years as they may have had different experiences.
- Some pregnant adolescents were not very open during the interviews. Others were shy and needed a lot of encouragement especially when it came to probing questions.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

The previous chapter discussed the experiences of antenatal care among pregnant adolescents in line with the ecological model. In this chapter a conclusion is drawn based on the adolescents' experiences of antenatal care. Recommendations and limitations of the study will be made based on the findings of the research.

6.2 CONCLUSION

The study has shown that adolescents had both positive and negative experiences. Some reported that the health care providers were kind and welcoming, while there were other incidences where some participants regarded them as being rude and humiliating. The study also revealed that nearly all the participants had a healthy relationship with older pregnant women, while others had negative experiences with them and as such these encounters came with feelings of shame, loneliness, discomfort, out of place, and discouragement. In addition, there were also issues to do with stigma and discrimination. The adolescents felt that they were stigmatized and discriminated upon not only from older women but also from the health care providers.

Age difference between the adolescents and other older women was also a source of concern for some adolescents. Due to the age difference, adolescents were unable to freely participate in antenatal class discussions. The study has also shown that all the adolescents had benefited from antenatal education. The learning points identified focused on prevention of HIV and Malaria, dress code for pregnant women and health diet lifestyle for pregnant women. Privacy and confidentiality was another issue that comes out in this study. It was noted that privacy and confidentiality was achieved for more than half of the participants. Long waiting hours was another negative experience reported by pregnant adolescents. Some reported that they wait long hours before antenatal care begun. Setting up an adolescent's friendly environment can mitigate the distress they encounter at the clinic.

The issues that have been raised by the participants in this study have the potential to influence health seeking behaviour not only for the participants but also from their families and friends. These issues may subsequently compromise the care rendered to pregnant teenagers and could pose a threat to the wellbeing of the unborn if the adolescent decides not to go for, or limit her antenatal care clinic visits.

Recommendations for Additional Research

Based on the findings from this study, additional research is needed to explore the experiences of antenatal care in other antenatal care clinics across the country in order to see whether the findings of this study are generalizable.

6.3 RECOMMENDATIONS

1. Current policies and practices of giving first priority to the women and their partners during the first antenatal visit can inadvertently discriminate against single and unmarried pregnant adolescents. Therefore so there is a need to work with policymakers and authorities to advocate for supportive policies and practices that recognize the unique circumstances of adolescents.
2. Antenatal care services are currently delivered within adult orientated classes and several issues of stigma, discrimination, discomfort, embarrassment among adolescents have been reported. It is therefore recommended the antenatal clinics should provide a policy of non-judgemental behaviour in their unit. A policy should be drawn up on how to deal with complaints and how to prevent them from occurring in the clinic environment.
3. This study indicated that some health care providers were rude in the way they communicated to the participants. Therefore, there is need to ensure that the health care providers are equipped with proper communication skills in order to deliver efficient services for the adolescents. The health care providers need to go for training programmes such as seminars annually to learn how to communicate effectively with adolescents.
4. Long periods of time spent at the clinic were among the many issues that were raised by the participants. It is therefore recommended that efforts should be made to decrease waiting time to receive care as well as the time spent at the clinic. This can be done by deploying more health workers at the health centres.

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APPENDICES

Appendix A

Experiences of Antenatal Care Among Pregnant Teenagers at Kanyama and Matero Referral Clinics in Lusaka District

Participant Information Sheet and Consent Form

This information sheet gives you information about the study. I would like you to read this form or someone read it to you in order for you to have all the facts about the study. Feel free to ask questions on all the issues that are not clear to you with the interviewer. If you feel you do not want to participate in the study, you are free not to and this will not in any way have a negative effect on you. If you agree to participate in the study, you should sign the consent form or put a thumbprint in the space if you cannot sign.

You will be given a copy of this form for you to keep. You are also free to stop this interview at any time if you change your mind (even without a reason) and again this will not have any negative effect on you in anyway.

Purpose of the Research Procedures

This study is being conducted by a student from the University of Zambia. If you have any questions about this study you can contact Ms. Bwalya Bwalya or Dr Joseph Zulu, Department of Health Promotion, School of Medicine, University of Zambia, Box 50110, Lusaka, Zambia. Telephone: 256181 or 252641.

You have been purposefully selected to participate as an interviewee on a study whose main aim is to explore the experiences of antenatal care among pregnant adolescents. Information will be collected on various issues. These issues include the experiences with the health care providers, organisation of the clinic and the experiences with other service users. The interview will take about 30 minutes.

Risks and Benefits

The study will not harm you in any way. However, the questions that I will ask you will be personal and about private experiences, there may be some risk of emotional discomfort during the interview process. However, you will be able to take breaks when need arise. In addition, a trained counsellor will be available for you to talk to if you wish so. I would also like to assure you that the information that will be shared will be kept confidential. One benefit of your participation in this study is that information you share about your experiences can be used to help other adolescents in the future.

Payment

There is no payment involved for taking part in the study. However, I will provide you with a snack after the interview.

Confidentiality

We will not tell other people that you are in this research and we will not share information about you to anyone who does not work in the research study. After the research is over, you will be informed about the results.

Information about you concerning the research will be kept safe after the research and no-one would have access to it except the researcher. Any information about you will have a number on it instead of your name and will be kept with a lock and key.

Appendix-B

CONSENT FORM

I hereby give consent to participate in the study that explores the experiences of antenatal care among pregnant adolescents.

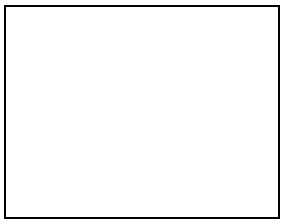
By signing below, I confirm that I understand that participation in this research is voluntary. I have voluntarily chosen to participate in this study. The material in the information sheet has been explained to me, and my questions answered to my satisfaction. I understand that participating or not, will not negatively affect me in any way and that I am free to stop the interview at any time even without a reason. I understand that my rights and privacy will be maintained. I have also been given a copy containing information about the study.

_____ _____

Signature of Participant Date

OR

Thumb Print of Participant (If Illiterate)

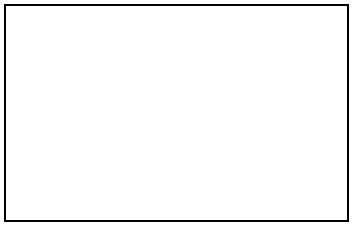


Name:_____ Date:_____
Participant

(Name and Signature _____ Date _____
Witness)

OR

Thumb Print



If the participant refuses to have any witness present, tick in these brackets ( )

For any ethical questions, contact, The Chairman, University of Zambia, Research Ethics Committee (UNZABREC), P.O Box 50110, Lusaka, Zambia. Telephone: 256067. Email:bwalyasinyangwe@gmail.com

Appendix-C

PARENTAL CONSENT FORM

Dear Parent/Guardian

My name is Bwalya Bwalya, a Master's Student from the University of Zambia. I would like your child to take part in a research study on the experiences of antenatal care among pregnant adolescents. The study will be carried out at Chingwele and Kanyama Clinics in Lusaka.

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

If you have any questions or concerns, please feel free to contact me by emailing me at bwalyasinyangwe@gmail.com or by calling me at +260 974 683805.

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

[ ] I grant my permission for Ms. Bwalya to include my child in her research study. I

Fully understand that data will be kept confidential and used only for research purposes.

[ ] I do NOT grant my permission for Ms. Bwalya to include my child in her research study on the experiences of antenatal care among pregnant adolescents.

Parent/Guardian's name: _____

Parent/Guardian's signature: _____ Date: _____

OR

Thumb Print (If Illiterate)

Researcher's Signature: _____ Date: _____

Appendix-D

CHILD ASSENT FORM

My name is Bwalya Bwalya. I am a student at the University of Zambia.

I am asking you _____ (Name of Participant) to take part in a research study because I am trying to learn more about the experiences of antenatal care among pregnant adolescents.

If you agree, you will be engaged in an interview. You will be asked to share your experiences of antenatal care within this clinic. You do not have to say who you are (your name) during an interview.

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

If you decide to be in the study I will not tell anyone else what you said in the study.

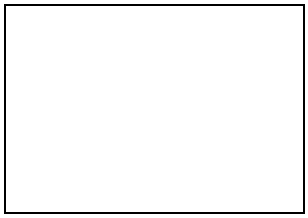
Even if your parents or guardians ask, I will not tell them about what you said.

Signing (or a thumb print if illiterate) here means that you have read this form and that you are willing to take part in this study.

Participant's Signature_____ Date_____

OR

Thumb print of participant



Researcher's Signature_____ Date_____

Appendix-E

INTERVIEW GUIDE: MAIN QUESTIONS

RESEARCH TOPIC: EXPERIENCES OF ANTENATAL CARE AMONG PREGNANT ADOLESCENTS

Name of Interviewer……..

Date of Interview……...

Interviewees ID…….

Good morning/afternoon. I am …….

This interview is about experiences of antenatal care clinic among adolescents. I am especially interested in your experiences at this clinic.

"If it is okay with you, I will be tape recording our conversation. The purpose of this is to enable me to get all the details and at the same time be able to carry on an attentive conversation with you. I assure you that your name and all your comments will remain confidential. I will be compiling a report without any reference to you and other research participant in this study. If you agree to this interview and the tape recording, please sign this consent form''

"I'm now going to ask you some questions that l would like you to answer to the best of your ability. If you do not know the answer, please say so.''

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS

Age at conception……..

Level of education……

Religion……

B. ADOLESCENT INTERACTION WITH PROVIDERS

1. What kind of a relationship do you have with the health care provider at this clinic (Nurse, Doctor)?
2. How do you relate with other pregnant women who come for antenatal clinic?
3. Have you at any time experienced any form of stigma within this clinic?

4. In what way has the antenatal education been of help to you?
5. What time are you supposed to report at the clinic
6. From the time that you report, how long does it take before you begin antenatal care
7. On average, what time is the antenatal clinic scheduled to close?
8. What time do you think is convenient for you to seek antenatal care?

EXPERIENCES OF THE CLINIC ENVIRONMENT

9. Does the facility provide a comfortable setting for you?
10. Does this clinic have a separate space to provide antenatal services for adolescents?
11. Does the clinic have a separate waiting room for adolescents?
12. Is there a counselling and screening area that provides both visual and auditory privacy at this clinic?
13. What do you dislike about the way in which this clinic is organised?
14. What do you dislike about the way in which this clinic is organised?

a. Experiences of pregnant adolescents with the antenatal care procedures

b. What has been your experience with the antenatal procedures (HIV testing, antenatal education)?

D. RECOMMENDATIONS

15. What do you think needs to change with regards to antenatal care at this clinic?

Thank you so much for giving me this opportunity to interview you!