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ADJUSTING ASPIRATIONS: EXPLORING AGENCY IN EARLY MOTHERHOOD IN AN URBAN AREA IN JOHANNESBURG, SOUTH AFRICA

by

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A THESIS

Submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of

Doctor of Philosophy

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2019

Declaration

I, Nirvana Pillay, declare that this thesis is my own original, unaided work. It is being submitted for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted before for any degree or examination at any other University or institution.

Signed

24th day of October 2019 in Johannesburg, South Africa.

Dedication

I dedicate this thesis to the mothers in my life, biological and social, for making my world a better place. The spirit of Lakshmi is abundant in my life: my mother, Dolly, who is a calm and consistent presence; Sa and Mol, my other mothers who love me unconditionally; and my daughters, Dhiya and Arya, who are my daily reminder of what it means to love.

Thesis materials

Presentations arising from this study

Oral paper presentation at Contemporary Ethnography Across Disciplines (CEAD) Conference, November 2016, University of Cape Town: "Adjusting Aspirations: Preliminary findings from a study on Early Motherhood in an urban area in South Africa."

Publications arising from this study

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Pillay, N. 2020. "I don't want friends…I have family" in Mkhwanazi, N. & Manderson, L. (Eds) *Connected Lives: Families, Households, Health and Care in Contemporary South Africa*. Cape Town, SA: Human Sciences Research Council. ISBN: 978-0-7969-25875-5

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ABSTRACT

Background

In South Africa, the health and wellbeing of adolescent girls and young women is a critical consideration in development policy. Addressing high rates of early motherhood is one area of policy and intervention aimed to improve development outcomes for young women, particularly in relation to education and health. The teenage pregnancy discourse post-1994 positions early motherhood as threatening to South Africa's development agenda; young mothers are perceived as a risk to the dominant social order and a challenge to achieving the education, health and social welfare goals of the developing state. This discourse positions young women as disempowered, irresponsible and without agency. In this study I explore the agency of young women who transition to motherhood earlier than socially and politically sanctioned. I examine the relationship between the agency of young mothers in the context of pervasive social and structural inequality, paying attention to *how* young mothers navigate the world of early childbearing.

Methods

This ethnographic study was conducted at a health centre in Alexandra, Johannesburg between September 2016 and September 2017. I interviewed 30 young mothers aged 18 to 20 years once, nine young mothers twice, and six young mothers three times. Four significant others (mothers, grandmother, father), identified as the person offering the young mother the most support, were also interviewed. I drew genograms and kinship network maps to understand the composition of households, families and kinship networks in which young mothers were embedded. Using a narrative approach, I developed case studies of young mothers who were interviewed three times. In addition, I interviewed six health care providers at the health centre to understand their experiences with, and perceptions of, young pregnant and parenting women. I also interviewed employees of a non-governmental organisation working with mothers at the health centre, and another one addressing employment for youth. I conducted all interviews in English.

Findings

The findings of this study resulted in three peer-reviewed publications. A fourth publication is currently under review. The key findings of these articles are summarised below.

Young mothers faced considerable barriers in continuing or completing school, securing economic resources and accessing appropriate and acceptable health services. Kinship support and networks were central to mitigating some of the barriers, to enable young mothers to continue with education or employment while caring for their babies. In most instances, families responded to unintended pregnancy through adaptive and malleable practices that accommodated the young mother and her baby. Many fathers were also involved in the lives of their babies, even when the couple was no longer together. The nature of economic and emotional support provided by fathers varied depending on relationship dynamics, family and economic circumstances.

Continuing with school was complicated for young pregnant and parenting women. Despite progressive legislation and policy, many schools continue to discriminate against them; overtly through denying access to school during pregnancy, and covertly through discriminatory and stigmatising practices. School attendance and continuation was facilitated by family support, the Child Support Grant, availability of crèches and other childcare arrangements, and enabling school environments.

Despite state commitment to adolescent friendly sexual and reproductive health services, health services were not sensitive to the particular needs of young pregnant and parenting women. Pervasive discourses of early motherhood perpetuated stigmatising attitudes of health care workers, and were a limitation to care. In particular, access to termination of pregnancy, and patient-sensitive contraception provision, were hindered by health care provider discrimination and limited health system capacity in the area of adolescent sexual and reproductive health.

Conclusion

The dominant, pejorative discourse of early motherhood strongly influenced the experiences of young pregnant and parenting women and affected the implementation of policy. In South Africa, there is little consideration of *how* to support young mothers after an unintended pregnancy. Young mothers adjusted their aspirations to accommodate and mitigate the negative effects of unintended pregnancy; they exercised agency along a continuum, influenced by enablers and constraints in the social and structural context. I recommend more targeted support for young mothers. Uppermost in the minds of young mothers in fragile household economies was economic security, and access to the Child Support Grant was critical. In addition, young mothers need safe and acceptable childcare, psychosocial support,

targeted assistance at schools during pregnancy and after, improved access to early pregnancy testing outside of health services, and sensitive contraception services after birth and beyond.

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Nolwazi, thank you for gently steering me to think like an anthropologist, for introducing me to "*Death Without Weeping*" (Scheper-Hughes, 1992) and "*The Vulnerable Observer: Anthropology that breaks your heart"*(Behar, 1996), amongst others. They were inspirational to my thinking and writing. Your thoughtful comments and insights influenced the direction of this thesis.

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To the young mothers and their babies: yours is a debt I can never repay. I hope my work does justice to your stories and that this thesis contributes to a new way of thinking about early motherhood that makes your path, and others that come after you, a little gentler.

Table of Contents

Declaration ..... **i**

Dedication ..... **ii**

Thesis materials ..... **iii**

Presentations arising from this study iii

Publications arising from this study iii

Funding iii

ABSTRACT ..... **iv**

Acknowledgements ..... **vii**

Table of Contents ..... **ix**

Acronyms ..... **xiii**

List of Figures ..... **xiv**

List of Tables ..... **xiv**

Preface ..... **xv**

SECTION A **1**

CHAPTER 1: A STUDY ON THE AGENCY AND ASPIRATIONS OF YOUNG MOTHERS **2**

The international and local policy context **4**

Terminology and definitions **6**

Study justification **8**

Problem statement 8

Rationale for study 9

Aim and objectives of the study **9**

Conceptual and theoretical framework **10**

Conceptual framework 1: The socio-ecological model 11

Theoretical Framework: discourse, structure and agency 12

Conceptual framework 2: A conceptual framework of the relationship between structure and agency in the discourse of early motherhood in South Africa 16

CHAPTER 2: A DISCOURSE OF EARLY MOTHERHOOD **20**

The dominant discourse of early motherhood **21**

Developmental Idealism and Early Motherhood 21

Adolescence in the context of Developmental Idealism 24

Causes and Consequences of Early Motherhood 25

Data on early motherhood 27

Structural responses to early motherhood 29

Education 30

Public Health 36

Social Protection 43

Limitations of structural interventions 45

An alternative discourse on early motherhood 45

A critique of the dominant discourse 46

An emergent and evolving discourse 47

Conclusion 51

CHAPTER 3: UNDERSTANDING AGENCY IN EARLY MOTHERHOOD 53

The study setting 55

Methodology 58

Study population and sample 59

Data collection 62

Data analysis 65

Positionality and reflexivity 68

Limitations 70

Ethical considerations 71

SECTION B 72

CHAPTER 4: RESULTS AND REFLECTIONS 73

Sample characteristics 74

The context of life and living in Alexandra 77

CHAPTER 5: I DON'T WANT FRIENDS...I HAVE FAMILY 78

Nobuhle's story 80

Ayanda's story 82

Betty's story 83

Conclusion 85

CHAPTER 6: KINSHIP CAPITAL 87

Abstract 90

Introduction 91

Considerations of care **93**

Contexts of care and living in Alexandra **96**

Variations in kinship networks and support across place **97**

Andiswa: Local urban kinship network 98

Ayanda: Dispersed kinship networks across the city and provinces 100

Connie: Dispersed kinship networks across urban and national borders 101

Kinship networks and kinship capital **103**

Conclusion **106**

CHAPTER 7: PATHWAYS TO SCHOOL COMPLETION **108**

Abstract **111**

Methods **113**

Results **114**

Remaining at school 115

Temporarily withdrawing from school 116

Permanent withdrawal from school 117

Further education and employment 117

Discussion **118**

Conclusion **120**

CHAPTER 8: CONFLICT AND CARE **121**

Abstract **123**

Introduction **124**

Study setting **126**

Methods **127**

Findings **128**

Health service delivery to young pregnant and parenting women 129

Health service providers perceptions of young pregnant and parenting women 133

Discussion **135**

Risk and Punishment 135

Knowledge and Ignorance 136

Conflict and Care 137

Conclusion **137**

SECTION C **139**

CHAPTER 9: AGENCY IN EARLY MOTHERHOOD 140

Disrupting and disseminating discourse 141

Intended pregnancy 142

Responsible motherhood.....143

Responsible fatherhood 145

Young families.....147

Exercising Agency 151

Considering care.....152

Reconciling education and motherhood.....155

Navigating the pervasive power of biomedicine 158

Aspirations before and after early motherhood 160

The case of Fezeka 164

Limitations.....166

CHAPTER 10: ADJUSTING ASPIRATIONS.....167

Recommendations for Policy and Programmes.....169

Social support 170

Education.....172

Health 174

Recommendations for future research.....176

Concluding comment.....177

REFERENCES 178

APPENDICES 201

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AYFS	Adolescent and Youth Friendly Service
CSE	Comprehensive Sexuality Education
ECD	Early Childhood Development
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
NAFCI	National Adolescent Friendly Clinic Initiative
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
WHO	World Health Organization

List of Figures

Figure 1. 1: A socio-ecological model to indicate the interaction between the young mother and her social context 12
Figure 1. 2 A framework of the relationship between structure and agency - conceptualising "vital conjunctures" 19

Figure 3. 1: Map of Alexandra township in Johannesburg, South Africa (Biofocuscommunicatie, n.d.) 55
Figure 3. 2: Map of Alexandra in the City of Johannesburg (*Google Maps*, 2014) 56

Figure 4. 1: Age of young mothers at first conception and first birth 74
Figure 4. 2: Number of young mothers with intended and unintended pregnancy 75
Figure 4. 3: Length of time young mothers had lived in Alexandra 76
Figure 4. 4: Living arrangements of young mothers 77

Figure 6. 1: Kinship network map of Andiswa (18 years old) 98
Figure 6. 2: Kinship network map of Ayanda (19 years old) 100
Figure 6. 3: Kinship network map of Connie (20 years old) 102

Figure 7. 1: Pathways to school completion after pregnancy 118

Figure 9. 1: Kinship network map of Fezeka (20 years old) 164

List of Tables

Table 2. 1: Comparative data of adolescent pregnancy, South Africa, 1998 and 2016 28

Table 3. 1: Sample of respondents per research method and study objective 65

Table 4. 1: Participant characteristics 75

Table 7. 1: Summary of school-related data at pregnancy 114

Preface

A PhD is almost always a personal journey, and mine is no different. I first attempted doctoral study as a junior lecturer at the University of KwaZulu Natal. This came to a grinding halt with motherhood, migration and work. Coming back to this in mid-life has been extremely rewarding, not least because it has been an immersion into the discourse of motherhood concurrent with my own lived experience. I was not a young mother, having begun childbearing in my early thirties, and in this regard I challenged the social and cultural script for Indian women in my community. The idea of appropriate timing of reproduction has always fascinated me. Who regulates women's reproductive desires and why? The topic of early childbearing was ever more poignant as I raised adolescent girls in an evolving discourse of gender, sexuality and risk.

I was often asked during my fieldwork whether what I saw and listened to was "too terrible" – reflecting my middle-class context where early motherhood is seen as one of the most disadvantaging things that could happen to a young woman. As the study progressed, and I began to make sense of this discourse, I paused to reflect on how and why this idea had grown. When I considered my family history, I noted that my grandmother was a young mother (as defined in this thesis); so too were many of my aunts and other female kin. What then made my contemporary community view early motherhood as so problematic? How had time and space transformed my social world so that the idea of early motherhood was now of such concern. These questions were not the focus of my study, but they were important to my reflexivity and so allowed me to complicate and trouble issues of gender, race, class, age and culture. Furthermore, my own reflections allowed me to move away from a traditional biomedical framing to a more nuanced framing of early motherhood.

This study was a dynamic and intellectually stimulating endeavour, representing the privilege of my class and social context, which allowed me to immerse myself in academic pursuit. To answer the question of whether the fieldwork was "too terrible," I present two verbatim fieldwork diary entries that reflect the complexity of my experience:

> *Fieldwork notes, 11 June 2017*. I left Nobuhle and her mum today feeling raw and gutted. It is too hard to see the incredible hardship and poverty people live in – people with whom I have now developed a relationship with, and who I care about and who I think have amazing futures if it were not for the reality of their poverty and all that

> that brings… I felt very aware of myself on the street – aware of my 'Indianness' and how obvious I was as a stranger to Alex.
>
> *Fieldwork notes, 17 October 2017*. I've been listening to interviews and checking them and coding, and it just struck me that I find the coding very boring but I LOVE listening to the interviews. There is something soothing about listening to these young women – their soft voices, their laughs, their cries. And particularly the sound of babies.

The central focus on motherhood, and the interaction with young women and their babies, was infinitely rewarding. This engagement compelled me to look at motherhood in social worlds that co-exist, yet are so different; it is a reflection of the personal and the political.

The Structure of this PhD thesis is as follows:

Section A – Introduction, Literature Review and Methods

Chapters 1 to 3 provide the background for the study, and include the introduction, literature review and methods.

Chapter 1: A study on the agency and aspirations of young mothers

This chapter introduces central concepts of the study including policy, terminology and theory. It provides a guide to the structure of the thesis and a roadmap of how the study was conceptualised, constructed and executed. The conceptual and theoretical frameworks of this study are provided in this chapter.

Chapter 2: A discourse of early motherhood

The literature review expands on the body of evidence relevant to the specific objectives of this study. This is presented under four main themes; the dominant discourse of early motherhood, secondary data on early motherhood, structural interventions addressing early motherhood, and the alternative, emergent and evolving discourse of early motherhood. The literature review is further expanded in the publications from this study in Chapters 5 to 8.

Chapter 3: Understanding agency in early motherhood

Chapter 3 describes the overall methodology, sample, data collection methods and analyses. It includes a section on limitations of the study, as well as methodological reflections on reflexivity and positionality. Particular elements of the methodology are described in each paper, as related to the specific study objectives the paper is addressing.

Section B – Results

The results of this study are contained in Chapters 4 to 8; Chapters 5 to 8 are standalone papers. At the time of submission of this thesis, two papers had been published, one paper had been accepted for publication and was in press, and one paper was under review. Each chapter begins with an introduction to the paper, as well as concluding remarks and linkages to the next paper, and to the whole body of work.

Chapter 4: Reflections and data

In this short chapter, I provide further reflections from the field. In addition, I present some simple descriptive statistical data from the field, which are relevant for the Chapters that follow.

Chapter 5: I don't want friends…I have family

This case study was the first paper emanating from this study, and reflects central themes that guided the development of a subsequent paper on kinship systems. Drawing on the narratives of three young mothers, the paper attends to the complexity of families and households in accommodating the needs of young women confronted with unintended, ex-nuptial motherhood.

Chapter 6: Kinship capital

This chapter expands on the case studies in Chapter 5, and explores the nature of support from family and others in mediating some of the challenges of early motherhood. It pays attention to the kinship networks of young mothers, and illustrates through case studies, how kinship capital is used to navigate the terrain of early motherhood. It expands on the idea of place and its impact of kinship networks and kinship capital.

Chapter 7: Pathways to school completion

Chapter 7 explores how young mothers make decisions with regard to school continuation while pregnant and parenting. It identifies the pathways to school completion for young mothers who were still in school at the time of pregnancy discovery, and elaborates on the reasons young women drop out of school permanently or temporarily, during pregnancy or after the birth. It highlights the support young pregnant and parenting women needed in order to continue with or complete school after an unintended, ex-nuptial pregnancy.

Chapter 8: Conflict and care

This chapter explores the provision of sexual and reproductive health services to young pregnant and parenting women. The paper presents the perspectives of young mothers, as well as that of health care providers, attending to questions of how services are provided and experienced. It examines sexual and reproductive health decision-making of young women

from before conception to after birth, understanding how health service provision facilitates and constrains access to health care.

Section C – Integrating Narrative

The integrating narrative concludes this thesis by exploring the central as well as emergent issues in the discussion, as well as the conclusion of the study finding. It also includes recommendations that are the result of the study findings.

Chapter 9: Agency in early motherhood

Chapter 9 provides a synthesis of the results of the study, and discusses the results against the literature and theoretical framing as they relate to the specific study objectives. It expands on the concept of agency of young women, in relation to considerations of care for their babies, continuing school or employment and navigating health services. The chapter draws on the theoretical framework to position the ideas of discourse, structure and agency to understand how early motherhood is experienced in an urban area in Johannesburg, South Africa.

Chapter 10: Adjusting Aspirations

The final chapter of the thesis provides the concluding comments, and sets out recommendation at each of the three structural levels addressed in this thesis. It further highlights areas for future research, drawing attention to the need for greater focus on the health and wellbeing of young mothers and their babies after an unintended, ex-nuptial birth.

SECTION A
INTRODUCTION, LITERATURE REVIEW AND METHODS



Image 1: “Shocking teens pregnancy, HIV stats at a school in Limpopo” (Mamokgere and Baloyi, 2018)

CHAPTER 1: A STUDY ON THE AGENCY AND ASPIRATIONS OF YOUNG MOTHERS

INTRODUCTION

The discourse of early motherhood in South Africa is intricately linked to broader social, cultural and political challenges within the wider development agenda. This is expressed in a post-apartheid policy framework that articulates the intention of the democratic South African state to achieve equitable distribution of resources and equal opportunities. It is operationalised through well-defined development goals in South Africa's National Development Plan 2030 (National Planning Commission, 2012) which reflects the global Sustainable Development Goals (United Nations, 2015). The narrative of early motherhood speaks of a post-apartheid generation of young people, particularly adolescent girls and young women, aspiring for autonomy in a context shaped by economic and social forces that are both empowering and disempowering. This study is essentially about this dialectic between structure represented through state policy, the institutions that implement them, and other more fluid social and community structures, and the agency of individual young women who transitioned to motherhood earlier than socially sanctioned. I use discourses of early motherhood as a lens to attend to the dynamic between structure and agency.

Consider this statement by Sesi (18), aged 16 at pregnancy discovery, describing her experience of antenatal care in Mpumalanga:

> They [nurses] were always making things hard for me. How could you get pregnant so young? Now you have HIV and you are still a baby. How are you going to grow and your dreams are…you don't have dreams anymore now. There is no more future for you.

Two years later, in reflecting on this exchange, Sesi (18) says to me with incredulity, "There is no more future for me? Like really, are you kidding? A baby is not the end of the world. That's what I realised after everything I went through for the past two years."

Now consider this statement by former President Jacob Zuma, first expressed in 2009, and reiterated in 2015:

> They [young teenage mothers] must be educated by government until they are empowered and they can take care of their kids, take them to Robben Island or any

> other island, sit there, study until they are qualified to come back and work to look after their kids.
>
> They don't know how to grow a child, how to look after them. They have become a burden to grandmothers, to society. So why should we just sit and look?
> Should we give them money or should we have vouchers that are very specific, either to buy food or uniforms for the school or to pay for the schools – so that the money will not be used for anything except the needs of the child…It is a matter to talk about… because there is no mother who is going to take a voucher and go to this, what is this for hair? A salon (Mail and Guardian, 2015).

Here, former President Jacob Zuma articulates a range of educational, political, popular, cultural and economic discourses that contextualise early motherhood in South Africa in the post-1994 context. I use the term "discourse" to refer to the way personal and political value systems are communicated and reproduced in the wider social context, often to reproduce hegemonic values. I draw on Michél Foucault's (1973) idea of discourse to refer to "well-bounded areas of social knowledge" (McHoul and Grace, 1993, p. 31), which enable and constrain ways of thinking, writing and speaking about a social object or practice within a particular historical limit (Seidel, 1993). Lupton (2010, p. 145) defines discourse as "a group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures." Understanding the social, political and economic context is central to understanding how discourses are produced and reproduced.

In his statement, former President Zuma first positions education as a vehicle for empowerment, so much so that young mothers must be imprisoned to achieve this if necessary. Second, he positions himself, the state and the wider society as guardians of disempowered, ignorant and irresponsible young women. Third, in dealing with irresponsible "teenage mothers," he seeks to protect the wider society, particularly grandmothers, from the consequences of "teenage pregnancy." He paternalistically offers the state as a vehicle to police their actions in the absence of the rational choices young mothers make for lifestyle (such as hairstyles) rather than caring for their children. In doing this, he creates the foundations for the discourse of "moral panic" (McRobbie and Thornton, 1995) which surrounds early motherhood in South Africa, and the pejorative stance on young women who have not practiced "disciplined reproduction" where education is achieved before reproduction (Johnson-Hanks, 2006, p. 2).

In this study, I seek to explore this tension: the complex interplay between power and policy, as represented by and through discourse, and the individual lived experiences of young women who have had had an early, unintended, ex-nuptial birth. This thesis offers an alternative lens through which to view early motherhood, paying attention to the experiences and voices of young mothers, and seeking to understand how young women navigate the world of early childbearing in an urban community in South Africa. I reflect on questions of discourse, policy, agency and aspiration in relation to care and support of young mothers and their children, in the context of early, unintended, ex-nuptial motherhood.

The international and local policy context

Adolescent girls and young women are the focus of extensive international policy. Global policy is framed by the Sustainable Development Goals (1, 3, 4, 5, 10 and 14) which address issues of poverty, health, well-being, education, gender, and inequality, and endorses the need to improve development outcomes for girls and women throughout the world (United Nations, 2015).

The United Nations (UN) H6 organisations, representing the lead UN bodies including the World Bank, World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) (UNAIDS), United Nations International Education and Children's Fund (UNICEF) and United Nations Women's Organizations (UNFPA, n.d.), have translated these broad development goals into specific policy targets that address sexual and reproductive health, education and early motherhood within a broader mandate to improve health services and health systems for women, children and newborns. These policies provide international guidance to improve the lives of adolescent girls and young women, specifically sexual and reproductive health outcomes, by decreasing the incidence of HIV and other Sexually Transmitted Infections (STIs), decreasing unintended early pregnancy and eliminating gender based violence, as well as increasing access to education and keeping girls in school. The overall policy focus is to improve access to and experience of services.

In South Africa, the foundation for the policy and legislative framework post-1994 is the South African Constitution, protecting the rights of all South African citizens under the Bill of Rights. The National Development Plan 2030 (National Planning Commission, 2012) is the

current blueprint for development policy, endorsing the global Sustainable Development Goals (United Nations, 2015), and articulates the importance of harnessing the potential of the demographic dividend to focus on young people and their nutrition, health, education, and employment, and to reduce gender inequality (National Planning Commission, 2012).

Development outcomes for adolescent girls and young women are circumscribed within a health policy framework dominated by South Africa's high HIV prevalence and the associated impact on the broader social and economic context. Adolescent girls and young women are disproportionately affected by HIV and STIs and are identified as a vulnerable population by the South African National AIDS Council (SANAC), a multisectoral collaborative partnership between government departments including health, education and social development (South African National AIDS Council, 2017a). There has been increased awareness of the importance of addressing the social and structural determinants of health for adolescents (Sumartojo, 2000; Rotheram-Borus, 2000). The National Strategic Plan for HIV, AIDS and TB (2017-2022) (NSP 2017-2022) uses a social determinants of health framework, that aims to decrease new HIV infections, decrease levels of teenage pregnancy, increase retention in school, reduce sexual and gender based violence, and increase the economic empowerment of adolescent girls and young women (South African National AIDS Council, 2017b). The NSP 2017-2022 addresses the disproportionate burden of HIV on young women in relation to young men, and the consequences of age disparate relationships.

Health policy in relation to young women particularly focuses on managing the prevention aspects of HIV, STIs and unintended pregnancy, as well as improving access to and experience of sexual and reproductive health services. Specific policies address the sexual and reproductive health and rights of adolescents, including improved access through creating adolescent and youth friendly services (AYFS) (Department of Health South Africa, 2011, 2017). In particular, access to contraception (Department of Health South Africa, 2012) and choice of termination of pregnancy (South African Government Gazette, 1996) are endorsed by policy and law.

Education policy relevant to early motherhood is framed by the South African Constitution and the South African Schools Act 1996 (Republic of South Africa, 2011), which guarantees the right of all South Africans to education. Specific policy focusing on early motherhood first emerged in 2009 with the controversial Measures for the Prevention and Management of Learner Pregnancy (Department of Education, 2007). In 2018, the Draft National Policy on

the Prevention and Management of Learner Pregnancy in Schools (Department of Basic Education Republic of South Africa, 2018) ratified the 2009 draft document into policy, and attended to many of the problems and complexities associated with it (Equal Education Law Centre and Section27, 2018). In particular, the policy provides guidance to officials, principals, school management teams and educators on responding to learner pregnancy.

Social development policy is at the nexus of health, education and rights to basic services and income, and attempts to pull together the various policy environments through the National Sexual and Reproductive Health and Rights Framework Strategy (2014-2019), co-ordinating the overall response to improving access to sexual and reproductive health and rights (SRHR) in South Africa. This includes identifying the need for effective community support networks for adolescents, an area often neglected in the overall policy context. In addition, the Child Support Grant, a means-tested monthly cash transfer for children 0 to 18 years, is one of the primary vehicles for poverty alleviation in South Africa, and is the mandate of the Department of Social Development and the South African Social Security Agency (Republic of South Africa, 2004).

Economic policy is widely addressed through the National Development Plan 2030, but is focused on youth through the National Youth Policy 2015–2020. This policy aims to empower young people to reach their full potential through strategies that focus on youth participation, empowerment and development (National Development Agency, 2015). The National Youth Policy fosters a new approach, away from "passive citizenry," to encouraging youth to be actively engaged in their own development with the support of government, where youth act as agents of economic and social engagement and change. Key proposed interventions of the policy relevant to this study include a focus on economic empowerment through addressing unemployment and joblessness, high rates of school dropout, poor health especially high HIV, pregnancy and maternal death rates, and violence, including gender based violence (National Development Agency, 2015).

Terminology and definitions

In this section, I outline terms used in this thesis, providing definitions and evidence where appropriate, as well as justification for why these terms are used.

The term *early motherhood* refers to motherhood that occurs before 20 years of age. Although numerous studies define early motherhood or early childbearing using different age limits (Boden et al., 2008; Woodward et al., 2013), I draw on the definition used by the World Health Organization (2011) which defines "early" as childbirth before age 20. WHO acknowledges the international lack of a standard definition, and recognises that the term "early" relates to the correlation between lower age and increased risk of adverse health and social consequences for the mother and her newborn, rather than chronology.

The term *young mother* refers to young mothers between 18 and 20 years of age: this age range is the focus of this study. In avoiding the term "teenage mother," I seek to move the discourse away from the pejorative framing and politicisation of early motherhood in South Africa. In doing so, I draw on the work of Geronimus (2003) and others (Barcelos and Gubrium, 2014; Gubrium and Shafer, 2014; Gubrium et al., 2018), who argue that the term ''teenage pregnancy'' is used as "an absorptive shorthand that strikes exposed dominant cultural nerves about race, responsibility, and sexuality along with rank feelings of disappointment and resentment," and prevents more nuanced and complicated framings of early, unintended motherhood (Geronimus, 2003, pp. 887–888). I use *young pregnant and parenting women* as an inclusive term to refer to women experiencing early, unintended, ex-nuptial pregnancy and motherhood (Gubrium and Shafer, 2014). Pregnancy was explored extensively in interviews with young mothers and hence I use the term to embrace their experiences from conception to motherhood. I use the term *father* to refer to the genitor. Where I refer to the father of the young mother, I state this explicitly.

Pregnancy includes "intended" and "unintended" pregnancies regardless of outcomes, that is, whether they result in live births, abortions or miscarriages (Sedgh et al., 2014, p. 302). *Unintended pregnancy* refers to pregnancies that may result in unplanned births, induced abortions or miscarriages. *Unplanned births* are births that are *mistimed* as they occur earlier, sometimes defined as two or more years earlier than desired by the mother, or that are *unwanted* by the mother (Coles et al., 2011, p. 3; Sedgh et al., 2014, p. 303; United Nations Educational, Scientific and Cultural Organization, 2017). Sedgh and colleagues (2014, p. 312) reflect that using definitions of pregnancy intention from statistical estimates used to calculate global, regional and national data lacks the nuances and complexity to understand this concept. For example, they fail to capture the qualitative differences in fertility intentions between women, fertility intentions over time in a women's life, emotional changes in

relation to a particular pregnancy, and fail to explore the implications of mistiming used between various studies.

In this thesis, I use the term *unintended pregnancy* and *unintended birth.* There are multiple factors that influence how a young women understands her pregnancy as intended or unintended, which may include the relationship with the father of the baby, her socio-economic status, her educational aspirations, her commitments to her family and social expectations (Coles et al., 2011, p. 2). Young mothers' understanding and descriptions of "intendedness" may also change over time from pre-conception to after the birth.

I use the term *ex-nuptial* to refer to unmarried pregnancy and parenthood. Unmarried childbearing is not new in the South African social and cultural context (Rabe and Naidoo, 2015). In using the term *ex-nuptial*, I do not seek to further pathologise early motherhood, or to assign a value to marriage in aspirations of "ideal" family formation; instead I use it to objectively describe one variable in the context of early motherhood.

Study justification

Problem statement

There is little known about how young mothers exercise agency after the birth of a baby. The question of how decisions are made, who makes them, and what influences decision-making for young mothers is under-explored. In much of the research, as well as in policies and programmes directed at young women, it is assumed that because of their age, early pregnancy is unintended and women have little power in deciding whether or not to keep the pregnancy, whether to stay at home with the infant and how to care for it, and how to combine mothering with other educational and/or employment commitments. Furthermore, while there is an extensive literature on the structural causes and consequences of early motherhood, like class, race, gender, education, and violence, we know little about *how* young women negotiate these structural determinants and exercise agency after the birth of a baby. An understanding of these issues is critical to ensure that appropriate care and support is provided to young pregnant and parenting women and their families to mitigate potentially disruptive effects of early, unintended pregnancy.

Rationale for study

The discourse of early motherhood in South Africa primarily focuses on younger teenage mothers (14-17 years), even though rates of pregnancy in this age group are substantially lower than in the 18 to 20 age group. The law considers women 18 years and older as adults with legal capacity. However, the law simultaneously recognises that children under 18 years have evolving capacity, particularly in health related decision-making, and that age and autonomy are emergent and are not defined only by chronology (Strode et al., 2010). Social norms frame adulthood as a time when schooling is complete, and when young adults have the capacity to make decisions and to operate as rational actors. It is not uncommon in South Africa for young adults between 18 and 20 years to still be in school. Young people between 18 and 20 years are simultaneously adults and adolescents, negotiating a complex world of decision-making and autonomy. They are in a period of transition.

This is exacerbated for young women confronted with early, unintended pregnancy and birth. Young mothers between 18 and 20 face multiple structural constraints, including limited economic capacity. This is also the cohort, in which rates of early motherhood rapidly increase, warranting an increased understanding of what happens for young mothers at this age, and to shift the focus on this age group as opposed to the current disproportionate focus on young mothers under 18.

The focus in public health and education has been on prevention, on accessing services and on retaining young women in school. Studies in early motherhood have explored agency and decision-making regarding contraceptive use, access to health services, and school retention. There is a growing body of research capturing the voices of young mothers, yet there is still a dearth of information on decision-making processes and of how they make meaning of their lives during early motherhood. More evidence is needed on *how* to support young mothers *after* the birth of their babies, for improved maternal and child health and other positive development outcomes for young mothers and their babies.

Aim and objectives of the study

The aim of the study was to understand how young mothers (18 to 20 years) make meaning of early, unintended, ex-nuptial motherhood, and create opportunities for agency, in an urban area in Johannesburg, South Africa. In this study, I explored the complex set of factors that impact on their decision-making. I focused on the agency of young mothers in relation to their

babies, their personal and family life, education, and access to health services, and explored how they mediated structural constraints in this process.

The concept of agency was operationalised by exploring how young mothers interpreted and made meaning of their situations, how they accessed and used support in their social and kinship networks, and how they made decisions around their lives and future, and the health and wellbeing of their babies. Decision-making was used as a conceptual tool to operationalise and understand agency. Carter (1995, pp. 61–77), drawing on the work of Sutti Ortiz (1973), refers to two kinds of decisions that are pertinent to reproduction; "planning decisions" which are made in advance of the activity and involve actively gathering information, for example, when considering termination of pregnancy or long-acting contraceptives, and "on the spot decisions" which are akin to gambles made just before the action is taken and involves little information, for example, the decision to use or not use a condom. It is important however not to see this as a binary of either/or but instead as a continuum of decision-making practices. I use the terms "navigate," "mediate" and "negotiate" to indicate that the structural environments of young mothers are in a constant state of flux, thus requiring constant adjustment of decisions and aspirations.

The overall objective of this study was to understand ***how young mothers exercise agency in relation to their own lives, and in relation to the health and wellbeing of their baby***.

The specific objectives of the study were:
Objective 1 - To explore the lives of young mothers in the 12 month period after the birth of the baby.
Objective 2 - To describe and analyse how and why young mothers make decisions around the care and wellbeing of the baby.
Objective 3 - To describe and analyse how childbearing impacts on a young woman's future plans for herself.
Objective 4- To describe and analyse how and why young mothers make decisions around their sexual and reproductive health before and after the birth of the baby.

Conceptual and theoretical framework

In this thesis I used a range of theories to provide insight and clarity on key concepts explored in the study. At the outset of the study, a conceptual model framed the research questions,

analysis and discussion. Towards the end of the study, a further conceptual framework was developed to position the findings of the study within and between the specific objectives of the study.

Conceptual framework 1: The socio-ecological model

The socio-ecological model, developed by psychologist Urie Bronfenbrenner (1994, p. 37) has been adapted and applied in varying contexts, and illustrates the developing person and the ecological system, that is, the "actual environment" within which growth of an individual occurs. The model is widely used because it lends itself to theorising extrafamilial conditions on intrafamilial processes; it provides a framework to understand the impact of the environment on individual development. It is therefore used in health research to indicate the relationship between the individual and the network in which he or she operates, and in prevention and health promotion programmes to show how individual behaviour is shaped by the larger environment. I use the model to indicate the interplay between the individual agent and the wider social context, as explored by Giddens (1984).

Figure 1.1 illustrates the young mother at the centre of the first circle, surrounded by concentric circles, representing "layers" of interactions between the mother and her environment, which form the basis of relationships affecting the young mother and the decisions she makes. The second circle represents the young mothers' network of family and friends. In the socio-ecological model, these two inner circles are often referred to as the micro-system. The third circle includes community structures like schools, health facilities, community, and non-government organisations; or the meso-system. Here, Bronfenbrenner (1986, p. 724) reminds us to pay attention not only to the "social address" – the combination of geography (urban, rural, region) and social background (race, class, religion) – but also to "what the environment is like, what people are living there, what they are doing." The three inner circles, or the micro and meso-system represent the immediate environment and key development setting for the young mother. The fourth circle denotes the national level, where policy and programmes on adolescent sexual and reproductive health and early motherhood are determined by influential government departments (health, education and social development), donors and non-governmental agencies. This also represents the level where the economic and cultural context affects individuals. The fifth circle represents the international policy and programmatic environment. These two outer circles are the macro-system. The socio-ecological model is an analytic tool which allowed me to explore and

understand the relationship between the young mother (individual or agent) and her social environment and support network (circles 2 to 5).

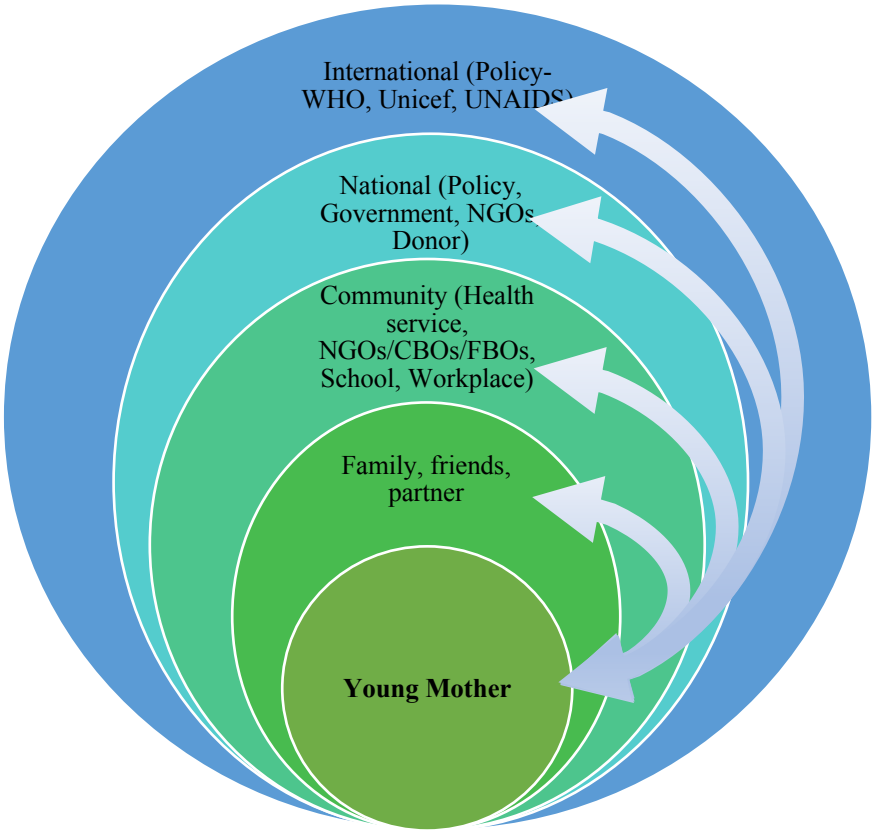


Figure 1. 1: A socio-ecological model to indicate the interaction between the young mother and her social context

Theoretical Framework: discourse, structure and agency

The discourse of early motherhood represents a particular social narrative that has changed over time. Discourses exist within a dynamic context of structure and agency. In exploring the ideas of discourse, structure and agency, I draw on the theoretical work of Michél Foucault (1973, 1977, 1984a, 1984b), Anthony Giddens (1984), Pierre Bourdieu (Bourdieu, 1977, 1990; Bourdieu and Wacquant, 1992; Jenkins, 1992) and Jennifer Johnson-Hanks (2006). The creation of discourses, who creates them, and why they are created, are time and space dependent and are the result of on-going social processes, dominant norms and economic and cultural values. No discourse is static; they are constantly unsettled by political, economic and

social agendas. Judith Butler (1993, p. 2) argues that discourse has "reiterative power" to produce the "phenomena that it regulates and constrains." The discourse of early motherhood in South Africa post-1994 is positioned against a broader African and international agenda, further explored in Chapter 2. This discourse tells us how young pregnant and parenting women are made, constituted or "subjectivated" (Youdell, 2006, p. 515) within an objective social reality, as represented by structures and institutions (economic, social, political) (Youdell, 2006, p. 512) that endure over time.

I use the term structure to refer to objective social reality, or the structuring principles of society. Structures are the spaces within which actors move, produce and re-produce historical patterns of social relations. Anthony Giddens' (1984) work on structure and agency is reflected in his seminal "theory of structuration", where structures are understood as "supra individual" in that they are spread across time and space beyond the scope of the individual agent (Giddens, 1984, p. 204). Structures consist of rules and resources, and are "always both constraining and enabling" (Giddens, 1984, p. 25). Race, class, gender and power are understood as macro-structuring phenomena. These influence economics, politics, norms and values and organisational structures (Sumartojo et al., 2000), and create the foundation for social institutions like schools, health centres, and churches.

Pierre Bourdieu and Lois Wacquant (1992, p. 17) use the term "field" in a similar way that Giddens (1984) refers to structure, to describe the "socially structured space in which agents struggle," or the social area where individual agents manoeuvre to take power over resources and access to them, a structured system of social positions which are occupied by individuals or institutions (Jenkins, 1992, pp. 84–85). Fields represent spaces of contest and competition, spaces of "historical dynamism and malleability that avoids the inflexible determinism of classical structuralism" (Bourdieu and Wacquant, 1992, p. 18). Thus Bourdieu and Wacquant (1992) add a level of complexity to the idea of structure by illustrating movement, fluidity and contestation, reminding us that structures are not static spaces.

In this thesis, I draw on Giddens' (1984) use of the term agency to refer to the purposeful actions of individuals. The classic theory of structuration explores the dialectic between agency and structure, and the extent to which they influence each other. Giddens' (1984) ideas around agency begin with the characterisation of the "agent", the "actor", the human subject, the "self." Agents – with hopes, aspirations and goals – operate within the boundaries created by social structures which influence their objective social situation and the extent to

which they exert agency within this. The agent operates on a number of levels, which indicates an active engagement with the world and an element of power. The agent operates with motivation, has an understanding of what he or she does; in other words, he or she is able to explain or rationalise the action, and reflexively monitor the action. Agents act within a continuum of motivation that ranges from the unconscious to the conscious. "To be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked, to elaborate discursively upon these reasons" (Giddens, 1984, p. 3).

Bourdieu (1977, pp. 78–79) similarly refers to habitus and practice to understand how individuals operate in the world. "Habitus" is that which is embodied in individuals, a way of being, which develops and evolves over time through experience and early socialisation. It is a collective homogenous phenomenon, mutually adjusted for and by a social group, a "structuring mechanism that operates from within agents, though it is neither strictly individual nor in itself fully determinative of conduct" (Bourdieu and Wacquant, 1992, p. 18). The actions of agents have two levels of outcomes or consequences, intended and unintended. Unintended consequences can either be non-significant or significant. All actions occur in contexts, or what Giddens (1984, p. 282) terms "contextualities of interaction," which are inherent in social reproduction. Central elements of contexts include concepts like time and space boundaries, and the co-presence of other actors (Giddens, 1987, pp. 115–120). In the "day to day" lives of agents, Giddens (1984) shows that "routine" (how agents control elements of their daily lives), "co-presence" (of other actors) and "knowledgeability" (conscious and unconscious) are important for agents to produce and reproduce the social system.

The collective phenomenon of life is continuously a process of adjustment between subjectivity (agency, habitus, practice) and objective reality (structure, field).

> The relation between the social agent and the world is not that between a subject (or a consciousness) and an object, but a relation of 'ontological complicity'…between habitus, as the socially constituted principle of perception and appreciation, and the world which determines it (Bourdieu and Wacquant, 1992, p. 20).

In structuration theory, Giddens refers to the "duality" of structure**,** making the point that agents and structure are not two independent sets of phenomena that exist as a "dualism" – static, rigid and in opposition to each other, but are instead a "duality" – moving and changing and constantly operating in relation to one another. This dynamic is mediated by power which is a central concept in relations of action and structure (Giddens, 1984, p. 284). Similarly

Bourdieu and Wacquant (1992, p. 19) describe how habitus is illustrative of "intention in action" but is simultaneously ad hoc and "within the limits of its structures, which are the embodied sedimentation of the social structures which produced it." Thus, habitus and field are relational because they function fully "only in relation to one another"(Bourdieu and Wacquant, 1992, p. 19).

Bourdieu (in Jenkins, 1992, pp. 69–72) describes the space between habitus and field as "practice." Located in time and space, practice is not wholly conscious or unconscious, but happens as life flows from one event to another, and begins in childhood where actors learn the "right" things to do. Bourdieu (1977, p. 79) writes: "Each agent, wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning." Practice describes *how* agency is exercised, and Bourdieu (1990) reflects on the interplay between structure and agency in what he called "subjective disposition" which guides the action of individuals. Practice is performance that is improvised, where improvisation is experienced as the exploitation of pause, interval and indecision. It is this point that Jennifer Johnson-Hanks (2006) calls a "vital conjuncture" (as explored in her formative book *Uncertain Honour*).

"Vital" signifies a demographic vital event which refers to any occurrence "to do with an individual's entrance into or departure from life, together with changes in civil status," for example, birth, death, and marriage (Johnson-Hanks, 2006, p. 24). "Conjuncture," a term used from Bourdieu (1977, p. 78), describes the short term conditions that emanate from social structures that form the basis of social action, in other words it is the "the site in which habitus is made and its consequences enacted" (Johnson-Hanks, 2006, p. 24). Thus, "vital conjunctures" are moments in time when change, uncertainty and potential are on the horizon, and when the actor considers their future potential – an "experience of future orientation, extreme uncertainty, and potential for radical transformation" (Johnson-Hanks, 2006, p. 22).

In this study about the dynamic between agency and structure, power is used as an integrating and permeating concept to understand the mediation between agency and structure. The critique of the concepts of agency and autonomy is that individuals are seen as "entrepreneurial actors who are rational, calculating and self-regulating. The neoliberal subject is required to bear full responsibility for their life biography no matter how severe the constraints upon their action" (Walkerdine et al 2001 in Gill, 2007, p. 74). I explored the relationship and interplay between resources and constraints (as represented by structure) that influence and affect the decisions made by young mothers (agency) in relation to early

childbearing. The aim was to explore how young mothers mediate these structures, that is, assert their agency to navigate the world of early childbearing. Giddens' (1984) ideas of "knowledgeability" (what agents know), "motivation" (why agents do things) and practical and discursive consciousness provided useful constructs to do this.

The idea that actions have consequences resonates throughout this study. Sexually active young women may or may not intend to "fall" pregnant, and fertility decisions can be both active and passive (Carter, 1995, p. 55). Yet either way, intended or unintended, a pregnancy is likely to be highly significant: it represents a rite of passage into adulthood, results in multiple and on-going responsibilities for the care of another human being, and results in women's immediate immersion into the world of production and reproduction. The daily lives of young mothers, the co-presence of other actors, and the power relations that determine the rules and mediate resources available to young mothers, are important elements of the study.

For the purpose of this study, the issue is *how* young women mediate structure in the exercise of agency. Gill (2007, p. 77) argues that "our job [as researchers] is surely to contextualize these stories, to situate them, to look at their patterns and variability, to examine their silences and exclusions, and, above all, to locate them in a wider context." Tamara Shefer (2011, p. 86) emphasises the need for this in the discourse of the sexual and reproductive lives of young women locally and internationally, and for the need "of such voices with the critical text, not necessarily in dialogue, but simply by way of reminding us of the centrality of the sensate and agentic bodies and minds of [which the book speaks]." In doing this, this study aims to disrupt dominant representations of early motherhood, by reflecting on the way in which power dynamics are perpetuated by only capturing and listening to the voices of older adults, men, white and the economically advantaged (Denzin and Lincoln, 2008; Alexander, 2012, p. 132). The intention was therefore to move the focus on young women from objects (contained in discourse, policy and intervention) to actors (who exercise agency in the context of structural enablers and barriers).

Conceptual framework 2: A conceptual framework of the relationship between structure and agency in the discourse of early motherhood in South Africa

Figure 1.2 is the second conceptual framework which developed iteratively as a result of the study. It captures the study in its entirety, combining the theoretical constructs, the objectives and findings. At the top of Figure 1.2, the agency of young mothers is represented as a continuum between structural barriers and enablers. The timeline of pregnancy is presented in

red at the centre of Figure 1.2 and indicates the timeline between conception, pregnancy, birth and after. I pay attention to the pregnancy period here as a point of various decision-making moments, or "vital conjunctures" (Johnson-Hanks, 2006). Objective 1 of the study which examines the 12 months after the birth of the baby, is captured in the entirety of Figure 1.2, and includes the theoretical framing of agency and structure. Objective 2, which explores the care and wellbeing of the young mother and baby, is situated between the two text boxes at the periphery of Figure 1.2, and includes social and structural barriers and enablers. These structures occur at a macro, micro and meso level, as described by the socio-ecological model in Figure 1.1. Objectives 1 and 2 were attended to in Paper 1 and Paper 2. The two structural institutions that were the focus of Objectives 3 and 4 of this study, namely, schools and Sexual and Reproductive Health (SRH) services are illustrated above and below the Timeline of pregnancy. Objective 3, which explored how childbearing impacted on plans for the future, is represented through decision-making around remaining at school or dropping out of school, permanently or temporarily. This was the focus of Paper 3. Objective 4 depicts the continuum of SRH services from contraception before pregnancy to contraception after birth, and is discussed in Paper 4. The papers that emanated from this study, as aligned with the study objectives, are also indicated in Figure 1.2.

The figure also illustrates some of the vital conjunctures of early, unintended, ex-nuptial pregnancy. Jennifer Johnson-Hanks (2006) describes how young women confronted with early, unintended, ex-nuptial pregnancy are confronted with the kinds of futures that were imagined, hoped for or feared, which in turn motivate specific decisions and courses of action. The "vital conjunctures" are "the moments of uncertainty and confusion that precede these acts" (Johnson-Hanks, 2006, p. 111).

> Young women facing an unintended pregnancy are not choosing *between* an abortion and a premarital birth, because both of these exist only as imagined potentials of the "choice." Instead, they envision themselves in a succession of possible future states in which the abortion or birth is only one step, until the conjuncture eventually closes as one of these potential futures grows thick and ripe, absorbing all imagination (Johnson-Hanks, 2006, p. 23).

Johnson-Hanks (2006, p. 23) reminds us that a "vital conjuncture" does not result in a choice or decision in its usual sense, but is more complexly linked to "socially constructed guideposts" like social expectation and aspiration, and are subject to the influence of "kin groups and domestic units" which constitute "'communities of practice' over which knowledge of, and decisions about, education and fertility are distributed" (Johnson-Hanks,

2006, p. 112). An example of a vital conjuncture in Figure 1.2 is illustrated at the point of pregnancy discovery. At this vital conjuncture, young mothers have to consider the horizon of possibilities and make decisions regarding termination of pregnancy, and school continuation.

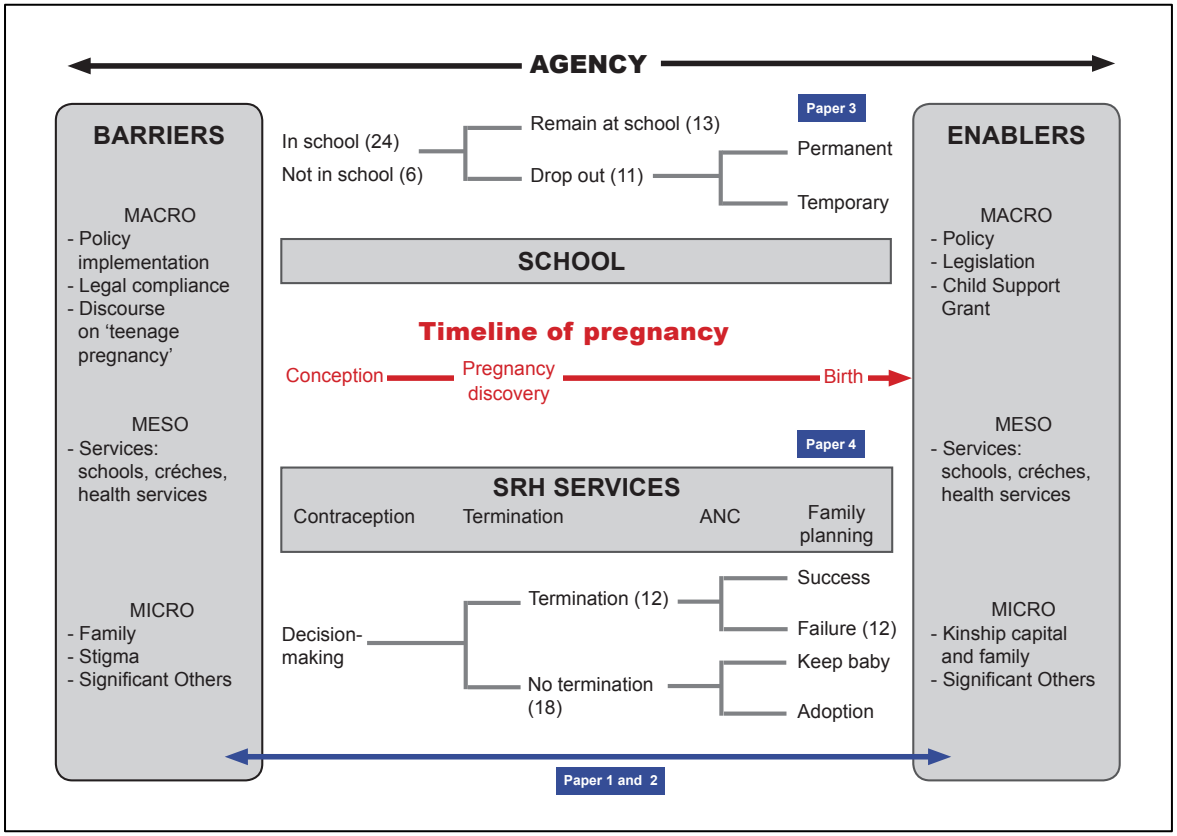


Figure 1. 2 A framework of the relationship between structure and agency - conceptualising "vital conjunctures"

CHAPTER 2: A DISCOURSE OF EARLY MOTHERHOOD

LITERATURE REVIEW

Teenage pregnancy is typically presented as a social problem. The images that preface Section A and Section C of this thesis were taken from newspaper articles that draw our attention to early motherhood as a non-idealised representation of motherhood (Seidel, 1998, p. 68). In each of these photographs, the image of a young woman in a school uniform *with* a pregnant belly is intended to evoke shock, shame, concern and fear, it is "represented as uncontrolled and uncontrollable, visibl[y] swollen with a lack of sexual restraint and adherence to normative understanding of appropriate fertility" (Barcelos, 2014, p. 483). This framing is circumscribed within a wider international discourse that positions early motherhood as ubiquitously dangerous, and teenage pregnancy is pathologised through public health, education, economic and ethnic discourses (Breheny and Stephens, 2010; Barcelos, 2014). This study is positioned in response to this discourse, and contributes to an alternative emergent discourse that considers the agency of young women and the structural context in which they live. I seek to understand how the dominant discourse influences young women's decisions, whether the dominant discourse of early motherhood can be changed, and why it is important and necessary to do this.

In this chapter, I elaborate on the dominant discourse, locating it within a global development framework called Developmental Idealism. I then review secondary data on early motherhood internationally and in South Africa. The chapter then addresses the structural responses that have emerged in relation to the dominant discourse, and the "crisis" that early motherhood is seen to present to the global and national development agenda. I discuss three key areas. These are education, public health and social support; and I explore the South African data, policy and interventions aimed to reduce and mitigate the effects of early motherhood in each of these areas. The chapter ends with a discussion of an alternate and emergent discourse in response to the dominant discourse, one that articulates more nuanced framings of early motherhood.

I focus predominantly on literature published after 1994, although I draw on earlier work to explore the evolution of early motherhood discourses. I pay attention to how early

motherhood has been understood after South Africa's liberation from apartheid as a particular contextual historical and development marker.

The dominant discourse of early motherhood

Teenage pregnancy or early motherhood as a social problem has captured the social and academic imagination for many decades. The literature is replete with studies that emerged in the United States and other high income countries from the late 1970s, and South African studies followed with similar vigour in the post-apartheid era. The discourse of early motherhood as a danger to the social and moral order has been framed around notions of ideal family development. Here, the nuclear family is understood as the appropriate space for children to be embedded, and there are dominant ideas of what constitutes appropriate timing of first birth and the planning that should accompany this. This discourse is situated within a wider development framework called "Developmental Idealism" articulated by the sociologist Arland Thornton (2001, 2005).

Developmental Idealism and Early Motherhood

The theory of Developmental Idealism was developed in the United States and describes an ideal model of development for society and individuals (Thornton, 2001). Developmental Idealism is premised on a prototype of a northwest-European model of development. It is based on five assumptions: that modern society – implying industrial production, urban life, high levels of education, rapid transportation and communication systems – is good and attainable; that the modern family – one that values extensive individualism, youthful autonomy, nuclear households, marriage at an older age, marriage arranged by the couple, affection in mate selection – is good and attainable; that the modern family is a cause and effect of a modern society; that individuals are free and equal within social relationships based on consent; and that modern political systems – in which freedom, liberty and consent are valued – are good and attainable (Thornton, 2001, pp. 454–455; Thornton et al., 2015, p. 76).

Developmental Idealism is located within broader modernisation theories of development. In her critique of Developmental Idealism, Susan Greenhalgh (1995, pp. 10–17) argues that it embraces an evolutionary, linear and Eurocentric view of development. This critique focuses on some of the fundamental assumptions of Developmental Idealism: understanding history as a unilinear process, collapsing history into traditional and modern phases, that women's

status improves with modernisation, and that Western reproduction favouring low fertility is good for everyone. Thus Developmental Idealism ignores that "what is good is culturally conditioned" (Greenhalgh, 1995, p. 17). However, Thornton (2001, 2005) and others (Thornton and Young-DeMarco, 2001; Binstock et al., 2013; Thornton et al., 1983, 2015) suggest that Developmental Idealism is important as a cultural model of development that contributes to social change, and that they are not proposing it is an ideal model of development. Despite the critique levelled against it, and whether it merely describes or proposes ideal forms of development, it offers a development template that has been powerful in its influence, and one that has framed the timing and sequence of development milestones internationally.

In particular, the idea of the modern family as constructed by Developmental Idealism has played a powerful role in constructing discourse around the family, and has created a prototype for what is viewed as ideal family formation (Geronimus, 2003; Binstock and Thornton, 2006; Bute and Russell, 2012; Binstock et al., 2013). Individual development is understood as a series of chronologically ordered developmental milestones, which must occur within a normative schedule (Furstenberg, 1976). Age is a primary variable used to define life course events in a linear path: chronologically from infancy to childhood to adolescence to adulthood to middle and then old age. Adolescence is the time between childhood and adulthood, when a young person is not quite adult and not quite child; adolescence is seen as a time of transition. Childbearing is valued as ideal when achieved after adolescence – throughout adulthood, although less so for older women – and deviations from this normative schedule, especially when it occurs outside of marriage, have resulted in concern and cause for intervention globally (Furstenberg, 1976; Luker, 1996; Geronimus, 2003; Macleod, 2011a; Koffman, 2012).

Global power relations created through colonialism, neo-colonialism and globalisation have resulted in an unequal distribution of wealth and resources between the global south and north. Dominance over political and economic development has been accompanied by a strong influence on cultural systems where values, beliefs and scripts are absorbed across national boundaries and create norms around the social and moral order. Thornton and colleagues (2015, p. 72) propose that these cultural systems are not a "monolithic set of rules and demands so much as a tool kit of scripts and schemas that people use in making decisions and relationships," and these cultural systems are "composed of schemas, scripts, values and beliefs, which vary in their endorsement depending on time, place and social context."

When young women become mothers prematurely, they deviate from the social and moral script for adolescents. This script suggests that the timing of first birth is important for socially sanctioned behaviours, and that childbearing is ideal when it occurs within a marriage, is planned, and when the mother is older and has completed her education. The nuclear family is set up as the ideal family, within which biological children are cared for by two parents (Geronimus, 2003, p. 886; Bute and Russell, 2012). Internationally, the data tells us that early motherhood affects young women from low income backgrounds, that it occurs most often occurs outside of marriage, and that race and class are crucial factors in determining predisposition to early childbearing (Ranchhod et al., 2011). This is not surprising given the history of colonialism and its disproportionate economic and social cost to Black and other indigenous people.

Framings of early motherhood are political, seeking to create hegemonic ideals of development and life course, in particular the idea of the nuclear family as a unit of society and hence social control. Geronimus (2003) and others (Luker, 1996; Macleod, 2009, 2011a; Ware et al., 2017) argue that this form of social control perpetuates the interests of the dominant classes who have both the social and economic means to reproduce the nuclear family, and for whom deviations from this ideal, like early childbearing, provide stressors to the wider system that is not in the interest of the dominant classes because of the social and economic costs. Ware and colleagues (2017, p. 506) argue that the idea of an ideal life course trajectory and definitions of good parenting practices are "produced and reinforced through a colonial gaze of dominant culture, class and gender expectations which exclude and sanction alternative life course trajectories." Thus, early motherhood presents a threat of moral degeneration and social decline (Macleod, 2011a, p. 5). Furthermore, early, mistimed pregnancy and parenting presents a rupture in assumed social hierarchies (Bhana and Mcambi, 2013) and is an affront to the social and moral order. Geronimus (2003, pp. 887–888) argues that the term ‘‘teenage pregnancy’’ is in itself a political tool.

This discourse of early motherhood is also powerfully gendered, with ascribed gender roles and moralising views on female sexuality "perpetuating the representation of teenage pregnancy as social decay and moral degeneration" (Shefer et al., 2013, p. 1). Early motherhood is seen as an outcome of the expression of female sexual desire that transgresses the moral order and is in need of correction and discipline (Stapleton, 2010, pp. 49–50). The role of men, and in this instance fathers, has historically rarely been subject to the same

moralising discourse (Mkhwanazi, 2010; Ngabaza, 2010). Care and caregiving of children born to young mothers is also feminised, and it is young women whose schooling is most likely disrupted or other women in their kinship networks with whom the burden of care rests (Bhana and Mcambi, 2013, p. 18).

Adolescence in the context of Developmental Idealism

The construction of adolescence as a distinct and separate life stage occurred in North America and Europe around the early 1900s, in association with social changes like the rise in universal schooling and the outlawing of child labour. These ideas subsequently spread through colonialism and neo-colonialism into Africa and other parts of the world (Macleod, 2009, p. 381). Adolescence includes the period between the onset of puberty and the beginning of social independence (Curtis, 2015, p. 1). The age range varies considerably across a continuum which is context, culture, and time dependent (Curtis, 2015, p. 26). Although in most countries young people reach legal adulthood at 18 years, the literature on adolescence extends the age from 10 years as the minimum and 25 years the maximum. This implies a wide range of ages and associated developmental discrepancy because of "the appreciated continuity of human development; a recognition of individual, cultural, gender and racial variability; the ascribed relative salience of specific developmental milestones, and a perpetually refined science of human development in a dynamically evolving society" (Curtis, 2015, p. 9). In this study, I use the World Health Organization (WHO) definition of adolescence as between 10 and 19 years (WHO, 2001, p. 2).

The health and education development agenda that developed in the global North, identifies adolescence as a critical time in the life course, associated with complex physical, psychological, emotional and social changes, with immediate and long term health and development implications (Delany-Moretlwe et al., 2015, p. 30). Adolescence is often associated with being a "problematic life stage in modern society" (Furstenberg, 2000, p. 897). Emergent female sexuality during adolescence is often framed as dangerous (Sax, 2010) In the public health discourse, adolescence is important as it is the time when the foundation for future health is laid (Sawyer et al., 2012). Numerous policies and interventions that target adolescents focus on the structural determinants (national wealth, income inequality, access to education and health services, employment opportunities and gender inequalities), as well as improving adolescents' daily lives with families and peers, and address risk and protective factors in their social environment to promote healthy development (Resnick et al., 2012, p. 1566; Viner et al., 2012; Delany-Moretlwe et al., 2015, p. 30).

A critique of this construction of adolescence is that it was founded on a conception of youth as "incomplete cultural actors and assumed that the transition to adulthood was profoundly shaped by species wide biological factors" (Cole, 2004, p. 573). Furthermore, it was framed by colonialist ideas which position this stage in life course development as one that has potential for disease (referring to early reproduction and abortion) and danger (privileging normative monogamy in the context of HIV) (Macleod, 2009, pp. 382–386), essentialising adolescence as a period of risk. These ideas have played a pivotal role in constructing the dominant discourse of early motherhood, where adolescent sexuality is associated with early reproduction, abortion and the spread of disease (Macleod, 2009, p. 382). This social and moral script of adolescence is created within the ideals of family formation, described by Developmental Idealism. It fails to recognise the complex ways in which transitions to sexuality and adulthood have been managed culturally and historically (Delius and Glaser, 2002; Cole, 2004). In South Africa, indigenous forms of adolescent sexual regulation were eroded by colonisation, Christianity, migration and urbanisation (Delius and Glaser, 2002).

Causes and Consequences of Early Motherhood

Early, unintended, ex-nuptial pregnancy and motherhood, and its attendant causes and consequences, are inherently gendered and undermine the aspirations of young women in multiple and complex ways. The *causes* of early childbearing are many. Risk factors that increase the likelihood of early motherhood include socio-economic disadvantage, being a child of a young mother, low levels of education and educational aspiration, and early sexual debut. In the United States, Kristin Luker (1996, pp. 115–116) and others (Furstenberg, 1976; Dash, 1989; Geronimus and Korenman, 1992; Edin and Kefalas, 2005) cite risk factors for early motherhood as poverty, being Black, early sexual debut, low education levels, inconsistent and ineffective contraceptive use (linked to low educational levels), poor neighbourhoods, little hope and low aspirations of improving lives, few if any successful role models, peer behaviour, and low uptake of abortion. This has been found to be true for other contexts (Stapleton, 2010; Kaphagawani and Kalipeni, 2017), including South Africa, where risk factors include race, class, gender and gender based violence. Associated with these are low educational attainment and low aspirations for the future (Morrell et al., 2012; Mkhwanazi, 2010; Wood et al., 2008; Varga, 2003; Jewkes et al., 2001, 2009; Macleod, 2001, 1999a, 1999b). In addition, studies have found that early sexual debut, gender based violence and age disparate relations (age difference of more than five years) contribute to early, unintended pregnancy due to reduced use of condoms (Jewkes et al., 2001; Pettifor et al.,

2005, pp. 60–64; Jewkes et al., 2010; Christofides et al., 2014b; Toska et al., 2015, pp. 60–64).

Young women who have an unintended pregnancy use contraceptives ineffectively and inconsistently, and there is a gap between reported pregnancy intention and enacted fertility behavior (Rusibamayila et al., 2017). Studies also point to an unmet need for contraception, exacerbated by health system challenges (Wood et al., 1998; MacPhail and Campbell, 2001; Satterwhite and Ramaswamy, 2015; Potter and Santelli, 2015; Self et al., 2018). However, this is not always a case of not having the requisite knowledge, or access, but is complicated because young women often do not "have sufficient motivation to try to avoid conception and/or prioritize contraception" (Sheeder et al., 2009, p. 302). Sheeder and colleagues (2009, p. 302) show that for many young women in resource poor contexts, the opportunity cost of pregnancy is low and the perceived benefits high, and thus there is low motivation to consistently and effectively prevent pregnancy; there is "little in the way of lost opportunities and adolescent childbearing is culturally and socially acceptable." Hardon and Moyer (2014, p. 111) further assert that it is sometimes an act of agency by young women when confronted by hegemonic biomedicine, as a way to "navigate their own reproductive desires" and to fulfil the "social expectations that young women in relationships have children."

The *consequences* of early motherhood are associated with lower social and development outcomes for mother and baby, and adverse social, physical and mental health outcomes throughout life. Socially and developmentally, women who have babies earlier in life are more likely to have experienced and to reproduce socioeconomic disadvantage, achieve lower levels of educational attainment, and experience higher levels of emotional and mental health problems later in life (Furstenberg, 1991; Manlove, 1997; Hobcraft and Kiernan, 2001; Lee and Gramotnev, 2006; Boden et al., 2008; Kavitha, 2013; Woodward et al., 2013; SmithBattle et al., 2018). The cause-consequence relationship is circular, with socio-economic disadvantage and early motherhood impacting on each other in both directions. It is contested as to whether or not young women have difficult lives simply as a consequence of having a baby at an early age, and whether young women can avoid difficult lives by simply choosing to delay childbearing (Luker, 1996, p. 110).

Recognising the interplay of various structural factors with early motherhood, public health research has focused on controlling for and excluding class, family and individual factors in cross sectional and longitudinal studies (Manlove, 1997; Hobcraft and Kiernan, 2001; Boden

et al., 2008). In a British based longitudinal study, Manlove (1997) found that after controlling for family, schooling, and individual factors, daughters of teenage mothers were more likely to have babies in their teens and into their early 20s, reproducing patterns of social, economic and educational disadvantage. Hobcraft and Kiernan (2001), looking at the same data and factoring in economic class, show that early motherhood affects outcomes later in life, more so for women who were poor to start with, but also for women who were not poor at time of pregnancy.

In a New Zealand based 25 year longitudinal study, Boden and colleagues (2008) found that after adjusting for confounding factors like socio-demographic background, family functioning, childhood behaviour and cognitive ability, early motherhood puts "young women at risk for educational underachievement and poorer economic circumstances" (Boden et al., 2008, p. 157). Using the same data, Woodward and colleagues (2013) compared the life course and family formation experiences of two generations of young mothers raising children in the 1970s and early 2000s. They found that early motherhood was an "even more deviant and disadvantaging life event than it was for previous decades" because unlike previous generations, many young mothers were raising their children "without the support of a partner, with limited material resources, and depending on government welfare and other forms of assistance to provide for their family" (Woodward et al., 2013, p. 307). They also argued that contextual factors like changing labour markets, requirements for higher levels of skill and employment, and the absence of strong family and kinship systems, contribute to the precarious position in which many young mothers find themselves. In essence, the greater the factors of disadvantage, the greater each bear on the other.

Data on early motherhood

The international data suggest that over time, fertility levels amongst all women have decreased as a result of declining early motherhood. This is also true for South Africa (South African Department of Health and South African Medical Research Council, 2002; Statistics South Africa, 2017a). In high income settings, from the 1960s, the combination of increased access to education and improved access to effective birth control meant that women had increased agency over their bodies, resulting in an increase in age at first birth and an overall decrease in fertility rates (Lee and Gramotnev, 2006; Richter et al., 2006). Contemporary international rankings of mean age at first birth indicate that there is still a huge variation between countries, reflecting differences in economic status, culture and educational policy.

Drawing on the most recent comparative data, in 2016 Korea had the oldest mean age at first birth at 31.4, compared to the USA at 26.6 (Organization for Economic Cooperation and Development, 2018). The Statistics SA report of Census 2011 (2015, p. 51) indicates the mean age at first birth in South Africa at 21.8.

The interpretation of data on teenage pregnancy in South Africa has been contested over the last 20 years, with debate on whether the rate is increasing or decreasing. A Human Sciences Research Council (HSRC) study by Panday and colleagues (2009), drawing on the Education Management Information System (EMIS) data, proposed that rate was increasing. On the other hand, the South African Demographic Health Surveys of 1998 and 2016, illustrated in Table 2.1, indicate a very slight decline over two decades in the percentage of women in the 15-19 year age group who had ever given birth from 13.2% in 1998 to 12.4% in 2016; and 16.4% in 1998 to 15.6% in 2016 of those who had ever been pregnant (South African Department of Health and South African Medical Research Council, 2002; Statistics South Africa, 2017a).

Table 2. 1: Comparative data of adolescent pregnancy, South Africa, 1998 and 2016

Age	**Percentage who have ever been pregnant/have begun childbearing**		**Percentage who have had a live birth**	
	1998	2016	1998	2016
15	2.4	3.8	2	2.4
16	7.9	7.5	5.2	3.5
17	14.2	14.8	10.7	10.8
18	24.6	22.6	19.8	20.0
19	35.1	27.8	30.2	24.5
TOTAL	16.4	15.6	13.2	12.4

Source: South African Demographic Household Surveys (SADHS) 1998 and 2016

In 2017, birth occurrences were 0.1% for mothers aged 10-14, 10.8% for mothers aged 15-19, 25.5% for mothers aged 20-24 and 26.2% for mothers aged 25-29 (Statistics South Africa, 2017b, p. 23). The median age for mothers for births registered in 2017 was 27.6 years – this is the same as the median age for mothers in 1999. The period between 1999 and 2006 saw a decrease in median age of mothers to the lowest in 2006 at 26.2 years, thereafter increasing to 27,6 years in 2017 (Statistics South Africa, 2017b, p. 24). As illustrated in Table 2.1, the South African Demographic Health Surveys of 2016, the latest report with age specific rates,

reported that at age 15, 3.8 per cent of young women had begun childbearing; at 16 it had almost doubled to 7.5 per cent; at 17 to 14.8 per cent; at 18 to 22.6 per cent and at 19 to 27.8 per cent (Statistics South Africa, 2017a, p. 12). Thus, almost 30% of young women have begun childbearing by age 19 (Statistics South Africa, 2017a). Early, unplanned childbearing accounts for an estimated 80,000 babies annually (Willan, 2013; Branson and Byker, 2018). Mchunu and colleagues (2013, p. 426) suggest that 35% of pregnancies among 15-19 year olds in sub-Saharan Africa are unintended, unwanted or mistimed.

Although rates have decreased marginally, Table 2.1 indicates that these shifts have not been significant over an almost twenty year span from 1998 to 2016. In 2016, rates of early childbearing were higher in rural (19%) versus urban (14%) areas, with the highest rates occurring in the Northern Cape (20.3%) and the lowest rates in the Western Cape (8.1%). The rate of early childbearing in Gauteng, where this study was located, was 14.1% (Statistics South Africa, 2017a, p. 12). The birth rates under 18 have declined, but with a rapid increase in birth rates between 18 and 20 (Ardington et al., 2011). While the increase in birth rate at this age is consistent with increased likelihood of sexual debut with age, it is still necessary to have a deeper understanding of what happens at this time for young women to warrant such a considerable increase in pregnancy rates after age 17. Furthermore, my data draws attention to why, in spite of growing interest and investment in reducing rates of teenage pregnancy, this has not happened at a more significant level.

Structural responses to early motherhood

Research has confirmed the importance of targeting structural drivers of poor development outcomes (Sumartojo et al., 2000; Blankenship et al., 2006; Parkhurst, 2012). International and national development agendas have therefore increasingly prioritised structural drivers like race, class and gender that predispose young women to early, unintended motherhood. Efforts to address the physical, social, cultural, organisational, community, economic, legal and policy environments that render young women vulnerable to poor development outcomes are key (Wamoyi et al., 2014, p. 2). Important too is the impact of structural violence which results from the failure of social structures, through policy and intervention, to remove the barriers that constrain rights and/or access to basic needs and services thereby addressing high levels of inequality and low levels of development (Farmer, 2004; Farmer et al., 2006). Structural interventions view individual agency as constrained and seek to address this (Blankenship et al., 2006). Responses that have emerged to address the causes and mitigate

the consequences of early childbearing aim to improve outcomes for mothers and their children, and respond to the data and evidence put forward through dominant discourses. This includes improving maternal education, access to social protection, maternal and child health, contraceptive use, and reducing repeat pregnancy, where repeat pregnancy for young mothers is defined as giving birth at least twice before age 20 (SmithBattle et al., 2018, pp. 2–3).

In examining three areas where structural interventions address early childbearing, namely, education, public health and social protection, the sections below begin with a brief overview of the policy and legislative environment driving the responses. Current policy emphasises the intersectionality of development issues. Thus efforts to prevent early, unintended pregnancy must be considered in conjunction with decreasing HIV and other STIs, and mitigating gender based violence amongst young women. However, the literature suggests that the focus on *prevention* dominates the policy and intervention space, and there is little emphasis on supporting and mitigating the effects of early, unintended, ex-nuptial motherhood.

Education

The relationship between early motherhood and educational outcomes is shaped by educational status, school dropout and pregnancy. I use the term "learner" to refer to children and young people in school, as used in the South African policy environment. School "dropout" refers to temporary or permanent withdrawal from school.

Education policy and early childbearing

Access to education is seen as a panacea to uneven development and a "social vaccine" against poor life outcomes (De Neve et al., 2015, p. e470). Johnson-Hanks (2006, p. 10). describes schools as a "moral economy" that regulates "honorable childbearing" that occurs *after* school. This is further reflected in policy. The protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) requires all African member states to take measures to keep girls in schools (African Union, 2013, p. 13). In redressing the inequality created by apartheid and its continued inequity, the South African Constitution, situated within a human rights discourse, looks to formal education as a means to improve life chances, guaranteeing equal access to education for all without prejudice and discrimination.

The South African Schools Act No. 84 of 1996 legislates the right of all children to access education, to redress imbalances created by apartheid and the associated unequal access to

education experienced by the vast majority of black South Africans (Republic of South Africa, 2011). The Act attempts to right multiple injustices and to "provide an education of progressively high quality for *all* learners" (my emphasis) (Republic of South Africa, 2011; Maharaj et al., 2000, p. 1). More recently the Draft National Policy on the Prevention and Management of Learner Pregnancy in Schools seeks to facilitate access to comprehensive sexuality education, sexual and reproductive health services and prevent the discrimination of learner pregnancy so that young pregnant and parenting women can continue their schooling: the Draft Policy also provides that "educators may refer pregnant learners to health clinics or school nurses for information on pregnancy termination" (Department of Basic Education Republic of South Africa, 2018).

Educational aspiration increased in South Africa post-apartheid, and is highly valued and defended as a pathway out of poverty, whether or not a learner has a child or children (Hunter and May, 2003, p. 32; Madhavan and Thomas, 2005). South Africa's National Development Plan 2030, the blueprint for socio-economic growth and development (Pillay, 2018), articulates education as a priority goal (United Nations, 2015; National Planning Commission, 2012). There is a concerted effort to increase the retention of young women in the school system and to encourage school completion: increased education is also associated with lowering the risk of HIV infection (Pettifor et al., 2008).

School retention for pregnant and parenting young women

Interventions that keep girls in school are important for all young women, and is a key focus of the South African government (National Planning Commission, 2012). Education is seen as protective because it heightens awareness about sexuality and sexual and reproductive health, delays sexual debut and pregnancy, and improves the chances of access to post-school opportunities and employment (Ardington et al., 2011). Higher levels of education is associated with lower levels of perpetration and experience of intimate partner violence (Mason-Jones et al., 2016; Gibbs et al., 2018). Education is deemed as necessary in the pathway to socio-economic success. Teenage pregnancy is correlated with poor educational outcomes, and higher educational status is associated with lower pregnancy rates and hence lower school dropout amongst adolescent girls (Chigona and Chetty, 2007; Jewkes et al., 2009). However, the relationship between early childbearing, education and socio-economic outcomes is not straightforward; and it is not clear whether delayed childbearing improves socio-economic position or whether socio-economic disadvantage is a cause of early childbearing.

In South Africa, school enrolment and retention is high during the compulsory years of school up to age 16, with girls advancing more than boys in primary school, but this changes for secondary school (Grant and Hallman, 2008, p. 369; Patel, 2012, p. 109). Dropout from secondary school is predominantly true for African and Coloured learners, with high rates of grade repetition and increased age per grade being one of the reasons for eventual drop out (Branson et al., 2014, p. 113). School dropout is higher for males than females from Grade 6, but equalises by Grade 11 with approximately 40% of all learners dropping out prior to the final matriculation year (Branson et al., 2014, p. 110). Young men cite not affording to stay at school as the primary reason for school dropout. Young women cite pregnancy or having a baby as a major reason for school dropout (Grant and Hallman, 2008; Ranchhod et al., 2011; Branson et al., 2014), with affordability being the second most cited reason (Branson et al., 2014, p. 113).

Unintended pregnancy is one of the main reasons for adolescent girls dropping out of school in South Africa (Maharaj et al., 2000; Grant and Hallman, 2008; Marteleto et al., 2008; Panday et al., 2009; Timæus and Moultrie, 2015), and more so amongst older girls at school who may assume they have attained sufficient education in a context where high levels of education achievement is not a norm (Madhavan and Thomas, 2005; Ardington et al., 2011). A secondary analysis of data from 2008 and 2010 found that young women who gave birth had twice the odds of dropping out of school, and nearly five times the odds of failing to matriculate (Timæus and Moultrie, 2015).

The relationship between pregnancy and dropout in is complicated in two ways. First, although pregnancy is a reason for school dropout, the rates of school attendance and continuation for pregnant and parent learners is high in South Africa. Thus, South Africa is different from other sub-Saharan African countries where many young women return to school after pregnancy, even if they do not complete school (Maharaj et al., 2000; Madhavan and Thomas, 2005; Marteleto et al., 2008). This has increased over time. Studies between 1993 and 2011, using three different data sources (Maharaj et al., 2000; Marteleto et al., 2008; De Lanoy et al., 2015), consistently show that young women attend school during pregnancy and after and that these rates are increasing, indicating the consistent implementation of policy endorsing the right of pregnant and parent learners to remain at school (Department of Basic Education Republic of South Africa, 2018).

Second, although learners cite pregnancy as a reason for school dropout, there is a range of contributory factors. Branson and colleagues (2014, p. 116) caution against simplistically looking at dropout as being caused by a single event or constraint (pregnancy), arguing that dropping out of school is instead more likely the result of other long term problems. These include falling behind at school, strongly associated with socio-economic circumstances and school quality, where low quality, poorly resourced schools are not able to support learners who are behind at school (Branson et al., 2014, p. 125). Other problems include pre-existing social and economic factors like poverty and poor academic performance which affect attendance and progress. In these cases, pregnancy becomes the precipitating cause for dropout, but is not the only cause (Panday et al., 2009, p. 21).

Branson and colleagues (2014) and others (Maharaj et al., 2000; Hunter and May, 2003; Ranchhod et al., 2011) show that socio-economic disadvantage is a critical factor in determining school dropout and other educational outcomes in South Africa. They further show that young mothers do not fare much more poorly than other learners. For example, Maharaj and colleagues (2000, p. 19), drawing on data from 1993[1] and 1997[2] illustrate that while levels of educational attainment for "teenage mothers" is lower than their non-pregnant peers, it is in fact not much lower, and that reducing early childbearing would not enhance the educational outcomes for those young women significantly: up to 90% of the differences in secondary school graduation rates are caused by other factors (Ranchhod et al., 2011, pp. 5–6). They demonstrate that even if young mothers had not had a birth, they would still have likely had a relatively low level of educational achievement (Ranchhod et al., 2011, p. 18). Ardington and colleagues (2015, pp. 285–290) support this with data from a study in rural KwaZulu Natal, South Africa, where even after controlling for socio-economic disadvantage they found that teenage mothers may have lower educational outcomes irrespective of whether they had given birth.

Conflict and care at schools

South African schools are spaces of contradiction. On the one hand, school policies are meant to align with the progressive international and local policy environment to encourage the retention of young women in schools (Department of Basic Education Republic of South Africa, 2018). On the other hand, they are spaces where dominant discourses of early,

[1] South African Livings Standards Survey (Maharaj et al., 2000)

[2] School Register of Needs Survey (Maharaj et al., 2000)

unintended pregnancy and motherhood flourish in light of public statements made by political leaders like former President Zuma, as well as stigmatising and discriminating attitudes of teachers and learners. These discourses position pregnant young women as irresponsible, negatively influencing and disrupting other learners, promoting and displaying sexual deviance, and presenting educators with multiple challenges as a result of absenteeism, grade repetition and poor performance, thus interfering with school efficiencies like learner progress and pass rates (Bhana et al., 2010; Nkani and Bhana, 2010; Kate, 2012; Shefer et al., 2012). Researchers have demonstrated that school management, teachers and peers show low levels of empathy, fail to consider personal and community contexts, and often ignore the constitutional and legal rights of pregnant and parent learners, often acting against the best interest of the learner (Chigona and Chetty, 2007; Shefer et al., 2012, p. 133).

Bhana and Ngabaza (2012) argue that schools are the spaces where the generational and age related conflict inherent in the idea of child and adolescent sexuality is played out, and where dominant assumptions of sex and sexuality are confronted. Schools therefore become the site where shame, stigma, blame, panic, punishment and fear are perpetuated in relation to the sexuality of young people. The pregnant or parenting learner heightens awareness and visibility of the sexuality of young people, particularly young women (Nkani and Bhana, 2010; Morrell et al., 2012). Pregnancy is seen as young women flaunting their sexuality, eliciting negative responses from teachers (Bhana and Ngabaza, 2012, p. 52).

In some contexts, once the baby is born and the hyper-visibility of the sexually active teenager (see Image 1, Section A and Image 4, Section C) has receded, learners experience a decreased negative reaction from teachers, and there is often more support for parenting than pregnancy (Bhana and Ngabaza, 2012; Bhana and Mcambi, 2013). However, this is not always the case. Parenting learners experience discrimination and shame at many schools, with educators often unsupportive and responding negatively to pregnant young women. Thus, re-entry into school by young mothers is often not practised, either due to a school level decision that she may not return or because the school environment is directly or indirectly hostile (Shefer et al., 2012).

Evidence on the support young mothers need to remain at or reintegrate in school during pregnancy and after giving birth, point to the importance of support from schools, as well as financial support and childcare (Madhavan and Thomas, 2005; Chigona and Chetty, 2007; Jewkes et al., 2009; Nkani and Bhana, 2010; De Lanoy et al., 2015; Pillay, 2018). In studies

exploring the experiences of pregnant and parent learners at schools, the dominant narrative of teacher's negative reactions is increasingly being challenged by evidence of care and support. Bhana and colleagues (2010, p. 877) argue that this affective discourse is linked to the significance of education held by the wider South African public, and its association with improved economic status. Teachers act in "uneven ways" across contexts, and in spite of progressive policy, teachers are limited by structural constraints which determine how much support they can offer to pregnant and parenting learners (Bhana and Ngabaza, 2012, p. 57).

Future considerations

Given that completing school for young Africans is intrinsically linked to persistent household disadvantage and poor school quality, with direct bearing on schooling and sexual behaviour, Marteleto and colleagues (2008, p. 367) argue that policy interventions aimed at decreasing pregnancy or improving performance of secondary schools are unlikely to yield change if the focus is not shifted to earlier in life, through improving primary schools and addressing the persistent disadvantages of poor households. Thus, addressing pre-existing adversity, particularly socio-economic factors and household level determinants, is critical in facilitating educational attainment (Ranchhod et al., 2011, p. 18). There has therefore been a national focus on Early Childhood Development (ECD) internationally and in South Africa (World Health Organization, n.d.; Atmore, 2013; Chan et al., 2017; Daelmans et al., 2017; Lo et al., 2017).

Completing school holds little promise for young people as high levels of unemployment, low levels of further education and training, and limited access to tertiary education leave many school leavers without jobs or educational opportunities after school (Branson et al., 2014, p. 116). Thus, keeping young women in school must be seen against the overall levels of education completion, and the future that education allows for young South Africans. Controversially, Lam and colleagues (2013, p. 266) caution against the widely held belief that more schooling results in delayed sexual debut, arguing that more exposure to schooling at the optimum age per grade exposes younger women to older sexually active adolescents who remain in the school system because of high rates of grade repetition. Thus, although young women in school are less likely to be sexually active than young women not in school, they interact with and are influenced by older sexually active young people.

Public Health

Data on the antecedents and longer-term consequences of early motherhood on the health of young women and their children raises significant public health concerns and demands a structural response from the public health sector.

Maternal and child health - consequences of early childbearing

Globally, an estimated 16 million young women between 15 and 19 years give birth annually. This constitutes 11% of all births; 95% of these occur in low- and middle-income countries (Cherry and Dillon, 2014, p. 7). These births account for 23% of the overall burden of disease for young mothers, including but not limited to higher risk of eclampsia, puerperal endometritis, systemic infections, postpartum haemorrhage, obstetric fistula, depression, and for the infant, stillbirth, low birth weight and asphyxia (Cherry and Dillon, 2014; World Health Organization, 2018). Before the age of 15, pregnancy is associated with high levels of morbidity and mortality for mother and baby, compounded by poverty and deprivation, with long term implications. Biologically, there are concerns that very young mothers (under 15) have not yet completed their own growth, are in danger of cephalopelvic disproportion, and may lack the nutrition required to sustain their own or foetal health in pregnancy. In South Africa, teenage fertility accounted for 36% of maternal mortality in 2010 (the maternal mortality ratio was 300 per 100 000 live births) (World Health Organization et al., 2015; Mkhwananzi, 2017, p. 12)); the main causes of pregnancy related mortality in adolescents is hypertension, abortion and injuries (de Wet, 2016).

In many low- and middle-income countries including South Africa, high levels of HIV and AIDS amongst young women have sharpened the focus on the sexual and reproductive health and lives of young women, and on early motherhood (Akelo et al., 2015). HIV prevalence among young women aged 15-19 was 5.8%, and 15.6% among young women aged 20-24 (Human Sciences Research Council, 2018). There is a disproportionate burden of HIV amongst young women in the 15-24 year age group, illustrated by the difference in prevalence between males and females. High levels of HIV prevalence among young women is attributed to age disparate relationships with men on average eight years older and who already have high prevalence levels (Dellar et al., 2015). Thus, HIV prevalence amongst young women has ignited not only a moral panic about adolescent sexuality, but has also sharpened the focus on early childbearing.

There is little known about the causal links between early childbearing, HIV and health outcomes for young mothers. In general, women are at greatest risk for HIV infection when pregnant because of pregnancy-related biological changes. Younger pregnant women may be further compromised because of the risks associated with having older male partners, higher probability of coerced first sex, and higher levels of gender based violence (Jewkes et al., 2001, 2009; Christofides et al., 2014b), with genital sores and lesions as a result of coerced sex and violence leading to higher levels of HIV infection (Ardington et al., 2015, p. 284). Yet, there has been little attention on HIV risk and mortality in relation to early childbearing (Ardington et al., 2015, p. 284). In a study based in KwaZulu Natal, South Africa, Ardington and colleagues (2015, p. 305) illustrated that women who have had a birth before 17 years have higher mortality risk than older teen mothers aged 18-19 years, and show that AIDS related deaths are more prevalent for teenage mothers, especially for women under 17 years, than for non-teenage mothers.

In determining the impact of early childbearing on the health outcomes of children born to young mothers, a similar complexity is evident, with high levels of socio-economic disadvantage masking other determining factors. There are no studies in developing countries that directly examine the causal pathway of early childbearing with child health outcomes, where maternal and household characteristics prior to the birth are controlled (Branson et al., 2015, p. 591). Historically, the focus has been on development and behaviour outcomes of children, and there is little in terms of health outcomes. One recent study in South Africa, by Branson and colleagues (2015, p. 592), found that children of young mothers are more likely to be born with low birth weight, to be shorter, and to be stunted.

Health policy and interventions

Public health policy seeks to address early childbearing by preventing and mitigating the effects of unintended conception (Jewkes et al., 2009). Policy focussing on prevention aims to increase education and awareness of sexual and reproductive health (SRH) through comprehensive sexuality education, make sexual and reproductive health services widely available and youth friendly, and increase access to contraception. International and South African health policy furthermore seeks to mitigate the consequences of unintended pregnancy for young women. This includes increasing the availability and accessibility of termination services, and improving maternal and child health services to promote better outcomes for younger mothers and their children.

Interventions to address early childbearing never stand alone and are located within the broader range of interventions to improve SRH outcomes for adolescents. The HIV epidemic in particular, and the data presented earlier which illustrates the disproportionate burden on young people, has sharpened the focus on SRH and driven the momentum for realising the SRHR of young people. The increased evidence on the pernicious impact of gender based violence on the sexual lives of adolescents has further increased the focus on addressing sexual and reproductive health from multiple angles, paying attention to the structural forces which increase the associated risks of HIV infection, intimate partner violence and early childbearing for adolescents (Wood et al., 2008; Jewkes et al., 2010; Christofides et al., 2014). Furthermore, poverty, particularly household food insecurity, increases experience of intimate partner violence (Gibbs et al., 2018).

In the last two decades, evidence on the challenges of implementing structural interventions to address health issues, has heightened awareness of the importance of dealing with the context in which health is produced and reproduced (Blankenship et al., 2000; Parker et al., 2000). This section looks at two areas of public health intervention that addresses prevention and mitigation of early childbearing, namely, Comprehensive Sexuality Education (CSE) and SRHR service provision. While discussed under this section on public health, CSE and SRHR in South Africa are the joint responsibility of the Department of Health and Department of Basic Education as described in the Integrated School Health Policy (Department of Health and Department of Basic Education South Africa, 2012).

Comprehensive sexuality education (CSE)

The United Nations Population Fund (UNFPA) (2014, p. 6), a key player in defining global SRH priorities, defines CSE as a basic human right crucial for advancing gender equality and improving sexual and reproductive health for in- and out-of-school children and young people:

> CSE is curriculum-based education that aims to equip children and young people with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality, in the context of their emotional and social development by embracing a holistic vision of sexuality and sexual behaviour, which goes beyond a focus on prevention of pregnancy and sexually transmitted infections (STIs) (UNFPA, 2014, p. 6).

The UNFPA guidance on CSE (UNFPA, 2014, p. 7) provides a solid base to steer countries towards effective and sensitive CSE programming. However, implementation is ultimately

dependent on nationally determined policies, discourses of sexuality and SRH of children and young people, as well as education and health resources and other locally determined contextual realities.

In South Africa, schools are the primary provider of CSE through a Life Orientation curriculum that evolved from a national Life Skills programme introduced in 1996 (Smith and Harrison, 2013, pp. 69–70; Wood and Rolleri, 2014). Outside of schools, sexuality education is delivered through peer education, community based programmes, and at clinics through community health workers (Francis, 2010, p. 316). Despite a set curriculum, the school-based Life Orientation programme has been unevenly delivered due to discrepancies in teacher training, curriculum and materials. This is compounded by differences in delivery associated with teacher efficacy in delivery, and personal morals and beliefs about sex education for young people (Smith and Harrison, 2013, pp. 69–70; Francis and DePalma, 2014). This mirrors international experience (UNFPA, 2014, p. 8) where teachers' strong opinions and sense of moral authority regarding young people's sexuality dominate both formal and informal discourses about sexuality within schools, and where teachers' inability and discomfort teaching about sex and sexuality impede school-based sexuality education (Smith and Harrison, 2013, p. 76). The South African Department of Basic Education responded by developing scripted lesson plans through the national Life Orientation curriculum, whereby teachers were trained in the language and tools assumed to be necessary and sufficient to deliver CSE (Wood and Rolleri, 2014).

While a focus on CSE is considered the remedy to the "problem" of addressing the SRH of children and young people, this must be balanced against social contexts in which young people live, as well as a wider critique of the link between knowledge and behaviour change. Gacoin (2016) and others (Francis, 2010; Wood and Rolleri, 2014) have critiqued the concept of scripted lesson plans. Gacoin (2016) further asserts that the focus on what people know, essentially the focus of scripted lessons, is self-limiting, and that it is instead important to look at "developing an understanding of the deeply discursive situated contexts" where knowledge is delivered, particularly relevant in South Africa where information on HIV and AIDS and safe sex practice is widely available, but where young people are still consistently unable to negotiate safe sex practice (Francis, 2010, p. 314).

Public health promotes the idea of parents communicating openly and clearly with children and adolescents and the subsequent benefits of increasing young people's agency in relation

to their sexual health, as well as promoting increased connectedness between parents and their children (Wamoyi and Wight, 2014). However, there are many barriers to SRH parent-child communication, more so in certain contexts where cultural and traditional, as well as pervasive discourses of morality hamper this (Wamoyi et al., 2010, p. 16). This is compounded by parent's discomfort and limited knowledge in sharing SRH information with their children (Mkhwanazi, 2010; Mkhwanazi et al., 2019, p. 33). Structural barriers play a significant role in minimising the kind of parent-child connectedness needed to communicate openly about SRH and include economic circumstances, gender inequality, migration, systems of social respectability, education and globalisation, which together provide a changing socio-economic landscape where traditional age and gender roles are challenged (Wamoyi and Wight, 2014, p. 172).

Despite these barriers, concern and fear about HIV has opened the spaces in homes, schools and communities to address sexual health (Jewkes et al., 2009, p. 683; Wamoyi et al., 2010): these were spaces that were relatively closed in relation to discussing sex, sexuality and unintended pregnancy. Thus, the HIV epidemic has facilitated more sharing of information and greater awareness about sexual and reproductive health. In sub-Saharan Africa, emerging evaluative research on parent communication with adolescents remains limited due to the qualitative nature of studies which are sensitive to local contexts and therefore limited in assessing applicability across a range of contexts. However, even though discussion is largely driven by HIV and AIDS within a discourse of danger and disease, and not the desire for open engagement about sexuality and reproduction, it is promising that parents are beginning to have these difficult conversations with adolescents, and that these spaces continue to widen (Wamoyi et al., 2010).

Sexual and reproductive health and rights (SRHR) and Sexual and reproductive health (SRH) services

In South Africa, the SRHR of adolescents is protected by the Constitution, and other legal and policy frameworks, which recognises the evolving capacity of adolescents at various ages and stages to make decisions regarding their SRH (Strode and Essack, 2017, p. 741). The policy and legislative environment in South Africa accepts that adolescent sexual activity and exploration is a normal part of healthy sexual development (Strode and Essack, 2017, p. 741), and that adolescents have the "right to explore their sexuality and engage in consensual sexual activities" (Essack et al., 2016, p. 196). This is aligned to international standards of good practice (World Health Organization, 2012).

While children under 18 years are legally considered minors in South Africa, they are nevertheless able to realise their SRHR in relation to a range of SRH interventions; contraceptives (age 12), HIV testing (age 12), male circumcision (age 16), virginity testing (age 16),[3] and termination of pregnancy (no specified age). For each of these, the evolving age capacity assumes various levels of decision-making determined by age of consent. This is further protected by guidelines stipulating capacity requirements, and public policy requirements which endorses counselling, assessment of 'the best interest of the child' and advice (Strode and Essack, 2017, pp. 742–743). These laws and policies are a critical enabler in facilitating access to services (Delany-Moretlwe et al., 2015, p. 31), and reflect a progressive stance removing some of the dominant barriers to SRH care for young people, where permission or approval from parents and guardians are obstacles to care (Delany-Moretlwe et al., 2015, p. 35).

In Africa, contexts vary widely between and within countries, and there are no "silver bullets" in adolescent SRH programming (Okonofua, 2012, p. 9). Barriers to SRHR for adolescents are persistent and occur at individual, system and structural levels. Internationally and in South Africa, individual barriers to SRH services for adolescents include costs (cash), competing demands (school, work), control over their time particularly in relation to school going adolescents where school and clinic hours are incompatible, location (proximity to services), transport and associated cost implications, and discomfort in communicating with adults, particularly fear, discrimination and stigma associated with health care providers (Frohlich et al., 2014, p. 688; Delany-Moretlwe et al., 2015, p. 34; Sychareun et al., 2018). System level barriers include lack of adolescent specific and adolescent sensitive services, poorly trained staff and health care providers attitudes where moral attitudes impact on the delivery of SRH services to young people (Smith et al., 2018; Weiss et al., 2018). This is particularly so in relation to services like contraception, termination, and pregnancy care. At a structural level, economic, political, cultural and religious factors impact on the realisation of adolescent SRHR (Okonofua, 2012, p. 9).

[3] The virginity of a women is usually tested by older women who take on the responsibility of SRH oversight of younger women – it is a cultural practice that is "dynamic, conservative, complex and contested" (Bhana, 2017, p. 74), with some defending the practice on cultural grounds and others seeing it as a violation of the rights of young women

The evidence on the barriers of care internationally and in South Africa (Warenius et al., 2006; Tilahun et al., 2012; Kennedy et al., 2013), and on the disproportionate burden of HIV on young people, has facilitated global and local momentum to improve SRH services to adolescents and young people. Services needed to be integrated to address multiple needs, as well as youth friendly to address the specific health and communication needs of young people (Delany-Moretlwe et al., 2015, p. 34). Youth or adolescent friendly services became the focus of international and local policies and interventions in the early 2000s, in light of the evidence on the disproportionate burden of HIV on adolescents, particularly young women.

In South Africa, the non-government organisation (NGO) loveLife led the design and implementation of the National Adolescent Friendly Clinic Initiative (NAFCI) from 1999, when a pilot of 10 clinics was launched with standards and criteria for implementation, and training for nurses in emergency contraception, dual protection and termination of pregnancy. In 2001, 30 more clinics were added to the NAFCI (Dickson-Tetteh et al., 2001). The programme was seen as a leader in the global Adolescent and Youth Friendly Services (AYFS) agenda, and South Africa was showcased by the WHO as an international case study (Ashton et al., 2009). The NAFCI was eventually taken over by the Department of Health in partnership with loveLife in 2009 and became integrated into the public health service.

In spite of a widespread belief among public health practitioners on the importance of adolescent and youth sensitive sexual and reproductive health services, to date there is relatively little evidence on the actual health level outcomes of these services, particularly in relation to early childbearing. In one recent study, Branson and Byker (2018) evaluated the impact of the NAFCI on early teen childbearing, education, employment and child health through geo-linking data on the timing and location of the NAFCI rollout to birth histories in the National Income Dynamics Study (national survey data) between 2001 and 2010. They found that the NAFCI had an impact on fertility timing by delaying rather than decreasing fertility, increasing years of schooling with no impact on likelihood of completing matric, and improvements in child health outcomes achieved through delaying childbearing into the later teenage years (Branson and Byker, 2018, pp. 22–23). Adolescents exposed to, or with easy access to, NAFCI, delayed childbearing by 1.2 years, completed more years of schooling and earned higher wages as young adults, with health advantages for children born to older teenage mothers (Branson and Byker, 2018, p. 24).

In examining the overall impact of NAFCI in terms of acceptability and availability of services to young people, studies have found that its major limitations were health care providers' attitudes and capacity, which remain critical barriers to NAFCI efficacy. Health worker attitudes include moral discourses around the sexuality of young people, shaming associated with this, including refusal to provide or refer for termination of pregnancy services, and inability to communicate effectively with young people as a result of the dominant moralising discourse, as well as the failure to consider individual and diverse contraceptive needs of young women. Capacity level barriers included systemic problems like workloads, poor or no training on communicating with young people, and inadequate information on contraceptive choices (Mathews et al., 2009; Ibis Reproductive Health, 2011; Holt et al., 2012; Alli et al., 2013; Geary et al., 2015; Pillay et al., 2019).

Social Protection

Social protection is one of the most contested responses to early childbearing. This section considers the role of the Child Support Grant as the main mechanism of economic social protection for young mothers in South Africa. I use the term social protection as an inclusive term for "economic protection" through targeted income transfers *and* other forms of social support, both formal and informal. I draw on Devereaux and Sabates-Wheeler (2004, p. 9) definition of social protection as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups." The economic or cash component of social protection in South Africa in relation to early childbearing is mainly through the Child Support Grant. However, it is also important to acknowledge the role of early childhood development (ECD) and care services as a core component of social protection (Razavi, 2011).

An important component of social protection is social support, which is also an essential objective of this study. An extensive review of the literature on social support, social and kinship networks is discussed in Chapter 5 and is not repeated here.

The Child Support Grant

Section 27 of the South African Constitution states that people unable to support themselves and their dependents must be provided with social assistance by the state (Department of Justice and Constitutional Development, 1996; Budlender, 2018). In the post-liberation period

(after 1994), the social protection system gained momentum and numerous grants were introduced to honour Section 27 of the Constitution. In 1998, the Lund Commission shaped the initiation of the Child Support Grant, a means tested unconditional cash transfer program designed to assist families living below an established threshold to provide a minimum level of social protection, with the express aim of improving outcomes for children under 18 years. At the time of initiation, the Child Support Grant was offered to children under seven years of age, and was expanded in 2003 to include all children under 18 years of age. In 1998 the Child Support Grant was R70 per month and in 2018 was R410 per month (Makiwane, 2010; Budlender, 2018). By the end of March 2018, the Child Support Grant was being paid to 12.3 million children every month (Budlender, 2018, p. 98).

The Child Support Grant has had an economic and social impact on children and their families in South Africa, specifically by mitigating vulnerability to food insecurity, and through impacting on the structural drivers of social vulnerability by removing barriers to access services like education and health (Devereaux and Sabates-Wheeler, 2004). The Child Support Grant provides a platform to protect families against poverty, often supplemented by beneficiaries with a variety of other income sources, and has been associated with HIV risk reduction (Patel, 2012; Hill, 2019).

The discourse in relation to the Child Support Grant and early childbearing is that is a perverse incentive that encourages early childbearing. It is argued that because poor young women receive financial support when they bear children, the Child Support Grant incentivises young women to become mothers prematurely, thereby increasing rates of teenage fertility (Makiwane et al., 2016). However, evidence from South Africa does not support this, showing that teenage birth rates have declined since the introduction of the Child Support Grant in 1998, that women over 35 years are the main recipients of the grant, and that many young women who qualify for the grant are not receiving it (Makiwane, 2010; Naong, 2011; Mchunu et al., 2013; Makiwane et al., 2016, p. 13).

In 2017, 76% of children in South Africa lived with their mothers and 38% were living with their fathers. Women continue to provide financial care and caregiving even though they are more likely than men to be under- or unemployed, and 77% of children in SA live in households with income from grants (Budlender, 2018, p. 94). The gendered nature of care in South Africa has meant that very little attention has been paid to the potential for the Child Support Grant to

disincentivise fathers who do not live with their children to provide support for their children (Patel, 2012, p. 118), thereby further entrenching dominant gender norms.

Limitations of structural interventions

The structural interventions discussed above are not without their limitations. CSE tends to be highly focused on HIV and AIDS, with a strong technical and moral approach (Francis, 2010). It fails to recognise young people as sexual agents, or to consider issues like culture, gender, religion, power or pleasure (Bhana, 2017, p. 77). Furthermore, the scripted guidelines developed by the South African Department of Basic Education does not seriously consider sexual diversity, focusing only on heterosexism with a "pervasive lens of heteronormativity" (Francis, 2012, p. 598). In addition, both CSE and SRH interventions are developed and tested in more developed contexts that are very different to the diversity of South African settings, and fails to consider the contextual nuances that impact on these interventions, like poverty levels, school resources, teacher education, cultural taboos (Wood, 2012, p. S20).

Wood (2012, p. S20) articulates the need for "an 'insider' approach to HIV prevention to be encouraged, to promote the development of an indigenous epistemology generated by Africans living in an African context – in contrast to the more prevalent 'outsider' approach of adopting programmes based on paradigms that have little relevance to the majority of the population." There is also very little evidence on whether all these interventions produce the desired changes. For example, sex education and SRH service are not on their own effective strategies for delaying parenthood (Harden et al., 2009, p. 8), and have been shown to result in a change in knowledge but there is very little evidence to suggest an actual change in risk behaviour or sexual health outcomes at the population level (Wamoyi et al., 2014). Thus, despite an enabling policy environment in all three areas of structural interventions discussed, negative discourses continue to impede implementation, access to, and delivery of services. There is therefore a significant tension between policy and discourse, illustrating that policy and legislation alone cannot achieve development goals. Dominant discourses continue to undermine many structural interventions, including stigma, discrimination, and ubiquitous gender, race and class inequalities.

An alternative discourse on early motherhood

> Teen mothers and their children are two particularly vulnerable groups in our society whose long term life chances are interconnected. They are both at critical points in

> their lives, where their courses may be shaped towards healthy development, stability and productivity or towards poverty and dependency (Luker, 1996, p. 110).

This excerpt synthesises the dominant discourse on early motherhood as presented. The preceding sections attended to the evidence on early motherhood and the structural interventions that seek to mitigate what is understood as the inevitable outcome of early childbearing. An alternative discourse on early motherhood seeks to complicate the conversation on the negative consequences of early childbearing, towards asking and answering questions that emerge from looking at the spaces between the cause-consequence framing. It seeks to understand the "causes of the causes" (O' Campo and Dunn, 2012, p. v), but more importantly, to move beyond the problem solving position of the dominant discourse which is steeped in biomedical determinism.

A critique of the dominant discourse

The revisionist school, which emerged in the United States from the late 1980s, challenged the dominant discourse of early motherhood. Furstenberg (1991, p. 128) summarises the central arguments of the revisionist school as follows: early childbearing is used and misrepresented by social scientists and policy makers to further the hegemonic social order that favours the economic and political agenda of the ruling class as "moral entrepreneurs" – early childbearing is an adaptive solution to problems faced by disadvantaged young people in the face of racial discrimination and economic marginalisation, and is a culturally rational response to deprivation and discrimination (Geronimus, 1987; Geronimus and Korenman, 1992; Luker, 1996).

While there are many critiques levelled at the revisionist school on the question of rational choice (Furstenberg, 1991, p. 136), the approach nevertheless opened up the space for research to understand the relationship between young mothers and their broader social and structural context, and to explore questions of agency, choice and decision-making, and to highlight the ambiguity inherent in a cause-consequence narrative (Barcelos and Gubrium, 2014). The revisionist school played a central role in unsettling the conventional narrative of teenage pregnancy as one of danger and disease, risk and resilience, cause and consequence; and questions a system of "stratified reproduction" whereby young women are situated at the bottom of a hierarchy of reproduction (Barcelos and Gubrium, 2014, p. 469; Ray, 2018, p. 469). In other words, it shifts the gaze *away* from biomedical determinism.

A further alternative response to framings of early motherhood is a feminist one, resulting in two schools of thought. The first school, a feminist empowerment approach, emphasises women's independence and self-development and is cognisant of young women's sexual desires and experiences. The second school, is situated within feminism from women of colour, and is based on a reproductive justice framework. This approach questions the framing of early motherhood as "inherently and ubiquitously problematic," and "emphasise(s) the racialised, classed and gendered discourses that regulate and pathologise black and brown women's bodies while privileging a white, heterosexual, middle-class life trajectory where childbirth (occurs) after economic independence and marriage" (Ray, 2018, p. 457). Inderpal Grewal (2013) cautions against the "outsourcing of patriarchy" by all feminists, where certain cultures and communities are considered inherently problematic, supported by a biomedical, scientific, expert gaze, where poor communities and their life choices are othered, as seen in the discourse of early motherhood (Shefer and Strebel, 2012, pp. 60–61).

An emergent and evolving discourse

A defining feature of an alternative discourse is its endeavour to listen to the voices of young women, particularly young pregnant and parenting women (Salusky, 2013; Brand et al., 2014a; Shea et al., 2016; Singh and Hamid, 2016; Neill-Weston and Morgan, 2017), seeking an "insider" perspective by considering young mothers on their own terms (Breheny and Stephens, 2007, p. 343). Studies undertaken from this perspective – mostly qualitative – have gained momentum and document the complexity that underlies early motherhood and its contextual and structural location. They seek to move the discourse away from that located in Western cultural superiority where science is used to question the rationality of having a child at an early age (Denzin et al., 2008; Breheny and Stephens, 2010; Jones et al., 2019), to explore more complicated framings. In doing so, these researchers do not seek to romanticise or refute the difficulties and complexity associated with early motherhood, like disrupted or delayed education and employment, nor to minimise the impact of gender based violence or other forms of structural violence. Instead, they further probe the experience of early motherhood to provide greater depth and breadth to understand the variety of expression and meanings ascribed to early motherhood, by young women themselves.

While early childbearing may not be a "rational choice" made by young women, it is plausible that risk taking is higher amongst poorer young women who do not have significant opportunities that may be threatened by early motherhood. In other words the opportunity cost of early motherhood is low, with little perceived loss unlike in middle or higher income

contexts where the costs will be much higher (Sheeder et al., 2009, p. 302). This may be so for young women who are socio-economically disadvantaged, unhappy, have low interest or success at school, or are despondent about future opportunity (Harden et al., 2009, p. 8). Pregnancies that are unintended are not always unwanted. Many young women see pregnancy as a means of achieving adulthood, finding a purpose to life, having someone to love, or strengthening the relationship with a sexual partner (Unger et al., 2000; Stapleton, 2010; Ngum Chi Watts et al., 2015).

Geronimus (1987, 2003), one of the first revisionist scholars, elucidates how early motherhood is an adaptive strategy for young African-American women, a social response to disadvantage. For these women, having children at a young age makes sense at a number of levels. It is a rite of passage into adult status; it makes sense given the kinship networks and family support that may be available when they are young, forming a safety network around mother and child; and it is seen as a sensible time in terms of life course as employment is most often achieved only in their twenties. Edin and Kefalas (2005, p. 6) in "*Promises I Can Keep: why poor women choose motherhood above marriage*," based on a five-year ethnographic study in urban Philadelphia, United States, show how having children is a "necessity, an absolutely essential part of a young woman's life, the chief source of identity and meaning." While the study is based on single motherhood, 72.8% of their sample of 162 women were teen aged mothers, and black or Hispanic. They show how for women living in urban low-income environments, marriage was something to aspire to later in life, whereas having children was central to who they were, even though in most instances their children were not intended.

In South Africa, Mkhwanazi and Bhana (2017), in *Young Families: Sexuality, Gender and Care*, illustrate the complexity and diversity of young families in South Africa, highlighting issues of agency, kinship, paternal involvement and the plethora of ways in which young parents and their extended networks mobilise and navigate support for young women confronted with early, unintended pregnancies. Gubrium and colleagues (2018, p. 215) argue that the literature emerging internationally pushes back against the shame based, single story framing of single and particularly early motherhood, to reflect the social inequality, social injustice and structural violence that more accurately contextualises this. I focus now on two select features of this alternative discourse, that is, agency and aspiration.

Agency

Agency refers to the way young mothers mediate and navigate structures and norms (Sniekers and van den Brink, 2019, p. 190). The concept of agency, as explored in Chapter 1, is used here to refer to the everyday agency young mothers use to navigate the world of early childrearing and the structures and norms that govern their lives, as experienced in communities, and in relation to health, education, and employment.

As discussed earlier, it is often assumed that young mothers do not have agency, and are unable to mediate the structural factors that predispose them to early motherhood. However, young women *do* have agency and *are* able to exercise it. A growing body of literature illustrates the multiple and complex ways young mothers exercise agency. Stapleton (2010), in an ethnographic account of young mothers in the United Kingdom, shows how even in the most challenging environments, young mothers were able to exercise agency in various ways: in relation to birthing choices, feeding, sleeping arrangements, and child care. She also shows how agency is often intercepted by power relations where, for example, health providers do not take seriously the choices and decisions made by young mothers, dismissing them as children and often acting punitively towards them for their mistimed pregnancies. In South Africa, Bhana and Mcambi (2013, p. 12) posit that the agency of young mothers' is often constrained by an ethos of shame and othering and is limited in contexts like schools and health services, where evidence of teenage sexuality is punished and power relations dominate the relationships.

The impact of discourse and the resultant feelings of shame, and the number of structural barriers young pregnant and parenting women face at institutions like schools and health services, however, does not mean that young women do not have agency, and do not actively make decisions around reproduction. When a young woman discovers she is pregnant, there are a range of decisions that she needs to consider; having and keeping the baby, having the baby but giving it up for adoption, or terminating the pregnancy. More often than not, these choices are deliberated very shortly after pregnancy discovery and before a young women has engaged the support of the father, friends or family, and when she may be most vulnerable especially when the pregnancy is unintended (Mlotshwa et al., 2017; Pillay et al., 2019). Furthermore, young women who continue schooling while pregnant and return to school after pregnancy as a mother, often while still breastfeeding, are "actively discarding a discourse of shame" (Shefer et al., 2013, p. 5).

In South Africa, the public health focus on the dangers of age disparate relationships has created a persistent, uncritical narrative around sugar daddies and blessors. Within this discourse, young women are seen as powerless in the face of the economic and strategic power held by older men, which undermines their agency (Ott et al., 2011; Potgieter et al., 2012; Harling et al., 2014). Furthermore, the social context is imbued with massive structural inequality, wherein pervasive gendered social norms are often expressed violently through rape and sexual coercion as an expression of hegemonic male power. Thus, women's decreased power and agency is embedded in patriarchal and cultural relations (Bhana, 2017). However, Bhana (2017, p. 72) argues that male power is not "automatic and monolithic" and women negotiate within these sexual and gender relations, cultural scripts and wider structural context.

Bhana (2017) and others (Hunter, 2002; Morrell et al., 2012) show that young women have sexual agency and use it assertively and instrumentally through decisions about partners, sex and economic transactions. Young women acting in a context of hegemonic male power and powerful cultural and moral boundaries assert agency in a number of ways within relationships with their sexual partners, family and community and in schools. Hunter (2010) and others (Bhana and Pattman, 2011; Ott et al., 2011; Potgieter et al., 2012; Shefer and Strebel, 2012; Harling et al., 2014) show how in the context of poverty, women negotiate their sexuality in ways that bring material rewards including cash and clothing. Bhana (2017, p. 76) further argues that teenage black Africans are sexual agents who draw on narratives of love in complex ways, thus resisting dominant constructions of their sexuality. Sexuality is negotiated within a context of hegemonic masculinity. In reflecting on this complexity of sex, love, hegemonic male power and gender based violence, Bhana (2017, p. 72) argues that "(w)hat is needed is a conceptualisation of power that encapsulates notions of love, affection and agency whilst also being in tension with discursive, material and cultural constructs of male power."

Aspiration

The question of aspiration occurs contradictorily in the literature on early motherhood; low aspiration is sometimes framed as a cause and consequence of early motherhood, while higher aspiration is often understood as a consequence of early motherhood. On the one hand, low levels of aspiration are associated with embedded structural inequality like class, race and gender discrimination where young people have little faith in a future where education and employment is unattainable. Low aspiration for education internationally and in South Africa

has further been linked to low expectation of young people from their parents, teachers and peers (Sheeder et al., 2009; Harden et al., 2009, p. 7). This makes childbearing a viable and realistic alternative. In some contexts, young women with low educational aspirations may be following a family trajectory of early parenting and may see "early childbearing as a way of achieving adult status, a sense of identity and competence" (Hanna, 2001, p. 102).

On the other hand, qualitative studies located in the alternative and emergent discourse, have honed in on the voices of young pregnant and parenting women and show that young mothers do have aspirations, in some cases more so as a result of early childbearing. These aspirations include education, employment, marriage and better socio-economic circumstances (Preston-Whyte and Zondi, 1989; Edin and Kefalas, 2005; Stapleton, 2010; Sniekers and van den Brink, 2019). Sniekers and van den Brink (2019, pp. 200–201) argue that early motherhood often makes young mothers more ambitious than some of their same aged peers – realising their ambition is seen as a means of navigating themselves out of the dominant discourse of early motherhood and its associated poor outcomes. While structural constraints make this difficult to achieve, it nevertheless remains important to take seriously the aspirations of young mothers.

An area of aspiration that is receiving increased attention over the past ten years is around the importance of improving the aspirations of ALL adolescents, where the opportunity cost is increased so that socially disadvantaged young people have increased access to opportunities in early adulthood, and there is greater commitment to delaying childbearing. In the context of socio-economic disadvantage and crippling unemployment, addressing forms of structural redress is critical to young people's investment in their future.

Conclusion

Pushing back against a discourse of danger, disease and lifetime disadvantage is challenging when the evidence on premarital, unprotected sex is compelling in terms of the HIV and STI, violence, and early parenting risks. It reflects the power inherent in biomedicine. Yet, it is critical to present the constantly changing and contesting discursive context that offer different ways of understanding how alternative subjectivities are created that have the potential to be "empowering and counter hegemonic" (Gubrium et al., 2018, p. 224). Contesting the ideals of the family and life course trajectories as espoused by Developmental Idealism provides an opportunity to abandon assumptions of the right time for motherhood,

and recognise the complexities of context and timing, intention, and wantedness in relation to childbearing.

CHAPTER 3: UNDERSTANDING AGENCY IN EARLY MOTHERHOOD

METHODS



Image 2: Pamphlet collected at Alexandra Health Centre (Field notes, 9 September 2016)

I collected this pamphlet at my first visit to the health centre in Alexandra, Johannesburg. I was intrigued by the use of the word "PASOP" boldly inscribed on the pamphlet. "Pasop" is an Afrikaans word, meaning "beware." My association with the term takes me to a security sign that was common on the walls of predominantly urban homes in middle- and upper-class neighbourhoods in apartheid South Africa, accompanied by a picture of a ferocious looking

dog. The aim of the sign was to convey the message "beware of entering this property"– the word "Pasop" evokes fear; a remnant of the spatial separation and racism that characterised apartheid.

On this pamphlet, PASOP is an acronym for "Prevent, Avoid, Stop, Overcome, Protect" – a warning around pregnancy and infection, in the context of HIV, AIDS and safe sexual and reproductive health (SRH) behaviour ("Pasop GP | Gauteng Department of Health," n.d.). This picture of the pregnant woman on the pamphlet has resulted in much discussion and debate. Is the woman young? Is she white or black? What were the creators of the material drawing our attention to – Age or race? (Field notes, 5 October 2018)

It is ironic that the first and only paraphernalia collected at the health centre resonates strongly with this study, particularly this chapter. This pamphlet was made available at a centre where young women seek SRH services. What would a young woman entering the domain of sex and reproduction feel when she sees this pamphlet? How is she meant to engage with a health service when she is already likely to be anxious and fearful, particularly after reading this pamphlet? In the context of public health, is the intention to provide information in a non-threatening and supportive way, or to serve an injunction to young women against the world of sex and reproduction. Who and what does the picture of the young woman on the pamphlet represent?

The use of PASOP warrants further inquiry to establish whether the pamphlet was intended to reflect danger, as captured in the dominant discourse, or whether this was poor judgement. It may be that young born-free women in an overcrowded urban township in South Africa, with little private space in this neighbourhood, have no memory of the sign to which I refer – further reflecting an important element of this chapter and the thesis: questions of habitus, positionality and reflexivity. I return to these issues towards the end of this chapter, after first providing a description of the methodological approaches, study setting and collection and analysis of data.

The study setting



Figure 3. 1: Map of Alexandra township in Johannesburg, South Africa (Biofocuscommunicatie, n.d.)

South Africa has a population of 57.73 million people, 14.7 million of whom reside in Gauteng (Statistics South Africa, 2018). The country has high levels of inequality and grossly uneven development patterns, with an official unemployment rate of 27.1% and a youth unemployment rate of 54.7% (Statistics South Africa, 2019a). It is the most unequal country out of 149 countries globally with a Gini co-efficient of 0.63 in 2015 (World Bank, 2019). The growth rate for 2018 was 0.8%, the current growth rate is 1.3% and 1.7% growth is predicted for 2020 (World Bank, 2019). In South Africa, many of the people who are most disadvantaged reside in townships on the periphery of the major cities. Alexandra, an urban township to the northeast of Johannesburg, was the setting for this study. "Township" was used to refer to underdeveloped, urban areas reserved for Black, Indian and Coloured people who worked in or near White areas during apartheid; today, it typically refers to especially impoverished areas of old townships, and to areas that include informal settlements.

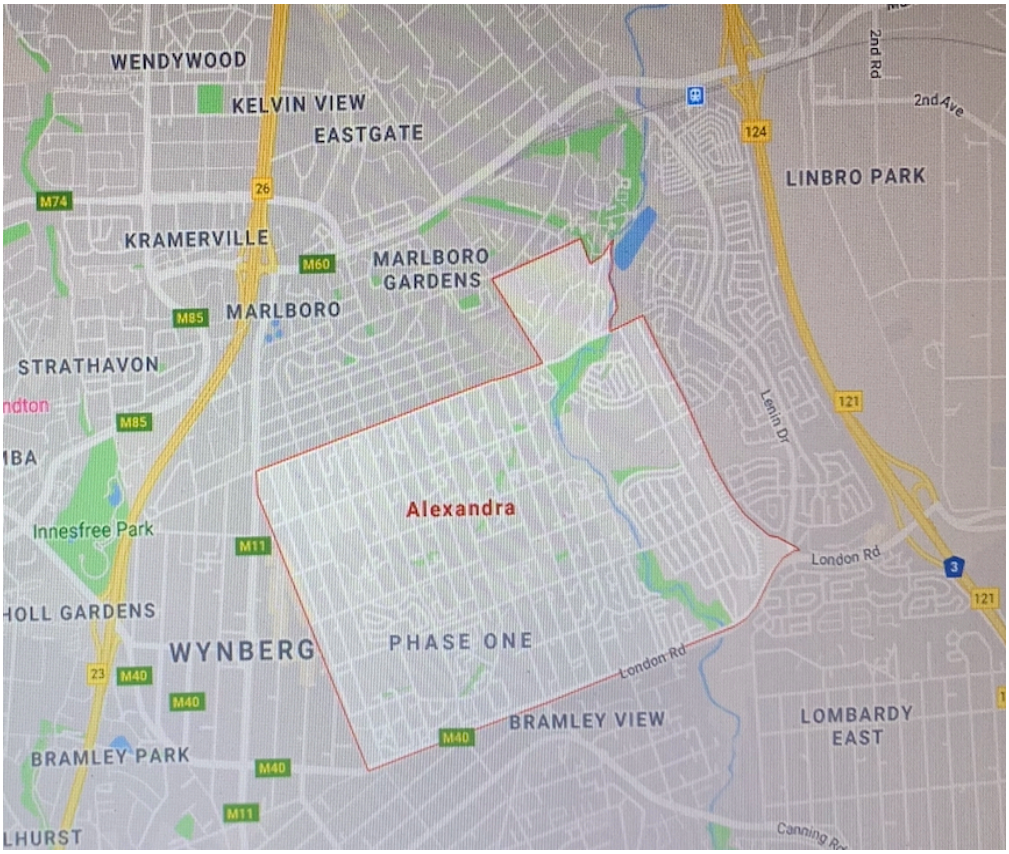


Figure 3. 2: Map of Alexandra in the City of Johannesburg ("Alexandra," 2014)

Alexandra was established in 1912 with the intent of accommodating a population of 70 000. A little more than a century later, it is an area of 6.91 kms squared, with approximately 63 737 households and 179 624 residents, the vast majority (99%) are black African (Census 2011 — Main Place 'Alexandra,' n.d.). The population has expanded and is characterised by constant movement of people to and from other parts of South Africa and neighbouring countries in southern Africa ("Alexandra Township, Johannesburg, South Africa," n.d.): it is a township of high mobility, transient settlers, and shifting households.

The fluidity of households and families in Alexandra is partly a legacy of South African apartheid (1948-1994) (Hall et al., 2018). Apartheid laws were enforced through punitive policies, structural and literal violence, and injustice. It encouraged migration for work with dire consequences for family life as families were split between urban and rural areas, with kinship networks created and recreated in response to fluxes in family circumstance (health, aging, death, children) and economic imperatives (Hall et al., 2018). Post-apartheid, economic migration was increasingly feminised, with growing numbers of women and children migrating to urban areas (Richter et al., 2006), attracted by opportunities for unskilled and

semi-skilled labour, particularly in the service sector. Understanding microenvironmental factors like migration and urbanisation in the local context characterise less distal influences in the lives of young mothers and are important to understand within the socio-ecological model (Figure 1.1,) (Gupta et al., 2008, p. 765).

In the study setting, the effects of structural injustice and poverty under apartheid continue. More than twenty years after the demise of apartheid, Alexandra is characterised by rapid growth, low levels of community development and investment, high unemployment, low household incomes and high levels of poverty, perpetuating extensive inequality and unequal development (Pernegger and Godehart, 2007, p. 3; Moya, 2018). On occasions, this has erupted within the township: Alexandra was a site of xenophobic violence both in 2008 and 2015, in reaction to the perceived threat by South Africans of foreign nationals competing for scarce economic resources (Khalo, 2012; Sello, 2015). Alexandra continues to be the site of conflict as a result of pervasive and enduring income inequality. Between April and June 2019, for example, there were extensive service delivery protests, reflecting community frustration at the lack of development and infrastructure in the area, and the disappointment that this was so almost 25 years after the end of apartheid:

> Alexandra is one of the country's oldest townships and one of the most squalid, despite being located a stone's throw from high-end Sandton City. The community continues to battle unemployment, poverty, crime and poor services. Residents' housing frustrations have been vented on foreign nationals who have been accused of being the cause of mushrooming squatter camps everywhere (Simelane, 2019).

There are no hospitals in Alexandra ("List of public hospitals and clinics," n.d.): the nearest hospital is Charlotte Maxeke hospital which is approximately 14km, difficult to reach in an emergency by public transport. However, Alexandra has five health facilities intended to meet non-emergency health needs; four are primary health centres offering a limited range of services during limited operating hours from 8am to 4pm, and one, offering a greater number of services, is a community health centre which is open 24 hours a day. Three health centres are run by the City of Johannesburg and two are run by the municipality ("List of public hospitals and clinics," n.d.; "Region E clinics," n.d.). Community Health Centres (CHCs) in South Africa offer a 24-hour service and include a clinic for the local community as well as a referral section with specialists (Department of Health, n.d.). They provide full antenatal and postnatal care, with a midwifery and obstetric unit, family planning, paediatric and

immunisation services. Primary Health Care (PHCs) centres offer a smaller package of services and have no midwifery and obstetric services.

Early motherhood has conventionally been associated with young women in poor communities, suggesting the value of working in a township. Alexandra was selected as the study site for this reason, although also because of its proximity to my home, so allowing me to adopt an ethnographic approach. My network with an NGO in Alexandra built through preliminary investigation of study sites, and on-going interest and observation of their work, also supported my choice. Alexandra has also not been the site of much research on young mothers, so avoiding a familiarity with research that might characterise women living in townships.

Methodology

> The only thing that keeps us from floating off with the wind is our stories. They give us a name and put us in a place, allow us to keep on touching (Tom Spanbauer 1992, p.190 in Pinnegar and Daynes, 2007, p. 35).

The study was qualitative and longitudinal, using an ethnographic approach. Qualitative research focuses on human action, interpretation and understanding (Pinnegar and Daynes, 2007, p. 4). Ethnography was historically used to describe particular societies, cultures or concepts at a particular point in time by a fieldworker "who was there" (Strathern, 2004, p. 7). "Being there" in the field and in the text is at the heart of ethnography (Geertz, 1988). It is suitable as a method to study small-scale societies, although it is an approach that has increasingly been used in contemporary social settings, institutions, and practices. Qualitative and ethnographic research methods are well suited to studying issues of family and kinship, where context, culture, everyday practices, narratives, and experiences all matter deeply (Weisner, 2014, p. 163). In this study, I was fieldworker, researcher and writer, and spent one year between September 2016 and September 2017 immersed in Alexandra, and returning intermittently to date when necessary. I did not reside in Alexandra as is often practiced in ethnography, due to "rational considerations" (Srinivas, 1976, p. 8) including my personal circumstance and my own position as a mother.

The methodological approach was narrative inquiry – the generation and study of stories, narratives, or descriptions of events (Pinnegar and Daynes, 2007, p. 4), which allows for

"thick description" (Lietz and Zayas, 2010, p. 194). Narrative research focuses on the collection, analysis and interpretation of stories, but it may involve varying research approaches, strategies and methods (Pinnegar and Daynes, 2007, p. 5). The choice of narrative inquiry requires that the researcher considers the relationship between the researched and the researcher, a move from the use of numbers to words as data, moving the focus from the general and universal to the specific and local; in this process, the researcher needs to be willing to embrace "alternative epistemologies or ways of knowing" (Pinnegar and Daynes, 2007, p. 7). Thus, central to a narrative approach is the exploration of the relational paradigm between the researcher and the research participant, as well as attending to that which is observed, unspoken and spoken (Gilligan and Machoian, 2002). It is an approach that I considered sensitive to understanding the lived experiences of young mothers who are the focus of discourse in South Africa that positions them as dangerous (Pillow, 2003) and irresponsible. In addition, narrative inquiry privileges the actor in her context (Mkhize and Msomi, 2016, p. 326), and is therefore used in critical research to include the voices that remain largely absent from discourse (Dunbar Jr., 2008, p. 87), as is true for young mothers.

The primary research methods were in-depth interviews and observations with young mothers and others in their social network, undertaken over a 12-month period. The interviews with young mothers gave them space to provide narratives of pregnancy and early mothering, in which context I worked to understand women's decision-making, and the agency they had for this, as they settled into the role and identity of mother. The interviews were open-ended and explored women's narratives of how they made meaning of early motherhood, and of how they interacted with the social and structural system to negotiate this.

Study population and sample

The primary location for the study was a health centre in Alexandra, which offers a range of services relevant to this study. These include Maternal and Child Health (MCH) services, with a Mobile and Obstetric Unit (MOU), the Extended Programme of Immunisation (EPI) for babies, and a paediatric unit. It included SRH services which offered contraception and the full range of HIV related services, including testing, counselling and treatment. Although legal and available through government health services, Termination of pregnancy was not offered at this centre, and for this purpose, women would need to go to health centres they were referred to, most commonly, on the basis of women's self-reports, Hillbrow Clinic. In

addition, an Adolescent and Youth Friendly Service (AYFS) opened in 2017 six months after the study had begun; consequently it was not used for recruitment.

Young mothers were recruited when they brought their babies to the centre for immunisation, usually at the six week post-natal visit. The Alexandra Youth Advisory Centre was used as a secondary study site. This NGO, not related to the AYFS, facilitates youth employment and is housed in the local municipality offices. NGO staff provided me with the space to meet and interview young mothers, especially those who were recruited outside of the health centre through snowball sampling.

Non-random, mixed, purposeful sampling was used to maximise the diversity of participants and so enrich my understanding of early motherhood. I considered the number of participants, the number of contacts with each participant, and the length of each contact (Onwuegbuzie and Leech, 2007, p. 117) to ensure that the sample size was adequate. The first level of sampling was purposeful. As indicated above, young mothers (18 to 20 years) were invited to participate in the study primarily through the well-baby clinic staff at the health centre. Nurses were the mediators for the study and played a critical role in the selection and recruitment of the sample (Kristensen and Ravn, 2015, p. 725). During recruitment, a nurse and/or I introduced and described the study, and invited any women aged between 18 and 20 years to participate. My relationship with the nurses reflect the messiness and "micro-politics of the field" (Simpson, 2006, p. 125), where nurses were gatekeepers to respondents and hence mediated the selection and information provided to women in the health centre.

The second level was snowball sampling, whereby initial recruits, and other contacts and relationships I had established in the field, identified further study participants. Snowball sampling allowed for recruitment through existing social networks of the target population (Gile and Handcock, 2010, p. 287); I assumed that young mothers would know of and refer other young mothers in their social or family network. This assumption was not correct and the respondents enrolled through the snowball approach were limited to three young mothers. The third level of sampling was maximum variability sampling to identify a diverse number of young mothers within the sample. Maximum variability sampling ensured that I engaged with a wide range of individuals, such that there was diversity among the women selected for the inquiry (Onwuegbuzie and Leech, 2007, p. 112; Vitcu et al., 2007). This variation ensured that I included young women of different ages (between 18 and 20); in school, returning to school, and out of school; with partners and without partners; living with families and living

without families; and in employment, looking for work, unemployed, or choosing not to be employed. To ensure this, I sampled ten young mothers in each age group (18, 19, and 20) at the first interview.

The sample included four respondent categories:

Young mothers. I aimed to interview each young mother up to three times over the 12 month period. Consistent with an ethnographic approach, the choice to interview each mother up to three times aimed to ensure that the sample of voices was adequately represented, that I would capture changes in circumstances and perceptions over a period of time, and to allow for attrition of the sample. This is critical in any ethnographic research, where a failure to recruit an adequate sample leads to "a crisis of representation and legitimation," contributing to an incomplete account of lived experiences (Onwuegbuzie and Leech, 2007, p. 107). In the end, I interviewed thirty young mothers once, nine young mothers twice and six young mothers three times – so resulting in a total of 45 interviews with young mothers.

Significant others (mother, partner, grandmother). Pretorius and colleagues (2015, p. 6) define significant others as a "trusted person" or a "very important person" to the research respondent. Of the six young mothers I interviewed three times and with whom I developed a personal relationship over the 12-month period, four facilitated interviews with a significant other – the person she identified as providing her with the most meaningful, extensive or sustained support since pregnancy discovery. An in-depth interview with the significant other was conducted to explore the breadth of support, and how it was offered. This included material, emotional, caregiving and other support during her pregnancy, during the time immediately after delivery and in the early months of mothering. This person was selected after the second or third interview. I contacted the significant other after receiving permission from the young mother, and invited him or her to participate in the study as a once off in-depth interview.

Nurses. I interacted with nursing staff at the health centre over the year of my research, but I also conducted six formal, once-off interviews to explore what services were provided and accessed by young mothers, and how nurses understood the position and agency of young mothers. Two of the health care providers were community health workers, and so were not trained or registered as nurses; the other four were professional nurses. However, in this study, I refer to all health workers as "nurses," as this was the everyday practice of the health

centre and the community members it served, and enabled me to better anonymise participants.

NGOs. Interviews with staff from NGOs were not intended as part of the study, but during fieldwork, with additional ethical clearance (Appendix 4), I met with staff from two NGOs that worked closely with young people in Alexandra. One of these NGOs provides psychosocial counselling and support to mothers (of any age), aiming to improve mother-baby bonding and associated outcomes. The second NGO facilitates employment opportunities for young people in Alexandra, and so offered a service relevant to many of the young women in this study. In many instances, I referred young women to these NGOs as and when appropriate.

Data collection

Semi-structured interview guides were used for each respondent type (Appendices 6, 8, 10, 12).

Young mothers. There were three interview guides for young mothers, with second and third interview guides developed on the basis of the outcomes of previous interviews. Each first interview lasted between 30 and 75 minutes. At the end of the interview, I requested permission from the young mother to interview her again, and to keep in touch with her via WhatsApp or SMS to arrange this. I provided R40 for data or airtime to facilitate this communication and transport.

There was significant attrition of the sample for second and third interviews, as seen in Table 2.1. Nine young mothers were interviewed in the health centre for the second interview. Six young mothers agreed to a third interview, of which five were conducted at the health centre and one in her home. The second and third interviews built on prior interviews and continued to explore decision-making in relation to education or employment, care of the baby, relationships and networks of support, and their sexual and reproductive health. The interaction of the young mother and her baby, nurses and significant others was observed.

The baseline interview with the 30 young mothers included background information and explored decision-making around the timeline of conception to the period after birth, as illustrated in the Conceptual Framework, Figure 1.2. A primary aim was to establish rapport with the young mother and to make her feel comfortable with the interview process. The

questions were open-ended and contained probes to encourage deeper sharing of information. I conducted all interviews in English. All participants were offered the use of a translator for the dominant language in the area, isiZulu. In all instances, participants refused. Most were comfortable conversing in English, although I felt that it would have been better to use a translator for three interviews where the woman's English language skills were quite limited. I was accompanied by a research assistant/translator to ensure that translation was available, and to facilitate ease of communication between myself and respondents.

The interview guides included the following key domains, influenced by the theoretical positions presented in Chapter 1 and drawing on Giddens' (1984) and Bourdieu's (1977; 1992) questions around structure (including context and field) and the individual (habitus, agency and practice). Key areas of inquiry from young mothers included:
Context – What happened when you found out you were pregnant? How did you make the decision to have the baby? What support did you get? From whom do you get support? Plans for the present/for the future? Enabling factors? Constraining factors?
Co-presence – Who are the people that support, guide or help you? What support do your family offer you? What support does the father of the baby provide to you? What support do your friends offer you?
Rules and resources – What is available for young mothers in terms of sexual and reproductive health services, childcare, access to school if schooling interrupted, access to further study, access to economic support? What are the structural constraints? What are the structural enablers? What economic capacity do young mothers have and how does this affect agency?

Agency was not explored as a discrete concept that could be assessed against a defined scale or set of answers, but through exploring the young mothers' stories and "meaning making" of their new roles and identity.

The timing, length and pace of each interview was determined by the young mother, and the ease with which she coped with the interview while caring for her baby (Pillay, 2018). The ethnographic nature of the study was founded on building relationships and trust, and every effort was made to ensure that mothers felt comfortable during the interview. I spent time during the interviews carrying, caring for and playing with babies, allowing mothers time to relax and talk to me after long waits in the immunisation centre. When agreeing to the interview, mothers were anxious about losing their places in the queues, and I addressed this

by arranging with nurses to allow a woman with whom I was talking to maintain her place in the queue. I had a basket of toys and soft baby books, as well as snacks for older babies or the mother. I believe that taking the time to build this rapport contributed to the trustworthiness of the data.

Data saturation, which refers to the "completion or fullness" of the data (Padgett, 2008, p. 171), was reached after approximately 20 first interviews, but I continued for multiple reasons; to get a breadth of responses, to dig deeper and to move from the general to the specifics as experienced by each individual young mother, to ensure further opportunities for second and third interviews as well as interviews with significant others, and because a larger sample size would allow for some basic descriptive statistics for comparison in the sample. Most importantly, narrative inquiry is not defined by number of interviews or saturation; each interview was a new story, with nuances, complexities and uniqueness.

Significant others: Four in-depth interviews were conducted with significant others; two mothers, one grandmother of the young mother, and one father of the baby were interviewed. These took place at times and places convenient for respondents, and included the workplace, where two interviews were conducted in my car for privacy and quiet, one at a home, and one at the clinic respectively. The interviews lasted between 30 and 60 minutes.

Nurses: Formal interviews with nurses at the centre ranged from between 30 to 60 minutes. The interviews included questions about nurses' perceptions and experiences of health service provision to young pregnant and parenting women, and their understanding of the contextual challenges facing young mothers. Nurses were also asked about general health system challenges, and about training in relation to providing SRH services to young people. In addition, there were many opportunities for observation, and informal conversations during the year of fieldwork; these were as valuable as the formal interview.

NGOs: I interviewed representatives of the NGOs for between 45 and 75 minutes. One of the NGOs helped facilitate this study and had played a role in the selection of Alexandra as the study site. I have had an enduring relationship with this NGO, and there were many opportunities for engagement and observation. I observed their provision of a "baby mat service" at the health centre which is a community parent-infant mental health intervention which involves facilitators sitting on a baby mat (blanket/rug with toys) to emotionally support caregivers through brief counselling and encouraging caregiver-infant bonding (Frost,

2016). The other NGO, a youth advisory NGO, offered a service to help link job-seeking youth in the community to potential opportunities, which included assisting youth with writing their CVs as well as preparing for interviews.

Extensive field notes, including a reflexive journal, were taken in addition to interviews and observations. This mix of methods, the wide range of respondents, and the process of coding and recoding allowed for triangulation of the data and ensured greater credibility and confirmability of the data (Shenton, 2004, pp. 64–66; Lietz and Zayas, 2010, p. 279). Table 3.1 summarises the number of interviews and other methods of data collection that were conducted in the 12 month period.

Table 3. 1: Sample of respondents per research method and study objective

Respondents	**Research Objective**	**Methods**	**No. of participants**
First interview with young mothers aged 18-20	1,2,3,4	IDI Observation	30
Second interview with young mothers aged 18-20	1,2,3,4	IDI Observation	9
Third interview with young mothers aged 18-20	1,2,3,4	IDI Observation	6
Mother, grandmother or father of baby	1,2,3	IDI Observation	4
Nurses	2,3	IDI Observation	6
NGOs	1,2,3,4	IDI Observation	2
TOTAL			57

Data analysis

Ethnography as a method is complex in terms of analysis, and requires the researcher to "sweep back and forth" and "swoop in and out" of the data (Padgett, 2008, p. 143). Data collection and data analysis were conducted simultaneously and iteratively. All interviews were transcribed verbatim by a professional transcription service. I reviewed all transcripts while simultaneously listening to the recordings to ensure accuracy. A first level of analysis was conducted during this process, allowing me to note emerging themes. All transcripts were entered into MaxQDA, a qualitative software programme. Formal thematic analysis enabled

me to efficiently identify a priori and emergent themes in the data. Emerging themes were analysed through constant comparison during fieldwork (to ensure iteration of the enquiry) and subsequently. A grounded theory approach was used where I began with open, line-by-line coding to ensure a comprehensive review of the data, and then moved to identify primary themes and sub-themes as a first step to connecting, conceptualising and explaining the themes and trends in respondents' experiences (Bhattacherjee, 2012, pp. 113–115; Cresswell and Poth, 2018, p. 203). The data were examined collectively to identify convergent and divergent themes, and variation and similarities between individuals, households and other variables. All codes and themes were discussed with my supervisors at regular intervals through fieldwork and after to ensure trustworthiness.

Once codes had been refined, and themes and central ideas extracted, I identified and explained the data's core meanings and related this to the etic (externally generated) themes around structure and agency; namely, meanings, motivations and knowledgeability. These were addressed in each of the publications. For example, support was a central theme in the data, and resulted in further analysis of types of support, genogram maps and kinship network maps which resulted in Papers 1 and 2 respectively. Decision-making in relation to school continuation, and with regard to sexual and reproductive health care decisions, were also major themes and resulted in Papers 3 and 4 respectively.

In addition to coding, I also entered all data into an Excel spreadsheet, for basic demographic information, and to record key variables. This allowed for some sorting of the data into variables which included support, household arrangements, school related variables, employment status, and health service usage like family planning and termination. This allowed for simple statistical analysis that was used for the purposes of description only.

A case study approach was used subsequent to data analysis. This approach was iterative and emerged as a result of the depth of data generated and the convergence of themes. Case studies are useful when asking "how" or "why" questions, when the researcher has little control over events and when contemporary phenomenon within real life contexts are involved (Yin, 2003, p. 1). Case studies involve "detailed examination of a single example" (Abercrombie et al. in Flyvbjerg, 2006, p. 220) and are well suited when in-depth fieldwork is undertaken by a single researcher (Yin, 1999, p. 1210) and where complex phenomena are being investigated. Furthermore, cases are well suited to narrative inquiry, as narratives capture the complexity and contradictions in life, and do not lend themselves to neat

classification and proposition. Thus case studies emerged for the six young mothers who were interviewed three times over the year; four of these included interviews with their significant others. These case studies presented me with an opportunity to create narratives of early motherhood in context using different data sources (Baxter and Jack, 2008, p. 544). Case studies are not generalisable to the wider population. While this is often understood as an argument against the case study, it is precisely the aim of good narrative research, where thick description uncovers ambiguity and complexity in everyday life events, and adds a further level of research questions (Flyvbjerg, 2006, p. 237, 2001, pp. 66–87). A case study approach is often used to generate hypotheses: this was not the case in this study, and the cases were instead used to dig deeper, and as a primary vehicle for analysis. The cases were useful to reflect on how findings related to the broader population, and to consider what other cases might look like in similar and different settings (Barnes and Weller, 2012, p. 30).

A further method used was genogram mapping, which began as genogram maps and progressed to kinship network maps. I began drawing genograms[4] during the transcript verification process to make sense of the family and kinship networks. I sought to understand and illustrate how young mothers understood the notion of family – biologically and socially – and to explore how households and families were constituted, as well as patterns of movement in and out of Alexandra. In second and third interviews I added to these by examining sources and forms of support, elaborated further in Chapter 6. The genograms of each young mother and her immediate kin network allowed for a description of networks of support, as well as mapping relationship and support structures of significance to the young mother. All genogram maps in their raw form, namely as they were drawn, redrawn and edited with each reading of the transcripts, are included in Appendix 16. All identifying information has been deleted in black. The messiness of the maps reflect complexity in making sense of kinship, and of the articulation between households in Alexandra and other areas and provinces in South Africa. The maps represent kinship network patterns at a single moment in time – second and third interviews allowed for a deeper understanding of shifts in networks of support.

Using all forms of coding and analysis, I paid attention to the relationships between themes or concepts, developed diagrams to map those relationships, and tested the themes against the

[4] The use of genograms was a natural tool for me as I studied Genetics in my undergraduate Science degree.

literature. Descriptions of patterns and regularities in the data were noted (Sandelowski, 2000, p. 338). Statistical evidence (national data) used in the study derive from secondary data. Where relevant, simple descriptive statistics from the data are used to show trends and particularities of this sample – the small sample size means that these are not generalisable in any way.

Positionality and reflexivity

Alexandra is notoriously unsafe and is associated with high levels of murder, sexual offences, assault and robbery (Crime Stats SA, 2018). The ethics committee required information on the measures I would take to keep safe. At the outset of the study, an NGO offered me transport into and out of Alexandra to ensure my safety, and friends and family warned me not to drive into Alexandra on my own. I was under no illusions that Alexandra is safe and took sensible precautions, but I did not feel afraid during the fieldwork, particularly when I was at the health centre which became my ethnographic home. I was conspicuous as an outsider in the township and at the health centre in every possible way. I am Indian, older, obviously middle class (car, clothing) and English speaking. I was often mistaken for a doctor, and mothers waiting with their babies were curious about my presence. I broke the ice by playing with their babies and chatting informally to them. In all my time at the centre, I was only asked once whether I was seeking health care – a clear indication of my "outsiderness" and the persistent racial and class divisions that characterise South Africa.

This sense of being an outsider required interrogating my own habitus to reflect how my age, race, gender, class, and education impacted on the study. Structural factors impact on the research process (Manderson et al., 2006). What I represented to young women, why they chose to participate in the study and why some remained in contact with me for the duration of the year and sometimes beyond, required me to think carefully about my position as a researcher, and to interrogate the hidden power relations between myself as researcher and the young women as respondents (Strathern, 2004, p. 10). Through a reflexive practice, I sought to understand how my primary experience of the world impacted on my understanding of the lived experience of the respondents (Bourdieu, 2003).

Notwithstanding social desirability bias, on reflection, it was possibly because of my age, my identity as a mother and my position as an outsider that allowed young women to feel comfortable with me to tell me their stories. Many young women reflected that no one had

ever been interested in their experiences of early motherhood, and that it was beneficial for them to share this with someone. On asking Nolu (18) how she had experienced the interview, she said, "It was fine. I feel good because I really needed somebody that I can talk to about the problems."

This signalled the line between myself and the young women, the complexity of relationships formed during ethnographic research and the responsibility I had as researcher. The "blurred boundaries" resulted in a sense of researcher saturation, an overwhelming sense of responsibility to represent the stories of women with accuracy and integrity to their meaning (Wray et al., 2007, pp. 1395–1396), reflecting the dilemma of ethics and positionality in research (Posel and Ross, 2014, p. 6). Furthermore, I went home after a morning at the clinic to my two adolescent daughters, constantly aware of our/their privilege. I feared that during fieldwork I was irritable (as a mother), sad and frustrated by the impotence of my position as researcher in the face of the glaring inequality so visible between my social home, my ethnographic home and the homes of young mothers: the multiple realities that co-exist in Johannesburg.

And then the data disappeared

In September 2017, towards the end of fieldwork, my bag containing laptop, field notebooks and audio-recorder were stolen from my car, ironically in a suburb outside the study site and a suburb which I knew well. This presented one of the biggest challenges to the study, emotionally and academically. While I was able to retrieve most of the data on my laptop, ALL my written field notes were gone – pages and pages of notes, scribbles, genograms, observations, reminders and contacts. I began the painstaking task of recreating the field notes from memory by listening to recordings, and reading transcripts. This exercise provided a pause for reflection, of the meaning of the study to me personally and the responsibility of the stories entrusted to me. I was faced with the challenge of how I was to represent young women and others accurately, highlighting that "ethnographic discourse is itself neither an object to be represented nor a representation of an object" (Tyler in Strathern, 2004, p. 8). I was mindful that whatever I present and what it evokes in the reader needed to "be understood as neither presentation or representation" (Strathern, 2004, p. 19). In essence, I had to write from memory, much like M.N. Srinivas did in writing the "The Remembered Village" – Rampura in Karnataka, South India (Srinivas, 1976), after his notes were destroyed in Stanford University in 1970 as he was about to write his book (Srinivas, 2000).

> …the best writing often emerged from disruption. To one such disruption we owe *The Remembered Village*. While visiting an American university, the Indian sociologist M. N. Srinivas saw the codings and analyses of 20 years reduced to ashes in an hour, sacrificed by an anti-war arsonist to political gods unknown in the Hindu pantheon. Only the field diaries remained, two continents away. On the advice of a colleague, Srinivas simply wrote from memory (Celarent, 2012, pp. 1870–1871).

Limitations

Language was one limitation to the study. Most young women spoke isiZulu at home, but were fluent and confident in English. All respondents were offered the use of a translator but refused; however, three interviews would almost certainly have generated richer data were it not for the language barrier. Valuing the choice made by respondents not to have a translator present, I continued the interviews even though I could have requested assistance with translation. It was not overtly evident whether language was a barrier in other interviews, and whether data would have been different if young women were interviewed in their first language. Where necessary, I sought clarity of meaning particularly in relation to understanding kin networks and sources of support, as it became clear after the first few interviews that English terms for blood relations did not do justice to kinship patterns. I also paid attention to variations in expression and meaning, especially as English was not the home language of any of the respondents. For example, Faith (62) referred to community gossip about her granddaughter as follows – "Ayanda was jumping and jumping and jumping" – to refer to people insinuating that Ayanda (19) was having multiple sexual relationships.

Securing second and third interviews with young mothers was difficult, despite multiple efforts to contact them. While cellphone usage is high nationwide, including in low income settings, mobile phones are frequently shared in families, numbers change and costs of data and airtime restrict usage. Attrition was anticipated because of the high rates of mobility in urban Johannesburg. A planned sample size of 20 mothers considered this attrition, anticipating that saturation would be reached with a sample of between 12 to 15 young mothers, or 36 to 60 interviews. A total of 45 interviews with young mothers were conducted. A further limitation was the small number of significant others interviewed. Here too, migration, employment, diverse household compositions, and practicalities of setting up

interviews were a barrier. Young mothers may also have been reluctant to refer on because they feared a violation of their privacy.

Ethical considerations

Wits Human Research Ethics Committee, Medical, provided ethics approval for this study, Clearance Certificate No. M160535 (Appendix 1). Johannesburg Health Research District Committee also provided study approval (Appendix 2) and the study is registered on the South African National Health Research Database. The theft of my laptop and data was reported and acknowledged by the Wits Human Research Ethics Committee, Medical (Appendix 3). Participants were provided with information sheets (Appendix 5, 7, 9 and 11), informed consent forms (Appendix 13 and 14) and a list of key resources (Appendix 15) as is common in ethical research practice. In addition, the spirit and ethics of the study was guided by the ethics guidelines of Anthropology Southern Africa and the American Anthropological Association (2012). The names of all study participants remained confidential, and pseudonyms were used for analysis and in publications; the age of young mothers is indicated in parenthesis as the age at first interview, unless otherwise stated. All names and identifying characteristics were removed from the kinship network maps in Appendix 16. Respondents were informed of the voluntary nature of participation and right to withdraw at any time. Where young mothers disclosed gender based or intimate partner violence, substance abuse, depression or anxiety, or any other psychosocial issues, I referred them to the NGO offering psychosocial services and sought advice on whether the young mother could continue to participate in the research. One young mother disclosed that her pregnancy had resulted from rape; she was withdrawn from the study and referred to the NGO.

In studying young mothers who have borne the brunt of a pervasive and stigmatising lens, and engaging with the social and political discourse around early, unintended childbearing, I am aware that those I seek to represent are removed from the findings of this study and all that is generated from it. Thus, I too play a role in excluding already marginalised young women from participating in the production and consumption of this knowledge (Dlamini et al., 2012, p. 56), and I take responsibility for this omission. In attempting to minimise this omission, as well as to ensure that the data was trustworthy (Lietz and Zayas, 2010), I revisited the recordings and transcripts repeatedly, ensuring that the range of voices are represented with fidelity to how they were spoken and my understanding of this, and representing as many of the voices of young mothers as was possible.

SECTION B

RESULTS

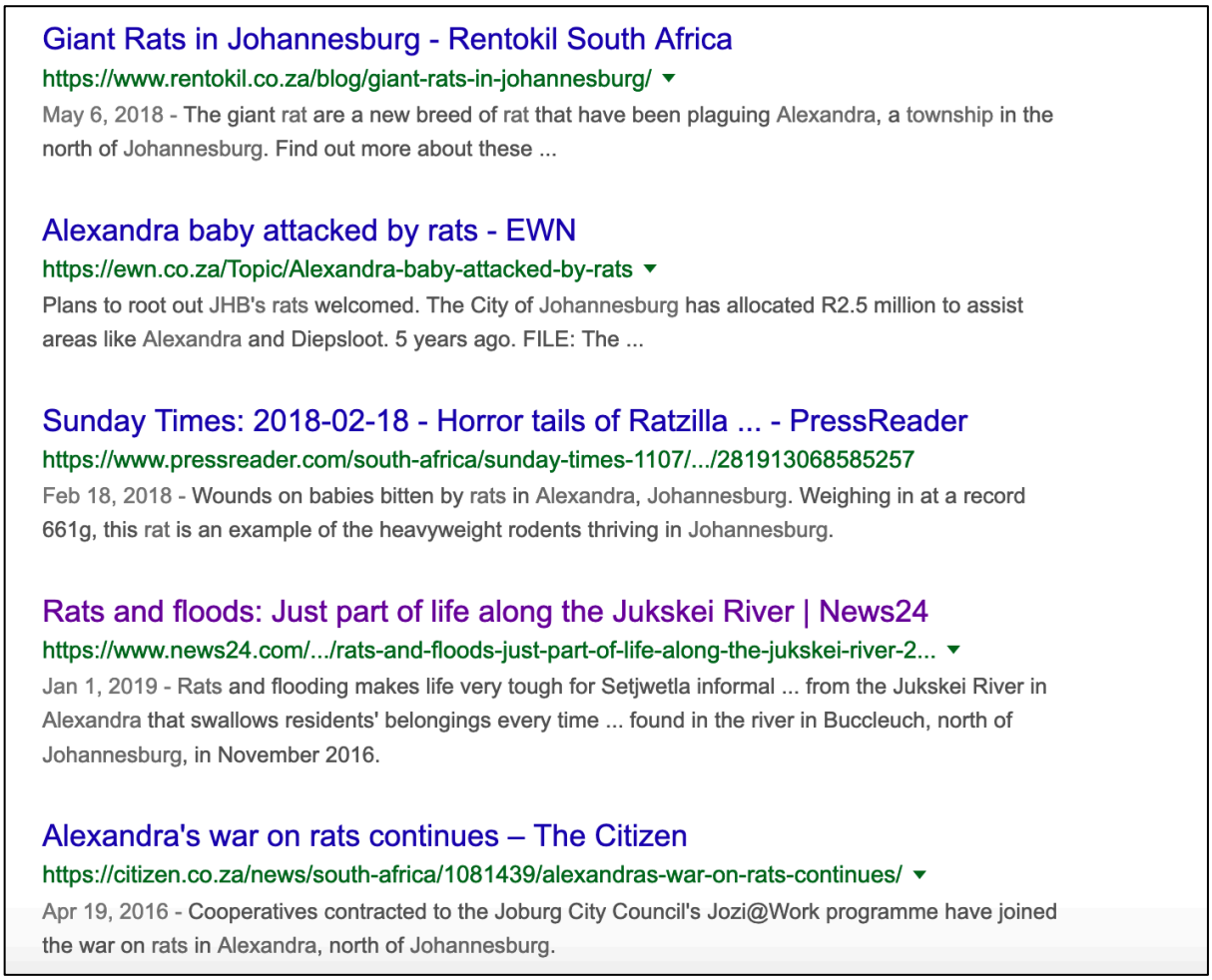


Image 3: Screenshot of website search for “rats” + “Alexandra” + “Johannesburg” (2 July 2019)

CHAPTER 4: RESULTS AND REFLECTIONS

In presenting the results of this study, this introductory chapter provides some basic data from the field. I preface this with a further reflection on my positionality as a researcher. I then provide some simple descriptive statistics of the study sample. These data illustrate the study findings in relation to key variables expanded and discussed in Chapters 5 to 9 of this thesis. I include a brief note on the context of life and living in Alexandra. I then present the four publications from this study, preceded by a brief overview of the papers and the relationship of these to specific study objectives.

Fieldwork reflections: Rats as a symbol of presentation and representation

Statistic and demographic data and newspaper articles cannot prepare one for the overcrowding, lack of sanitation and chronic rat infestation that characterise Alexandra. Image 3, a screenshot of a web search for the key terms "rats + Alexandra + Johannesburg" (2 July 2019) indicates the pervasive presence of rats in this township. Rats in Alexandra, was one of my biggest challenges in fieldwork.

> *Fieldwork notes, 3 June 2017.* There were rats/mice everywhere [at the health centre]. The first time I saw a mouse it was running on the counter and I almost jumped into Sesi's lap, and then there was one running on the floor …Sesi suggested that we sit outside even though it was a cold winter day. So we did. She said when we saw the rats, "What is wrong with these people? Don't the inspectors see those rats? How can this be at the clinic?"

Knowing that many young women and their babies I had interacted with were sleeping under makeshift roofs crawling with rats gives me nightmares to this day. In this study, rats were a symbol for me of presentation and representation, of whether I authentically represented Alexandra and the young women, and of how I used their narratives to avoid the "elision between fieldworker, writer and author"(Strathern, 2004, p. 9) that all too often occurs. It is through reflexively considering my position that I had to consider how rats were a personal symbol of the very worst of life; I have a deep fear of them irrespective of whether they are in my own home, a cage, a laboratory or in a health centre in Alexandra. Rats were a pervasive presence in the health centre, crawling on desks and seats, and scurrying about on roofs and in the streets of the township. In the presence of rats, I felt more vulnerable as an observer than I had ever felt under any other circumstances during the fieldwork (Behar, 1996). Maintaining my composure through this was difficult and I sometimes failed: on many occasions I was calmed by the presence and poise of young mothers.

> Those rats are part of us, although they make us sick. They don't fear humans at all. You must see them in the evening when they come out of their holes. I assume that we have thousands and thousands of them here… They sometimes enter our shacks and sit next to us. They are part of our lives. The only thing missing from them is that they can't speak; if they could they would chat with us (Seleka, 2019).

Sample characteristics

Qualitative research does not attempt to quantify findings. However, simple quantitative data analysis is useful for description (Padgett, 2008, p. 167), and is presented here as a prelude to the results. As illustrated in Figure 4.1, all women in the study conceived before age 20. One woman conceived at 14, and the majority conceived at age 17 and 18, consistent with national data.

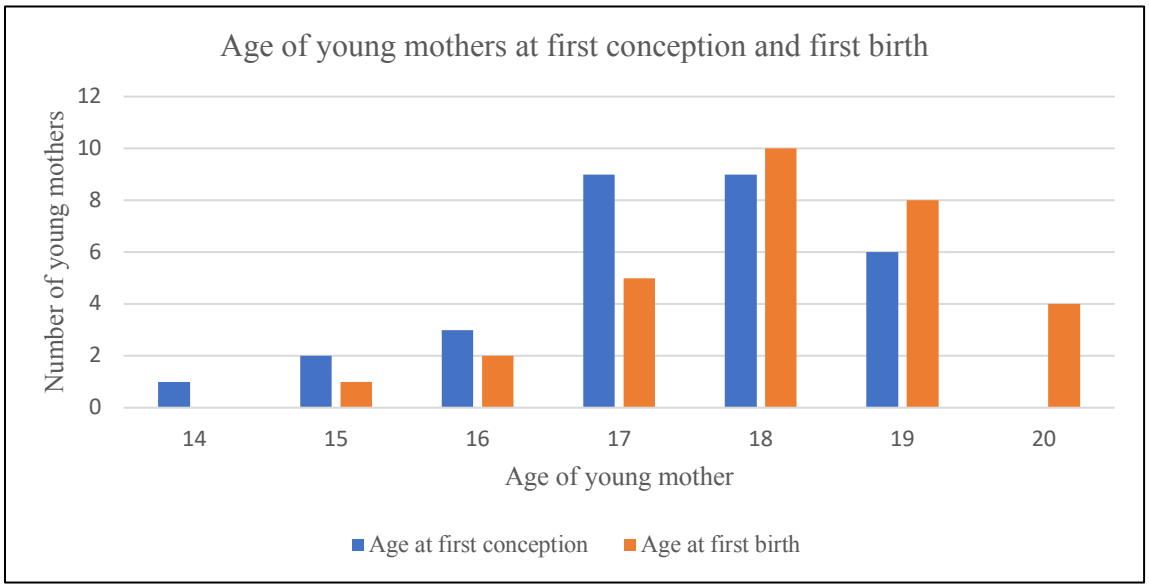


Figure 4. 1: Age of young mothers at first conception and first birth

The study aimed to understand unintended, ex-nuptial motherhood. However, during interviews it emerged that two young mothers had intended to fall pregnant, as seen in Figure 4.2. Of these two young women, one actively tried to conceive, while the other young woman wanted to fall pregnant but was still surprised when she did so.

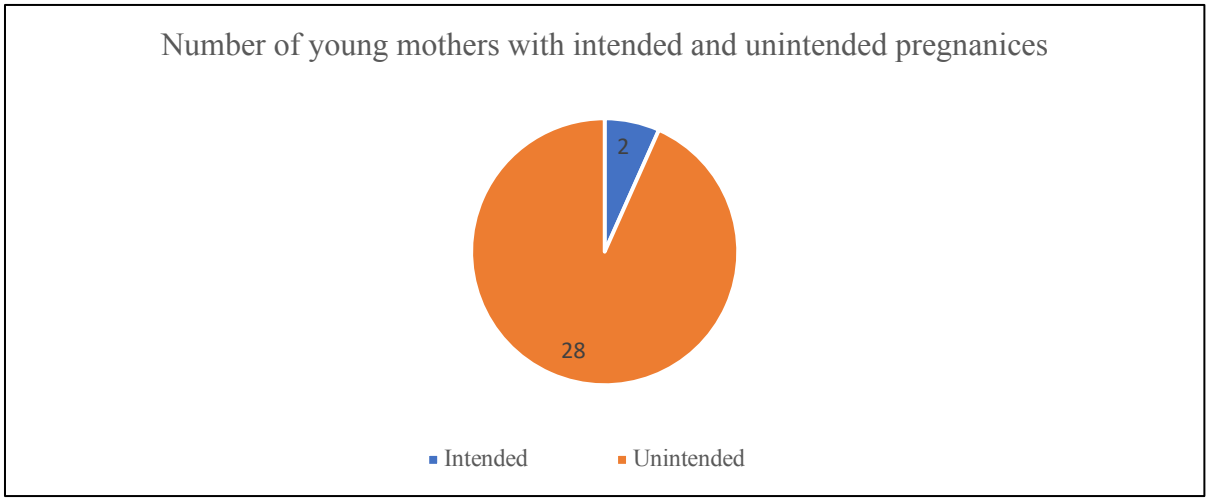


Figure 4. 2: Number of young mothers with intended and unintended pregnancy

Table 4. 1: Participant characteristics

Number of children	**Number of mothers**
1 child	27
2 children	2
3 children	1
Relationship status	**Number of mothers**
In a relationship with the father	18
Not in a relationship	11
Do not know/did not want to discuss	1
Child Support Grant	**Number of mothers**
Receives Child Support Grant	19
Does not receive Child Support Grant	9
Not eligible for the Child Support Grant	2
Age of father (in relation to age of mother)	**Number of fathers**
Age not known	2
Between 0 and 5 years older than mother	19
More than 5 years older than mother	9

Tables 4.1 provides some background of the participants: the number of children young mothers in the sample had, the relationship status with the fathers, whether the mother did or

did not receive the Child Support Grant, and age differences between the young mother and the father. This illustrates similarities and variability in the sample. Eleven young mothers did not access the Child Support Grant. This was because they did not have a South African identity document, a legal requirement for South Africans citizens who are sixteen years or older: some were unable to get the identity document because either they did not have a birth certificate or the death certificates of their parents. Young mothers who are not South African citizens are not eligible for the Child Support Grant.

The data also draws our attention to the nature of movement into and out of Alexandra, and the sense of this urban township as a settlement of constant flux. Figure 4.3 illustrates this.

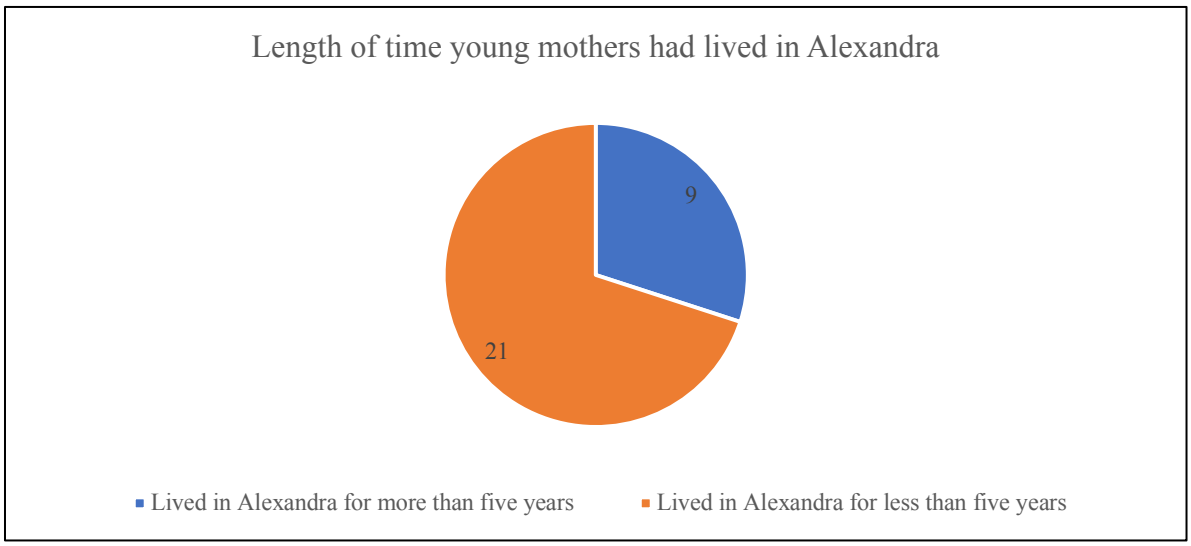


Figure 4. 3: Length of time young mothers had lived in Alexandra

Furthermore, the data elaborates on living arrangements and how households are constituted. The kinship network maps in Appendix 16 further highlights this. Figure 4.4 illustrates that young women mostly lived with female kin; the vast majority lived with their mothers. Four young women were living with the fathers of their babies.

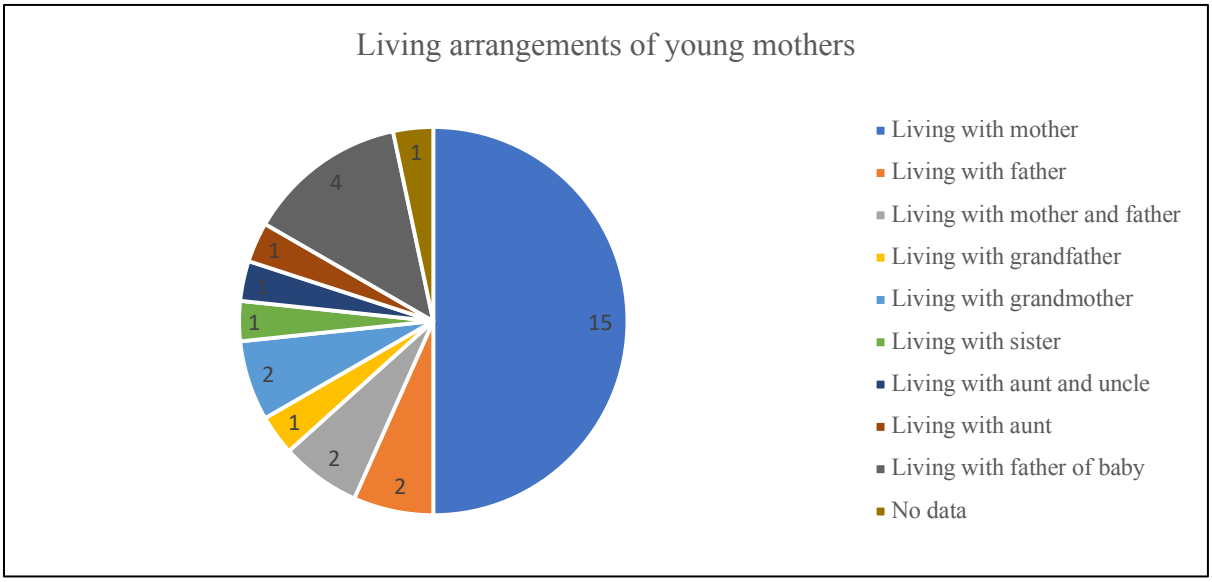


Figure 4. 4: Living arrangements of young mothers

The context of life and living in Alexandra

I have described everyday life in Alexandra in Chapters 5 to 9 of this thesis. However, here I draw attention to some key elements of life in this densely populated, highly mobile township as it impacts on and shapes the lives of young mothers. As discussed in Chapter 3, Alexandra is overcrowded. Households provide little space and privacy, there is limited access to clean drinking water and safe toilets, and high levels of crime make movement and mobility within Alexandra stressful. Young women resident in Alexandra for most of their lives described Alexandra as a space of disruption and danger, with rising levels of service delivery protests in relation to poor services, crime, limited availability of living spaces and rising levels of unemployment. Young women often referred to themselves or family members as "just sitting" to describe the experience of unemployment. For young people under 20, there are few social and recreational spaces. Yet, for young mothers who came to Alexandra in their teenage years, it offered the promise of education, jobs and opportunity associated with living in a large city. Young women who relocated to Alexandra as a result of the pregnancy did so for support from a mother or grandmother, greater anonymity, and access to further opportunities after motherhood. As the study findings in Chapters 5 to 9 will show, the experiences of young mothers in this township varied, and the interplay between their personal circumstances and the urban environment resulted in multiple experiences of early motherhood.

CHAPTER 5: I DON'T WANT FRIENDS...I HAVE FAMILY

PAPER ONE

Pillay, N. 2020. "I don't want friends…I have family" in Mkhwanazi, N. & Manderson, L. (Eds) *Connected Lives: Families, Households, Health and Care in Contemporary South Africa*. Cape Town, SA: Human Sciences Research Council. ISBN: 978-0-7969-25875-5

Introduction

This case study addressed the following objectives of the study:

Objective 1 - To explore the lives of young mothers in the 12 month period after the birth of the baby.

Objective 2 - To describe and analyse how and why young mothers make decisions around the care and wellbeing of the baby.

Three cases from the study are presented here. The book *Connected Lives: Families, Households, Health and Care in Contemporary South Africa,* edited by Nolwazi Mkhwanazi and Lenore Manderson (2020), emanated from a collaborative workshop of scholars interested in families and households in March 2017, in which I participated. The case study explores how young mothers, located in households in a poor urban area like Alexandra, Johannesburg, navigated early motherhood, school completion and employment seeking. They are based on three interviews each with three young mothers and two significant others – a total of 11 interviews. These cases allowed me to move from the simple to the complex, by exploring relationships in depth (Yin, 2003). The case studies do not represent the stories of all young mothers, as no single case is capable of reflecting the entire phenomenon of early motherhood (Strathern, 2004, p. xiv). Neither are they generalisable, as is consistent with the use of information from single cases and small samples, but they are included to illustrate variations of experience and how this impacts on young women (Flyvbjerg, 2006, p. 230).

The case study used a grounded theory approach, and the narratives of Nobuhle (18), Ayanda (19) and Betty (20), generated central themes subsequently explored for all young mothers. These include the nature and value of support; that is gendered, fluid, dynamic and provided in multiple ways, including material, emotional, informational and caregiving. The cases also illustrate how the fathers of the infants navigated relationships with young mothers, in order

to be present and supportive of their children. Importantly, the cases introduce the cultural concept of "damages" or *inhlawulo*– an amount paid by the genitor and his family to the family of (young) mothers when a baby is conceived out of marriage. The payment of damages signifies a commitment to the baby and mother. It is an important cultural mechanism to safeguard their wellbeing, and was an emergent theme throughout this study. The payment of damages reflects how cultural norms and associated practices are reproduced even in urban contexts where families and kinship networks are more dispersed.

The cases disrupt notions of traditional nuclear families, illustrating fluid forms of family, childcare and living arrangements. The cases begin to explore how aspirations inspire agency; young mothers aspiring to complete education or seek employment exercise agency with the support of their families and kin. The case of Nobuhle (18) draws our attention to Intimate Partner Violence in South Africa, which was not a dominant theme in this study but draws our attention to this reality for many women in South Africa. The case highlights the gender and power dynamics that make young women vulnerable, particularly in the event of early, unintended, ex-nuptial motherhood, when economic precarity increases vulnerability.

"I don't want friends…I have family" in Mkhwanazi, N. & Manderson, L. (Eds) (2020) Connected Lives: Families, Households, Health and Care in Contemporary South Africa. Cape Town, South Africa: Human Sciences Research Council. ISBN: 978-0-7969-25875-5

In the absence of support from the state and other social, educational and development stakeholders, families play a crucial role in the lives of young mothers after an unplanned or mistimed pregnancy. Three young mothers – Nobuhle (age 18), Ayanda (age 19) and Betty (age 20) each had unplanned and mistimed pregnancies, and here, I examine how their families respond to the unanticipated pregnancy, and how the young mother and her baby were cared for and absorbed within existing, extended and new family networks. The research on which this case study is based began at the Alexandra Community Health Centre's well-baby clinic, which young mothers and their babies attend for routine baby examination and immunisation. Here I met Nobuhle, Ayanda and Betty; I interviewed each of them three times between September 2016 and August 2017, and also interviewed a significant other person in their life including a mother, grandmother and father of the baby. As our relationship grew and more trust developed, our meetings moved out of the health centre and into their homes and workplaces.

Writing of multiple generations and family members can be confusing. So, to clarify: I use the term "young mother" to refer to the protagonist of the story – Nobuhle, Ayanda and Betty. I refer to her mother as "mother," her mother's mother as "grandmother" and her baby as "son/daughter."

Nobuhle's story

Nobuhle is 18 years old when I first meet her at the Health Centre. She is with her 6-week old daughter Titzi. Nobuhle was 17 when she conceived, 18 when she gave birth. She passed matric at the end of 2015 at the age of 17 with a Diploma, and became pregnant very shortly after writing her examination. Passing her final year of secondary study with a Diploma means that Nobuhle is not eligible for tertiary studies in South African universities; she would have to upgrade her matriculation should she want to study further. Nobuhle aspires to do this, and to pursue a social work degree. When we first met, Nobuhle was in a long-term relationship with Solly, Titzi's father. They had been together for two years when Nobuhle became pregnant.

When I first meet Nobuhle, I am struck by her confidence, energy, ease and pride in her new infant. Describing her health during her pregnancy, Nobuhle animatedly stated, *"I was able to run very fast and I would jump off things, I was very active, I was very hyper, my mom was always scared, I would climb on top of the bed... jump."* In the first interview she seemed to be a young woman determined to overcome the challenges presented to her as a young mother. But as we got to know each other over the year, Nobuhle was not always this positive and excited. As our relationship deepened I began to make sense of her life, her relationships, her struggles, and dreams. In our time of contact, Nobuhle began with the faith that her relationship with Titzi's father would endure, and that they would be able to raise Titzi together and begin a little family of their own. She was certain that Solly and his family would pay damages to her family, and perform the traditional rite of acknowledging paternity and accepting the new baby into the family. She was sympathetic to Solly not having paid damages yet because he and his family did not have enough money, and both Mavis, her mother, and Nobuhle allowed him access to visit Titzi even though the damages were not paid. However, Nobuhle grew increasingly wary of the future of the relationship, after being physically abused by Solly a number of times.

Nobuhle and Titzi live with her mother, Mavis (41), in a single rented room in Alexandra. Her nuclear family includes Mavis, her father (separated from Mavis since 2008) who also lives in Alexandra, and an older brother (22) at school and living in Limpopo with Mavis' family. Their household in Alexandra consists of Mavis, Nobuhle and Titzi. They live on a household income of approximately R3 000 which Mavis earns, and the R380 child support grant. This is supplemented by the occasional work that Nobuhle gets at a clothing store, after losing the part time job she had held at a fashion store because of absenteeism due to one of Solly's beatings. Solly offers occasional support in the form of food or clothes for Titzi but this is not regular. Nobuhle's father also occasionally gives his ex-wife and daughter money for food or meat, but this is not reliable.

Over the course of the year I was in contact with Nobuhle, she told me of her battles and victories as a young mother, of her on-going struggle to find employment and of the enduring love and support she has received from her mother. In this time, Nobuhle had to negotiate the end of school with disappointing results; a pregnancy and birth; having and losing a job; a traumatic and stressful love relationship; and the endless pursuit of finding employment in an economy unkind to young people in general, and particularly challenging for young mothers. Other family members and Solly step in and step out; there is nothing that sustains their

commitment to the household. Hence it is the mother-daughter dyad and the strength of their bond that adapts and meets the changing context of their lives, including the joint planning and decision-making around Titzi's wellbeing and care.

Ayanda's story

At our first meeting, Ayanda is 19 years old, and her daughter, Lumile is one. Ayanda was 17 when she conceived, 18 when she gave birth. She completed matriculation at the end of 2014 at the age of 17 and found out that she was pregnant in early 2015. Ayanda had an incomplete matriculation result as she did not write the examination for two of her subjects, and spent part of 2015 upgrading her matriculation results so that she could pursue tertiary studies. Lumile's father, Nde, is 22, and he and Ayanda had been together for four years when Ayanda became pregnant. Although Nde wanted Ayanda to keep the baby, he chose to leave their relationship. He has had no contact with either Ayanda or his daughter Lumile.

Ayanda is a fiery, confident young woman, easily able to articulate her views and confident with me from our first meeting. She exudes ambition and drive, and does not seem deterred by life's difficulties throughout my interaction with her. At no point in my relationship with Ayanda does she describe sadness or despair or disappointment, even when it is clear that there are many challenges and difficulties she has experienced in life. Ayanda's mother died in 2002 from breast cancer and her father died in 2008. Ayanda left her father's family in Soweto in 2010 to live with her grandmother, Faith (62) in Alexandra. She was her parent's only child, but refers to her cousins with whom she lives as her younger brothers.

Ayanda lives with her grandmother Faith, her aunt (mother's sister) and her aunt's sons (14, 12 years old) in a one room dwelling in Alexandra owned by Faith. Both Ayanda and Faith describe their relationship as a special one, with Faith investing in Ayanda through expensive private education and providing her unconditional support despite her disappointment in the pregnancy. The household income consists of approximately R7 000 earned by Faith, and other ad hoc money provided by Ayanda's aunt's income as an occasional domestic worker. Ayanda receives the child support grant. The household monthly income is above average for a household in Alexandra, but there is still the constant struggle of meeting the needs of the entire household, including baby Lumile. At our second meeting in January 2017, Ayanda tells me that Lumile is no longer living with her in Alexandra, but has been taken by Ayanda's second aunt to live with her and her husband in Rustenberg. She explains that her aunt had no children of her own, and was happy to support Ayanda and the family so that

Ayanda could continue her studies and look for work, all of which were difficult to manage while caring for a baby. This was particularly important as Faith had just retired. Ayanda had enrolled at a local college to study human resource management and was also working for a commission based sales company where she was in training. Ayanda had great hopes that with drive, commitment and hard work she would earn good commission showcasing to management her potential to lead her own team.

Lumile's care arrangement in Rustenberg is not unique. It is not uncommon for babies and children in South African urban townships to be raised by family members outside of the township. Child care is often onerous and stressful for mothers in poor urban areas, créches and other family support are limited, and lack of resources often drive the decision to reign in the support of the wider family network in caregiving. What is striking about Ayanda's case is the almost fluid way in which Lumile and Ayanda are held within the wider family network, Ayanda's pragmatic approach to Lumile being cared for by an aunt who has no children of her own, and of how the entire family seeks to support Ayanda as a potential breadwinner. Ayanda's own determination and her almost "sensible" approach in accepting a better care arrangement for Lumile, sets her apart from the dominant narrative of the passive teen mother. Lumile becomes absorbed into a second family in Rustenberg, while simultaneously maintaining her family in Alexandra, and her connection to them. Ayanda is confident that Lumile knows of their mother-daughter bond, even though she calls Ayanda's aunt "Mamma:"

> Ai that one, she'll never forget me, there is no way. Because when they came she could see I know this person, she was busy staring at me and then the next thing she wanted me to carry her and then from there I couldn't go out without going with her… if I go to the shop, I must take her with me and she didn't sleep if I'm not sleeping at night. We have to switch off the lights and she makes sure that I'm right next to her you see, ah she won't forget me that one.

Betty's story

Betty is 20, and her son Mpho is six months old when we first meet. Betty was 18 when she conceived, 19 when she gave birth. Betty was in Grade 11 when she found out about her pregnancy and decided to drop out of school the following year, during her matriculation year, in the month Mpho was born. Mpho's father, Junior (27) and Betty have a complicated relationship. They had been together for five years at the point Betty became pregnant. Their relationship started in the Eastern Cape where they had met at school; they parted ways for a

while, and then reconnected when they both ended up in Alexandra. Junior had encouraged Betty to keep the baby when they she discovered she was pregnant. But Betty's relationship with Junior appeared fragile; she was uncertain of their relationship status and continuously worried by his infidelity. Junior himself was clear that they were not in a relationship other than that through their shared relationship with Mpho, and towards the end of my contact with Betty, she too was clear that their relationship as a couple was over.

Unlike Nobuhle and Ayanda, Betty was withdrawn and quiet, and very sad the first few times we met. She struggled with Junior and used the phrase "it's complicated" often to refer to their relationship. The strain of having a baby without having her own income weighed heavily on her, and she constantly struggled to find employment so she could have financial independence.

Betty and Mpho live with her uncle (mother's brother) and aunt (mother's sister, although referred to as Betty's sister in our conversations), the aunt's two children, and her grandmother in a house owned by her grandmother in Alexandra. There are seven members of the household. Betty describes her living arrangements as adaptable and impermanent; she lived with her mother while she was pregnant, and shortly after giving birth: there she was cared for and where she learnt the basics of infant care (bathing, feeding) from her mother. She then moved in with her aunt and uncle so that she and Mpho could have more room. Unlike the earlier cases, where the families are split between "home" (Limpopo and Eastern Cape), almost all of Betty's family resides in Alexandra. The family households are supported primarily by Betty's aunt who works full time and Betty's mum, who works part time as a domestic worker. Betty does not know what either of them earns. By the end of my fieldwork, Betty had found a job in the deli counter of a local supermarket. I encountered a very different young woman at our last meeting. Betty was happy, chatty, and confident. She was clear that her relationship with Junior was over, but she was happy that he was still involved in Mpho's life and she was keen to encourage and nurture this.

Financial independence for Betty was the major source of distress in early motherhood, not necessarily the unplanned baby Mpho, or her difficult relationship with Junior. When Betty started her new job, she would leave Mpho with a caregiver to whom she pays R450 a month. When she came home late from work, or needed to leave early to work, one of the family members stepped in and helped Betty by fetching Mpho from the caregiver and bathing and feeding him before Betty came home. Betty's story tells of the support networks intrinsic to

large extended families. Her use of the terms brother and sister, and not uncle and aunt, indicates that notions of nuclear families are fluid, shaped by roles not genealogy, and constituted in multiple, flexible ways. Mpho becomes absorbed into a wide family network, where his mother, her mother, and her siblings rally around and support Betty, particularly when she was financially dependent on them. Junior's support become peripheral to the maintenance of the family and household, yet Betty actively encourages Junior's relationship with his son, and acknowledges that his support, although ad hoc and inconsistent, is valuable to her: "When he asks me to bring the baby I don't have a problem, I bring the baby to him. When he want to come and see the baby I don't have a problem, he come and see the baby."

Conclusion

Nobuhle's, Ayanda's and Bettys' stories tell a larger story about the families and households of young mothers and their babies in one poor South African urban township. Each of these stories shows how love, care and generosity are provided to young mothers and their children in uncertain and fragile household economies. Families, households and their networks come together to offer care in times of stress, even when unanticipated events strain existing scarce resources, particularly when the unplanned and mistimed pregnancy potentially limits the young mother's chance of education and employment achievement. This is important in a context where parents and caregivers dream and aspire that their children will help their families out of hardship and poverty. For households in poor urban areas in South Africa, there is very little consistency and guarantees of financial resources, but even in these circumstances, families make a plan and accommodate unanticipated events. They show us that families and households are fluid and fragile, are complex, and exist beyond the boundaries of the traditional nuclear family.

The fathers of the babies, in the cases of Nobuhle and Betty, also represent alternative narratives to that of the absent young father. In both cases, even though their relationships with the young mothers did not endure, both fathers remained committed to their babies, and offered some source of support in the form of Pampers (disposable nappies), food and occasional cash, as well as regular visits to their babies. Even though both families would like the fathers to observe the traditional rites of acceptance of the baby into the paternal families, they show a willingness to adapt the rules and practice to support the father-baby relationship. While men in general, and fathers in particular, are present in these stories, the dynamics of care and support are strongly gendered in these and other families and households in South

Africa, with older women offering the bulk of financial and caregiving support for their daughters and granddaughters.

CHAPTER 6: KINSHIP CAPITAL

PAPER TWO

Pillay, N., Kinship capital: Young mothers, kinship networks and support in urban South Africa. (Under review).

Introduction

This paper addressed the following objectives of the study:

Objective 1 - To explore the lives of young mothers in the 12 month period after the birth of the baby.

Objective 2 - To describe and analyse how and why young mothers make decisions around the care and wellbeing of the baby.

The themes that emerged from the case study were expanded in this paper: I narrow the lens to look at the specifics of families and kinship networks in providing care and support to young mothers and their babies. I explore the particularity of living in an urban area and its effect on the creation and adjustment of kinship networks. This paper contributes to an extensive literature on social support and kinship and care practices for individuals and families living under stress, as a result of changes in family context and socio-economic precarity (Razavi, 2011; Casale and Gibbs, 2015; Manderson and Block, 2016; Manderson et al., 2016a, 2016b; Reynolds, 2016; Mlotshwa et al., 2017; Hall et al., 2018).

During the early phases of analysis, I drew genograms to make sense of young women's immediate families, extended families and wider kinship networks to explore how they understood (or failed to make sense of) the idea of the traditional nuclear family and its contingent relationships. I began this process to explore the meanings ascribed to family as understood socially and biologically, as well as to understand how kinship networks operated within and between geographical borders. The concept of support was examined by expanding on the ideas of social networks and social capital (Coleman, 1988; Berkman and Glass, 2000; Madhavan S et al., 2003; Pronyk et al., 2008; Madhavan and Landau, 2011; Marshall et al., 2014), and I pay attention to *what* constitutes support, *who* offers it and *how* it is offered. This highlights the value of different forms of support important to mediate the negative consequences of early motherhood. Here too, I pay attention to agency and aspiration and how family and kinship networks coalesce to care for young mothers and their

babies, and how they support young women to mediate the challenges of early motherhood to achieve some of their ambitions.

Genograms and kinship network patterns were drawn for all young mothers in the sample (Appendix 16), seeking to understand the forms of co-habitation, and what constituted households, families and kinship networks. South Africa is recognised as an outlier in terms of parental cohabitation arrangements, with low rates of parental cohabitation. This is similarly found in some of the neighbouring countries that have a long history of supplying labour to South Africa, illustrating the enduring impact of labour migration (Hall and Richter, 2018, p. 25). In reflecting on the kinship network maps, I again use cases to represent the articulation of support across borders in multiple ways; across urban, provincial and national borders. This elucidates the enduring feature of migration and mobility as an ever present dynamic of urban life in South Africa (see Figure 4.3), and locates early motherhood within this. The paper explores how kinship capital emerged as a durable form of social capital, allowing for elasticity in household composition and movement patterns for young mothers and their children into and out of urban areas.

This paper is currently under review. The format and referencing style has been amended to comply with this thesis. Figures and Table numbers have been amended for continuity, and differ from the journal format. Monetary data and currency conversion is dated to the submission of the paper in December 2018.

Kinship capital: Young mothers, kinship networks and support in urban South Africa

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Abstract

In South Africa, the discourse on early motherhood is immersed in rhetoric of shame and blame, and rarely considers the agency of young mothers. In this article, I explore networks of support for young mothers and their babies after an unintended, ex-nuptial birth in a resource poor urban setting. This article draws on in-depth interviews conducted with thirty young mothers aged 18 to 20 years old and follow up interviews conducted with nine of them. The interviews focused on three main areas: pregnancy and birth; education and continuing education; and support networks. In this article, I draw on three cases that reflect the variability in support and kinship network patterns. I use genograms and kinship network maps to identify sources of support and kinship networks within and outside households. Paying attention to the location in which networks are embedded, the article highlights the role of kinship networks and other forms of support in mitigating some of the negative consequences of early, unplanned motherhood. I show how young mothers draw on support from family and kinship networks which in turn adapt and reconfigure to provide support, allowing young mothers to exercise agency in relation to aspirations around educational attainment and income generation.

Keywords: early motherhood; urban; kinship network; agency; social support; South Africa.

Introduction

Every year an estimated 16 million girls between 15 and 19 years old become pregnant worldwide, accounting for 11% of all births; of these, 95% occur in low and middle income countries (Cherry and Dillon, 2014, p. 7). The high rates of early childbearing in low and middle income countries raises concern because of the reported consequences of early motherhood, particularly as it relates to social and economic disadvantage and the long-term effects of school disruption and limited economic opportunity (Boden et al., 2008; Hobcraft and Kiernan, 2001). Internationally and in South Africa, the focus of studies on early motherhood has been on whether early childbearing precipitates social and economic disadvantage (Hobcraft and Kiernan, 2001; Boden et al., 2008) or whether it is an outcome of it (Geronimus, 1987; Lee and Gramotnev, 2006). Some studies have considered the complexity of the link between early reproduction and life chances (Luker, 1996; Geronimus, 2003; Magadi, 2017), and others are exploring agency and autonomy during early motherhood (Macleod, 2011b; Jewkes and Morrell, 2012; Shefer et al., 2013) including questions of how to support young women transitioning into motherhood while managing the competing demands of other adolescent roles, like school completion, income generation and healthy sexual and reproductive health development (Macleod and Tracey, 2010; Hill et al., 2015; Singh and Naicker, 2017). This is important to mitigate the social and economic disadvantage associated with early motherhood.

In South Africa total fertility rates are decreasing (South African Department of Health and South African Medical Research Council, 2002; Statistics South Africa, 2017a) and there has been a slight decline among women age 15-19 years who had ever given birth from 13.2% in 1998 to 12.4% in 2016 (South African Department of Health and South African Medical Research Council, 2002; Statistics South Africa, 2017a). Rates of early childbearing are higher in rural (19%) than urban (14%) areas (range 8.1-20.3%). There is a rapid increase in the birth rate of women between 18 and 20 years old, and by age 20 about 30% of women have had at least one live birth (Statistics South Africa, 2017a). This is a key point in many women's lives, as they conclude schooling, embark on post-secondary education, or seek employment. My study focussed on the age group 18-20 years for these reasons. In order to move away from the pejorative framing and politicisation of early motherhood in South Africa, I use the term "young mother" as an inclusive term for all young mothers between 18 and 20 years of age.

In this article, I pay attention to kinship networks and the role they play in supporting young mothers confronted with an early, unintended, ex-nuptial birth in Alexandra, an economically marginalised urban area in Johannesburg, South Africa. The flexibility and fluidity of kinship networks as an adaptive response by families to disruption has been well documented (Manderson et al., 2016a; Sooryamoorthy and Makhoba, 2016). Early, unintended pregnancy, is also well documented in South Africa (Madhavan, 2010; Madhavan et al., 2014a; Mkhwanazi and Bhana, 2017; Shefer, 2011). Scholars working in the area of families, gender and early motherhood, have articulated the need for an expanded scholarship on the spatial distribution of kinship networks, complexities of care and caregiving, and questions of agency and autonomy of young mothers (Hodes, 2017; Madhavan et al., 2014a; Ngabaza and Shefer, 2017). In particular, Madhavan, Mee and Collinson (2014a, p. 402) affirm the need to know more about the "spaces not shared but none the less crucially important in the lives of children" as seen in the role of multiple households in kinship care practices; and suggest greater exploration of the "spatial distribution of kin across households, and the connections between households."

This article contributes to, and expands on, existing scholarship on early motherhood in South Africa in three ways. One, by paying attention to kinship networks in an urban area, particularly the spatial distribution of these networks and their articulation with kinship networks outside this urban space. Secondly, by using kinship network maps, kinship networks are visually presented to include details of household composition, relationships to other households within and outside the urban context, as well as sources of support within the kinship and other social networks. Thirdly, it explores how young mothers exercise agency within these networks.

Movement and economic migration are enduring features of poor urban areas. In this article, I explore how kinship networks configure and operate to support young mothers within this context by examining the context and kinds of support offered within and outside kinship networks. Who provides support, what and how support is provided, what networks exist and what networks are created, becomes critical not just for the young mother, but for her family and household. Thus I draw attention to how the help provided facilitates the accommodation of a new baby into the family, while also supporting the young mother as she takes on the role of motherhood. In doing so, I engage with the intersection of individual agency and decision-making, and the social support manifest in networks.

The larger study consists of 30 young mothers. During the fieldwork, I drew genograms of each young mother to understand the family composition. Using the genograms, I identified households of significance to the young mother, which evolved into kinship network maps. The kinship network maps were used to make sense of networks of support, and to understand the relationships between family and kinship networks in Alexandra, its surrounds, and beyond. Complex patterns emerged that extended beyond the nuclear family, the household and outside the spatial or geographic boundary of Alexandra. I noted household composition, the split of families into multiple households in and out of Alexandra, kinship ties, the nature of the relationships between individual family members, and between the young mother and the father of the baby. In particular, I noted the household in which the young mother and her baby were located and their primary caregiver in each instance. I asked each respondent who they identified as the most significant source of support and explored details of the nature of support. The maps, as I describe below, illustrate who offers support and the kind of support provided to young mothers.

In analysing support, I have adapted House and Khan's (in Cohen and Syme, 1985) categories of support, and used material, emotional and informational support. I added caregiving as a category of support. I define material support to refer to instrumental support through assistance with shelter, money, food and clothes; emotional support to denote love, care, sympathy and understanding; and informational support to include advice, information and guidance. The kinds of support, identified in the legend of these maps, were illustrative and do not reflect either the "quantity" or "quality" of support offered for any one woman. The genograms use the traditional notation of squares for males and circles for females; crosses indicate death; and the solid black circle represents the central individual, the young mother. Support from other social networks is represented as a box at the bottom of each network map.

Considerations of care

Despite historically high rates of early motherhood among Black and Coloured communities, the discourse of early, unintended, ex-nuptial motherhood in South Africa is one of moral degeneration and shrouded in blame and shame (Macleod and Tracey, 2010; Mkhwanazi, 2012; Shefer et al., 2013). In recent times this negative view of early motherhood is amplified (Christofides et al., 2014a; Mkhwanazi, 2012) because young women between 15 and 24 years old shoulder the burden of the HIV epidemic (South African National AIDS Council,

2017a). A young woman with an unintended pregnancy carries a double burden of shame, in failing to protect herself from pregnancy, and HIV and other STIs. Her agency with respect to decision-making around her own and her baby's future is rarely considered. The agency of young mothers is often undermined because of attention paid to structural determinants of early motherhood like sexual violence, gender discrimination and age disparate relationships (Hunter, 2002; Macleod and Tracey, 2010; Jewkes and Morrell, 2012; Mkhwanazi and Bhana, 2017).

Agency and decision-making are intricately connected, but it is important not to conflate the two concepts or to assume that one either has agency or does not. Agency is the ability to exert one's will and to act in the world (Giddens, 1984). Contexts and domains shape the ability of individuals to exercise agency, and the extent to which they are able to do this, as articulated by Giddens (1984) in his theory of structuration, in which he argues that human action is mutually and circularly shaped by structure and agency, without precedence to one or the other. Exploring the intersection of individual agency and the structural context in which it is exercised, allows for a nuanced discussion, illustrating that "agency and non-agency stem from a series of negotiations and shifts in discourses and power within and between these domains" (Foucault, 1980 in Boehm et al., 2011, p. 9). For young mothers, it is important to look at this intersection to explore how they mediate structural forces like gender discrimination, migration and poverty, and assert their agency to navigate the world of early childbearing.

Johnson-Hanks (2006, p. 22) describes an unplanned pregnancy as a "vital conjuncture" in the life of an adolescent woman, a transformative life event that affects her future, a moment embodied by change and uncertainty, where she has to consider the implications for her future. The pregnancy presents a moment of deviation from the adolescent script, when adolescence is disrupted to include the category and role of "mother." At this vital conjuncture, the young woman has a number of choices including termination, keeping the baby, or offering the baby up for adoption, either formally, through personal arrangement, or abandonment. Continuing with the pregnancy and keeping the child often depends on the support of her kin, particularly in providing material support and childcare.

An unintended pregnancy introduces a new family member into a household. It is a disruption not just in the life course of the young woman, but also for her family and household, and requires the negotiation of family resources and considerations of care, particularly when

young mothers are still in school, aspiring to complete their studies and pursue employment. According to Manderson & Block (2016, p. 212) "families continually stretch their emotional, physical and economic capacities to provide care for kin who become sick, disabled or orphaned," and this applies equally to the care for infants born outside the boundaries of the conventional trajectory of family development, as illustrated in the edited volume *Young Families: Gender, Sexuality and Care* (Mkhwanazi and Bhana, 2017).

In most contexts, adolescent pregnancies challenge socially assigned roles of adolescence and force the emergence of new and complex subjectivities. Given that mothers have material, social and emotional responsibilities (Manderson and Block, 2016, p. 209), questions arise as to who will provide care. Will care be provided by the mother of the young mother, or by the young mother herself, or by someone else? Traditional kinship care practices are disrupted by practices of migration (Boehm et al., 2011, p. 10; Sooryamoorthy and Makhoba, 2016), as is common in South Africa as a result of mobility patterns arising from apartheid. South African apartheid laws governing access to places resulted in multiple forms of migration with dire consequences for family life in rural and urban areas.

African families have a long history of adaptation borne out of structural injustice, punitive policies and poverty, resulting in multiple forms of kinship networks created and recreated in response to fluxes in family circumstance (health, aging, death, and children) and economic imperatives. Disruptions caused by population mobility reconstitute social relations, so that families create and expand on networks that become embedded in new places (Madhavan et al., 2014a; Boehm et al., 2011, p. 10). In urban areas in South Africa, care is complicated by economic realities in environments where there is limited access to kinship support (Clark et al., 2017), as distinct from rural areas where kin – other mothers, grandmothers, unemployed female kin – not engaged in wage labour may be more available for childcare (Mtshali, 2016; Sooryamoorthy and Makhoba, 2016). Urban settlement and women's changing economic participation thereby challenge established "extended family care strategies" (Reynolds, 2016, p. 257).

Kinship networks are one kind of social network, which generates, to a varied extent, social capital and social support, contributing to the reproduction of families and communities. Thus, kinship networks operate in similar ways as other social networks in formal institutions like schools, workplaces and churches. Kinship networks create the terrain and resources for families, particularly in areas where there are limited economic and institutional resources to

respond to the demands of daily life. For young mothers in poor, urban, migrant spaces, support is critical because they may have limited access to resources and support of their natal or extended family (Clark et al., 2017) and of the state (Blackie, 2017). Furthermore, the characteristic of the neighbourhood in which social networks are embedded influences network patterns and the kinds of social support they lend themselves to (Cattell, 2001, p. 1512).

Social capital is embedded in social networks as practical, material and affective support. Support to new mothers, of any age, is understood as integral to, and protective of, successful transition into motherhood. This is possibly more so for young women, who may have especially limited resources. The question of how young, unmarried mothers access support within networks is complicated by their divergence from the norms and rules of adolescence, and they may be considered by their kin and community as undeserving of support. While it may be that kin "step in" to support a young mother with an early, ex-nuptial birth, complexities underlie the availability, size and capacity of kinship networks in urban areas.

Contexts of care and living in Alexandra

South Africa has high levels of unemployment, resulting in competition for scarce jobs (Moya, 2018). Where men were previously the primary economic migrants, women are now central players in migration and urban employment, often the primary breadwinner in households, and not available for childcare (Mkhize and Msomi, 2016). Their economic participation challenges assumptions about gender roles, traditional African kinship networks, and caregiving practices (Clark et al., 2017). More than twenty years after the demise of apartheid, Alexandra is characterized by rapid growth, low levels of community development and investment, high unemployment, low household incomes and high levels of poverty, perpetuating extensive inequality and unequal development (Pernegger and Godehart, 2007, p. 3).

At the same time, the post-apartheid period has led to the increased feminisation of economic migration, with the increasing migration of women and children to urban areas (Richter et al., 2006). This is the case in Alexandra, where the primary source of employment for women is domestic work to wealthier households in and around Johannesburg. Designed for a population of 70 000, Alexandra has grown rapidly as a result of population movement from other parts of South Africa and neighbouring countries, with approximately 179 624 residents

and 63 737 households resulting in the expansion of informal housing – now an estimated 20 000 shacks ("Alexandra Township, Johannesburg, South Africa," n.d.; Frith, 2011). Alexandra was the site of xenophobic violence in 2008 and 2015 due to the threat experienced by South Africans of foreign nationals competing for access to scarce economic resources (Khalo, 2012; Sello, 2015).

Variations in kinship networks and support across place

At the first interview, fifteen young mothers were living with their mothers and other family members in a single household (no fathers), two lived with both parents and siblings (conventional nuclear family), one lived with a grandfather (no parents), two lived with their father (no mother), one lived with a sister (no parents), two lived with their grandmother and other family members (no parents), one lived with an aunt and uncle, one lived with an aunt, and four lived with the father of their babies. When asked to identify a "significant other," the person in their life who offered them the most significant support, fourteen young mothers identified their mother, one her father, two their grandmother, four their sister, one a friend, one an aunt, one a mentor at school, and six the father of the baby. At the first interview, 18 of the 30 young mothers were in a relationship with the father of the baby. Twenty fathers were providing some support to the young mother and her baby, two of whom provided support even though they were no longer in a relationship with the young mother. For three young mothers, the father of the baby was their sole source of support and they received no support from family.

The findings are not generalisable given the sample size or recruitment, but they illustrate the complexity of household configurations, sources of support, and variations in relationship dynamics with the father of the baby in this township. Below, I present three case studies chosen for their variations in kinship network configuration across place. The cases are constructed at a moment in time, from interviews with the young mothers over a 12 month period. Using the kinship network maps, I explore care and support arrangements across households and families within and outside Alexandra. All personal names are pseudonyms. In the first case (Andiswa), I describe a local urban kinship network entirely embedded in Alexandra; in the second case (Ayanda), I describe a dispersed kinship network across urban and provincial boundaries. In the third case (Connie), I describe a dispersed kinship network spatially distributed across urban and national borders. In each case, I elaborate how the network and its location shapes the agency of the young mother in relation to her aspirations

for her future, as well as in relation to care provided to both young mother and her infant. Although the cases do not reflect changes in kinship network composition, structure or movement over time, they were selected from the wider sample to illustrate the range of kinship configuration and patterns of movement.

Andiswa: Local urban kinship network

Andiswa was 18 years old, and her baby Sbo was 18 months old, when we first met. Andiswa's family are long term residents in Alexandra, spread over two households to accommodate the entire family: houses in Alexandra are typically small, with one or two rooms. Andiswa and Sbo live with her mother in one household; her siblings live in another (Figure 6.1). Andiswa's sister provides both households with material support. Her mother, Beauty, is unemployed and is Sbo's primary caregiver.

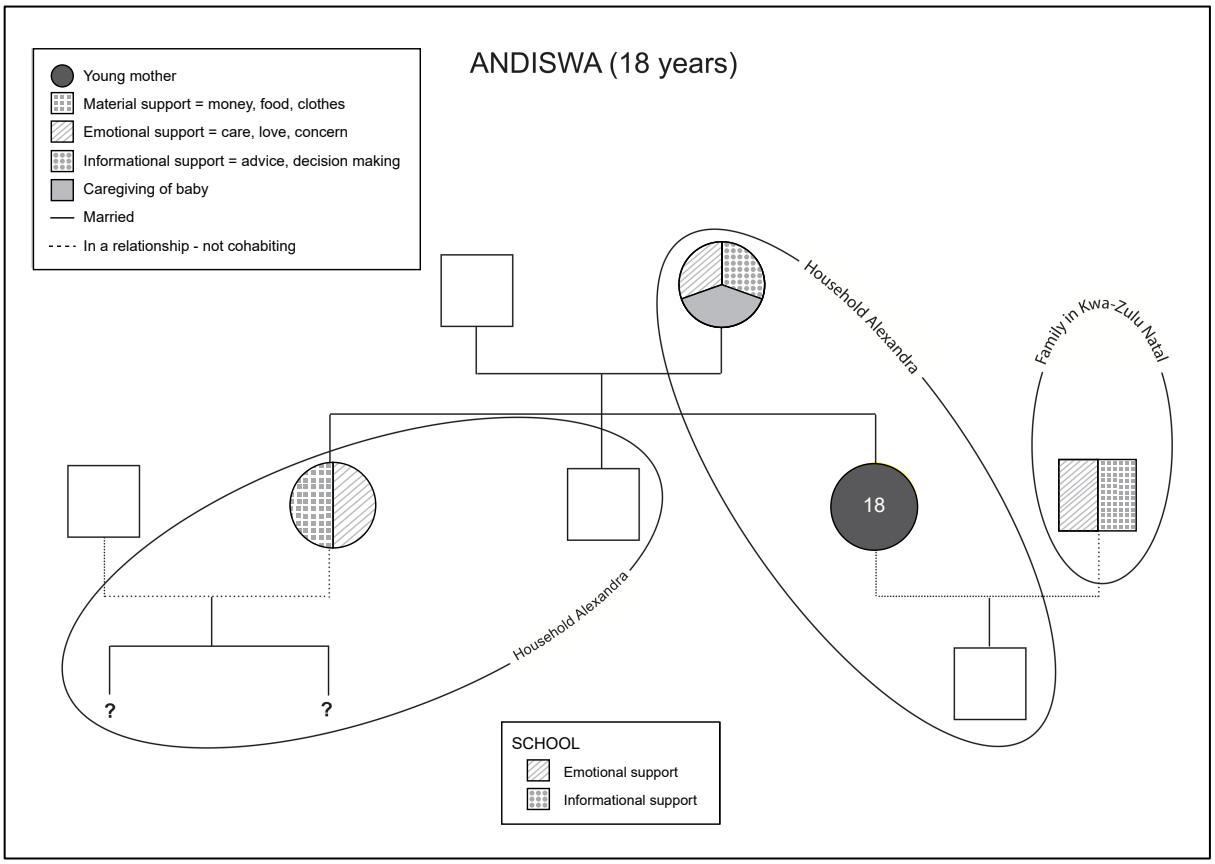


Figure 6. 1: Kinship network map of Andiswa (18 years old)

Andiswa has been in a steady relationship for over three years with Sbo's father, Themba, who moved to Alexandra from the neighbouring province of KwaZulu Natal. Themba is employed and is able to provide reliable emotional and material support to Andiswa; he

originally provided ZAR700 (US $48) per month, by increased this to ZAR1500 (US $104) when Sbo was enrolled in a crèche. Themba and his family have paid ZAR10 000 (US$690) *inhlawulo* ("damages") to Andiswa's family for the unintended pregnancy, and by doing so, acknowledged paternity and accepted responsibility for the baby.

Themba's material and emotional support is important to Andiswa, and has helped her cope with the significant distress she experienced as a result of the unintended pregnancy. However, it is her own kinship network that is critical to facilitating school attendance and participation, and provides her with the support necessary to achieve her aspirations around school completion. Outside her kinship network, the support offered through the school context is an important source of encouragement in mediating her role as mother with her ambitions for success at school. In particular, two teachers offer her emotional and informational support. Mr Luthile is the only person at school to whom she had disclosed her pregnancy:

> My teacher said I can see that you are no longer asking questions. You are no longer raising your hands in the school, uh in the class. What's wrong? Then I told the teacher what's wrong. Then he gave me options.

By identifying her change in class participation, Mr Luthile helps Andiswa navigate the early period of pregnancy discovery, disclosure and decision-making, when Andiswa was afraid of the reaction of others in her kinship and social network. Mr Luthile advised her against an abortion, thus helping her make one of the first and most difficult decisions a young woman is confronted with early in pregnancy. He encouraged her when she returned to school to continue studying. In addition, his small acts of kindness like enquiring about Sbo and offering to buy Andiswa lunch when he finds her without, assures Andiswa that she has support in an environment where she feels embarrassed and ashamed. Similarly, when Andiswa returned to school after the birth, another teacher, Mr Thima, paid attention to her and included her in field visits and educational excursions, renewing her hope that she might potentially pursue tertiary studies to become a lawyer.

Andiswa's experience illustrates a functional, supportive kinship network within Alexandra that offers her material, emotional, informational and caregiving support, allowing her to manage the demands of motherhood and schooling. The combined effect of a strong kinship network, a school environment that offers practical support (extra classes), individual teachers who demonstrate care, and a committed boyfriend provide her with a strong network of support. Although her relationship with both teachers are transient, their acts of care and

encouragement sustain Andiswa's commitment to her educational aspirations, and have provided her with resilience after an event that some experience, and is always represented, as irreconcilable with future aspiration.

Ayanda: Dispersed kinship networks across the city and provinces

Ayanda was 19 years old, and her baby daughter, Lumile, one year old, when we first met. By age 10, both Ayanda's parents had died and she lives with her grandmother, Faith (62), her maternal aunt and her aunt's two sons, aged 14 and 12. Their household of six, in a single room in Alexandra, is primarily supported financially by Faith, who earns a salary of ZAR7 000 per month (US$483): this is higher than average for someone living in a South African township (Statistics South Africa, 2017c, p. 17). Ayanda's maternal aunt has part-time employment, providing the household with intermittent material support. Lumile's father has not acknowledged paternity and does not provide any support to Ayanda or Lumile.

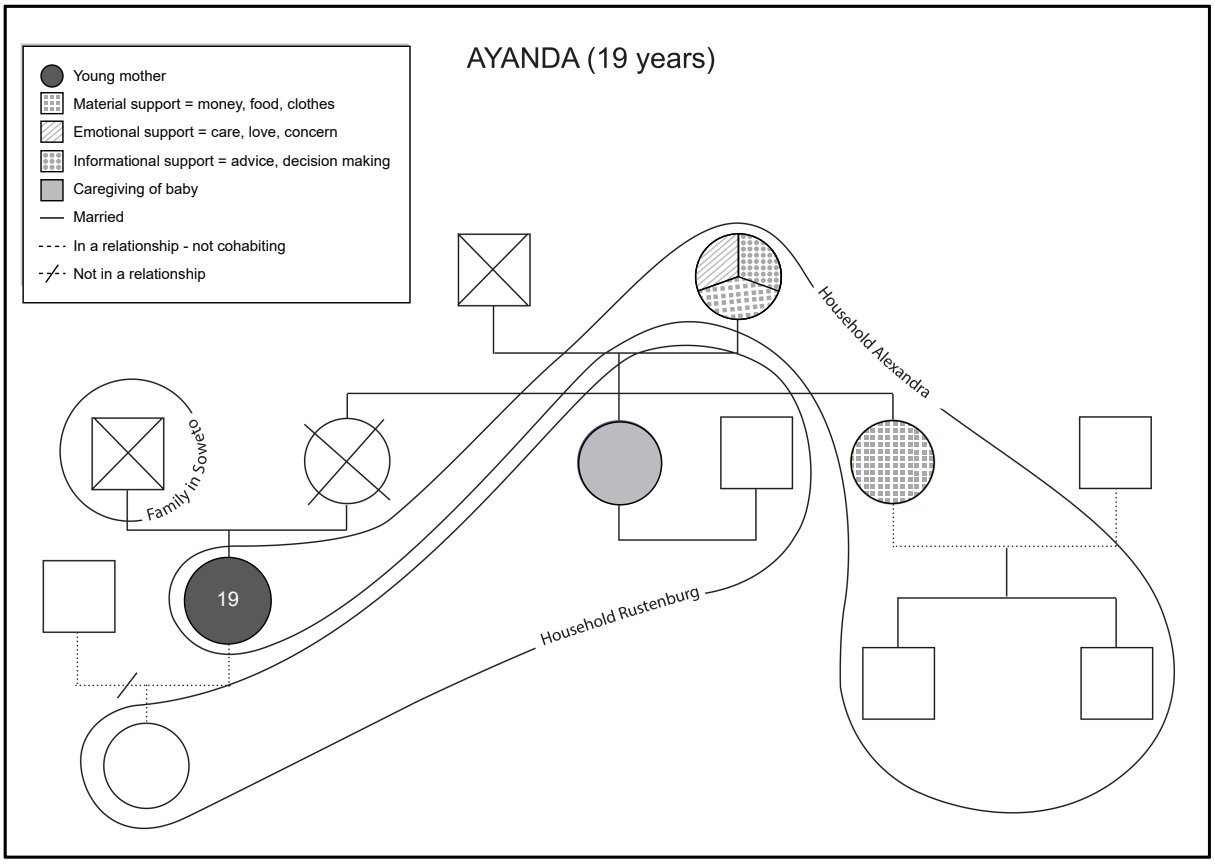


Figure 6. 2: Kinship network map of Ayanda (19 years old)

When Lumile was one year old, Ayanda, together with her grandmother and aunts, made a decision that Lumile should live with Ayanda's maternal aunt in Rustenburg, a town 160

kilometres from Johannesburg in North West Province (Figure 6.2). The aunt is married, has no children, is unemployed and supported financially by her husband. The family in Alexandra were struggling with income generation, and caregiving and space for three children, and it therefore made sense that the aunt "steps in" as caregiver to Lumile. Ayanda wanted to work and become financially independent, and so Lumile's fostering was a practical solution to changing circumstances, reproducing a practice of informal child fostering well established in South Africa (Richter and Morrell, 2006, p. 197; Reynolds, 2016). Shortly after Lumile relocated with the aunt to Rustenberg, Ayanda began work as an intern in a marketing company, and was working towards a promotion to area manager. Ayanda and Lumile's care arrangements reflect variations in family and kinship networks that are created and recreated in response to the changing needs for emotional, material and financial support.

The constant movement of members of Ayanda's kinship network reflects the patterns of many domestic migrants living in urban Johannesburg, illustrating the need for families to respond creatively and pragmatically to disruption and unanticipated life events. Ayanda had initially lived with her parents. When her mother died, she lived with her father's family in Soweto (an urban township approximately 57km away from Alexandra), and after her father's death, she continued to live with her paternal grandmother. When she died, Ayanda moved to Alexandra to live with her maternal grandmother, Faith. Aged 19, Ayanda's life is marked by movement and adaptation. Reflecting on her separation from Lumile, Ayanda is confident that their bond is strong, and is happy that Lumile is thriving in Rustenberg. The kinship network ensures that the young mother and her baby have constant interaction through regular visits between Rustenburg and Johannesburg.

> Ai, that one [Lumile], she'll never forget me, there is no way. Because when they came [to visit] she could see I know this person [Ayanda], she was busy staring at me and then the next thing she wanted me to carry her and then, from there, I couldn't go out without going with her... and she wouldn't sleep if I'm not sleeping [with her] at night, we have to switch off the lights and she makes sure that I'm right next to her.

Connie: Dispersed kinship networks across urban and national borders

Connie was 20 years old, and her baby Jeffrey 10 weeks old, when we first met. Connie and her boyfriend, Miracle, are both cross border migrants from Zimbabwe, living together in Alexandra. Although the pregnancy was unplanned, the couple were excited about the baby. Their relationship is serious and Miracle is saving for payment of *ilobola* (bridewealth) to

Connie's family. Their relationship is deeply patriarchal, and there are times when Connie alludes to Miracles temper and her fear of this. Miracle makes the decisions and Connie complies; Connie does not work because Miracle believes she should remain at home and care for their baby. Connie has not completed her matriculation and has no desire for further education, but she would like to work when Jeffrey is a little older. Miracle has a good job, and is a responsible father and provider, earning a steady ZAR5 500 (US $379) a month, increasing up to ZAR7 000 (US $483) with overtime work. As the sole caregiver of Jeffrey, with almost no social network in Alexandra and away from her family in Zimbabwe, Connie is lonely.

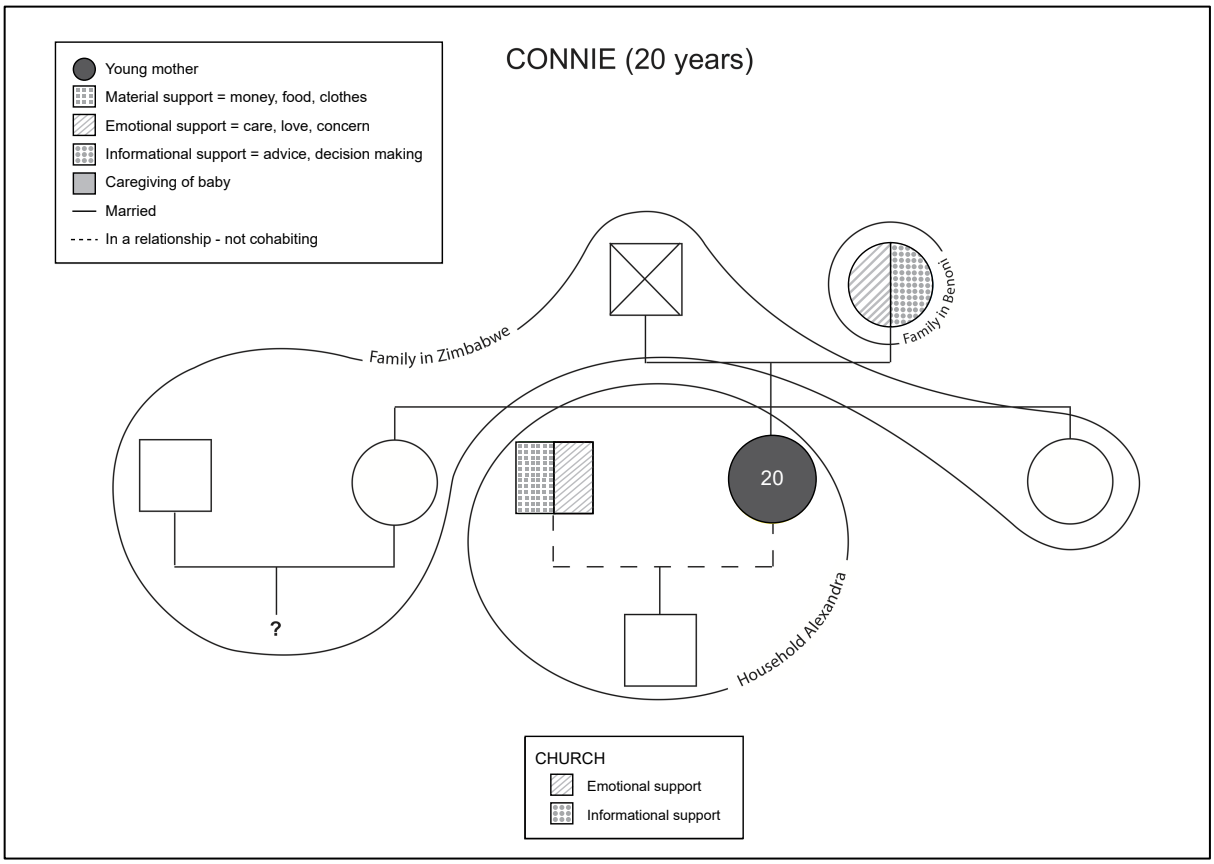


Figure 6. 3: Kinship network map of Connie (20 years old)

As reflected in Figure 6.3, Connie and Miracle have a large kinship network spread between Johannesburg and Bulawayo, Zimbabwe. However, this provides them with little opportunity for day-to-day support, because of distance (approximately 847km between Bulawayo and Alexandra and a 15 hour bus trip at a cost of ZAR350/trip [US$24] during non-peak and ZAR800/trip [US$55] during peak season), and the costs and difficulties associated with travel. Connie previously lived with her mother and aunt in Benoni, an urban area

approximately 40km away from Alexandra; she had relocated to Alexandra to live with Miracle during her pregnancy. Connie's mother cared for her for three weeks post-partum, but the distance between their homes inhibits regular caregiving and limits Connie's access to the care and companionship of her mother. The remainder of Connie's family is in Zimbabwe, and the distance inhibits regular access, contact and support. In addition, Miracle is deeply distrustful and cautious. He does not like Connie to associate with non-family residents in Alexandra, reflecting the fear of xenophobia experienced by cross border migrants.

Without support from her kinship network, Connie and Miracle seek social connection through membership to an African-based apostolic church with a strong following in Zimbabwe and South Africa. Connie seeks friendship, companionship and belonging in this church. Often the young family spend their entire weekend at church gatherings. The women of the church maintain a WhatsApp group, and hold weekly Sunday meetings where they support and counsel each other. While the Church offers spiritual support, the informal network it generates is the prime source of support for Connie.

> Last week I told them [women on the WhatsApp group] that I don't know what's going on with my family. You know, I'm still young and it scares me these things so I don't know what can I do. So they said "we can't come, but we can help you with prayers and the stuff like that"…And then if there is someone who has airtime, then he [she] will call me to confirm that situation for the moment [the situation I am experiencing].

Kinship networks and kinship capital

In South Africa, kinship networks have a well-established practice of malleability, providing care and support for children born out of marriage, especially when the mother is young and still in school (Madhavan, 2010; Mkhwanazi and Block, 2016). Over time, this practice has increasingly expanded to include paternal kin (Mkhwanazi and Bhana, 2017; Mkhwanazi and Block, 2016). Kinship networks produce a form of social capital that is family based, providing families with practical support and advice in times of unanticipated disruptions, including an unplanned pregnancy. Kinship capital, present as multiple resources within the family, and harnessed at different moments of disruption, allows for resilience when circumstances change. Kinship capital is not constant, nor is it always available, perhaps especially in urban settings where employment is limited and so economic security is fragile. The availability of kinship capital requires that families recalibrate at different points in time depending on family members' individual capacities, need and circumstances. In the cases

presented above, kinship capital emerges in varying degrees at different times to support young mothers. Their experiences illustrates the fluidity and variability of kinship capital across contexts, but also its robustness when rules like trust and norms are transgressed (Coleman, 1988; Cattell, 2001), as in the case of early, unplanned, ex-nuptial childbearing.

Kinship capital provides for multiple forms of caregiving, allowing for elasticity in normative caregiving practices, and creating new positionalities (Boehm et al 2011, p. 12). The data from the wider sample and cases confirm this, and illustrate that care for children as a form of kinship capital is overwhelmingly gendered but not fixed: the role shifts and reconfigures across networks as and when needed, with grandmothers, sisters, aunts, and other women providing support. This is clear for Andiswa and Ayanda, where caregiving is fluid, pragmatic and dynamic, and more communal than individual. However, the cases also reflect the involvement of fathers and their families in the creation of kinship capital, illustrating the variability in the role fathers play and challenging assumptions about absent fathers (Richter and Morrell, 2006; Madhavan et al., 2014b; Mkhwanazi and Block, 2016; Mkhwanazi and Bhana, 2017). This is further supported by the larger sample data, where 20 out of 30 fathers were providing material and other forms of support to their babies.

Kinship capital is not geographically fixed; it operates outside single households and extends over distance and borders. Kinship capital coheres and disaggregates care across borders, including suburbs and settlements within the city, and provincial and national boundaries. Distance and borders both restrict and promote the creation of kinship capital. As noted above, economic migration to Johannesburg has a long history, and still both long and shorter term migration are common (Madhavan and Landau, 2011). Migration shapes family structure for many participants in this study, and even for long-term residents in Alexandra, there is always some articulation with other provinces. For example, Andiswa's boyfriend was an economic migrant, and his kinship network in KwaZulu Natal provided baby Sbo with extended kinship capital; the paternal kinship network is a reserve on which this young family could draw.

Ayanda's baby, in contrast, was absorbed by the kinship network and cared for by her maternal aunt, who travelled with the baby regularly across provincial borders between Johannesburg and Rustenburg. Thus baby Lumile is able to continue to have contact with her mother and wider kinship network, facilitating her access to kinship capital across borders at different points in time. In contrast, the weaker kinship capital available in Alexandra for

Connie highlights the harsh realities of cross-border migration, and particularly the social isolation that makes Connie vulnerable in relation to her partner. However, an extensive kinship network in Zimbabwe is available and in reserve for herself and baby Jeffrey.

Decision-making and agency are enacted in complex ways within kinship and other social networks, illustrating how contexts and domains fundamentally shape the exercise of agency (Giddens, 1984). Agency, operationalised here as decision-making, is complicated by practical every day considerations that may be navigated with the help of family and others, including the availability of caregivers within local kinship networks, household space, financial support from the father of the baby, and intentions to complete school or seek employment. These all involve negotiations with family around the pragmatics of care of an unplanned baby. Structural considerations include economic pressures, employment opportunities, local infrastructure and resources like availability of crèches and access to social welfare. These factors directly impact on the practical and affect the decisions that are made around care for the baby and future plans for young mothers. They are also factors that young women and others must work around; they have little power to directly influence them. Thus, agency and structure are constantly being mediated (Giddens, 1984).

The exercise of agency by young mothers is not in making a decision as an autonomous act, or through complex processes of conversation and negotiation with their kin. Rather, it is the way that young mothers draw on the support accessible in their networks to help them realize their aspirations. These cases illustrate that young mothers enact agency in varying degrees with the support of family and others. Andiswa is able to continue school with the combined support of her mother (caregiving), teachers (information, emotional) and boyfriend (material, emotional), thereby achieving agency with respect to her educational aspirations. Ayanda is supported by a multigenerational family to facilitate her aspiration around income generation. In both cases, structural limitations like availability of crèches, unemployment and poverty, are mitigated by kinship capital and other support. In both cases, the young mothers opt for their babies to be cared for by kin rather than crèches in Alexandra, citing overcrowding and low levels of care as reasons for this. Both Andiswa and Ayanda's experience show that there is no simple dichotomy of having agency or not, but instead there is a tenuous state of flux, with constant articulation between the practical and structural factors that influence their capacity to make choices. Kinship capital and other support provided within networks facilitate connectedness and reciprocity. These are protective and allow for this articulation.

Connie's circumstances as a young mother illustrates that where kinship capital is weaker, because of distance and limited sources of support in the network, agency may be reduced and vulnerability higher. Connie's position as a cross border migrant, and geographical distance from her home to that of her mother, limits her access to kinship capital for care and support, rendering her potentially more vulnerable in her relationship with a dominant partner. Although Connie has settled into nuclear family life with her boyfriend and baby, she is more vulnerable than Andiswa and Ayanda. Yet the "strength of weak ties" (Granovetter, 1973, 2005), those that she has in the Church women's group, facilitates Connie feeling supported; the women's' group's presence and their promises to help, sustain her, endorsing Madhavan and Landau's (2011, p. 486) observation of the role of Pentecostal churches in urban cities providing social support to cross border migrants.

Conclusion

This article adds to an emergent discourse on the role of kinship networks in mediating and mitigating the negative consequences of early, unintended pregnancy. At this 'vital conjuncture' in the lives of young women, where their potential future is determined, kinship networks play an important role in supporting young mothers navigate the world of early childbearing. Networks facilitate or limit the decisions a young mother makes in relation to her own future; education, employment and caregiving. Thus, kinship, as a structure, influences the capacity of young mothers to exercise agency. The cases in this article illustrate that kinship capital and social networks are facilitative of young mothers' agency in varying degrees. However, this is not always the case, and it is important to bear in mind that they can also be restrictive of young women's agency.

Location makes a difference to the functioning of kinship networks and the support that they are able to offer. In poorly resourced, migrant urban cities, kinship capital is not always easily accessible for child care and other kinds of support that young mothers may need. However, in these contexts, kinship networks reconfigure and adjust in multiple ways to absorb shifts in circumstances to provide care for the young mother and her baby. The cases show that young mothers draw on kinship capital first, and in its absence draw on other weaker forms of social capital. Early unintended, ex-nuptial motherhood requires adjustment of aspiration, and young mothers exercise agency in multiple ways within and outside their kinship networks to achieve this. The data highlight that kinship networks are neither neutral or static, nor are they necessarily enduring; they change and adapt as circumstances dictate. There is no single story

or representation in them, and each case reflects a moment in time, under circumstances that are fluid and fragile.

Endnotes

This study was conducted for a PhD in the School of Public Health, University of the Witwatersrand, Johannesburg, South Africa. Ethics clearance was received from the University of the Witwatersrand Human Research Ethics Committee (Medical; M160535). Permission for the study was granted by the Johannesburg Health District Research Committee. The study is registered on the South African National Health Research Database.

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CHAPTER 7: PATHWAYS TO SCHOOL COMPLETION

PAPER THREE

Pillay, N., 2018. Pathways to school completion: Are we winning the fight? *South African Journal of Child Health* 12 (2 Suppl 1):S15-S18. DOI:10.7196/SAJCH.2018.v12i2.1530

Introduction

This paper addressed the following objectives of the study:

Objective 1 - To explore the lives of young mothers in the 12 month period after the birth of the baby.

Objective 2 - To describe and analyse how and why young mothers make decisions around the care and wellbeing of the baby.

Objective 3 - To describe and analyse how childbearing impacts on a young women's plans for herself in relation to her future.

An enduring theme in the discourse of early motherhood is the disadvantage that compromised education confers to young mothers and their babies. In South Africa, unlike other sub-Saharan African and other international contexts, early motherhood and schooling is not incompatible. However, understanding the barriers and enablers of school continuation and completion is important to mitigate the consequences of early motherhood, and give expression to legislation and policy. This paper on education examines the pathways to school completion for young women who have an unintended, ex-nuptial pregnancy. I address Objectives 1, 2 and 3 of this study as education and school completion were uppermost in the minds of twenty-four young mothers in school when they conceived. Their concerns about the future were largely nested in education and post-education aspirations. In this article, I present the pathways to school completion and continuation for these young mothers, expanding on the sequence of events from learning of the pregnancy, disclosing the pregnancy and decision-making with regard to schooling at this vital conjuncture. I also explore the future plans of the six young mothers who were not in school, and the barriers and enablers in achieving these.

I add to the existing literature on the value of financial support and childcare on school continuation for pregnant and parenting women, illustrating that in an urban area in Johannesburg, South Africa, the combination of the child support grant *and* availability of paid care through community caregivers and créches, facilitates school attendance. This was

particularly so in this urban area where other forms of kinship care were not always available. The data that I analyse further confirm the role school policy and/or support from teachers at schools play in decision-making around school continuation. I highlight the distressing reality that schools continue to exclude young pregnant and parenting women from school attendance, indicating the need for more extensive monitoring of school compliance with national policy and legislation if South Africa's development goals are to be met.

This special issue of the *South African Journal of Child Health* had a limit of 3 000 words and 25 references. The discussion on education and early motherhood is therefore expanded in Chapter 9.

The format and referencing style has been amended to comply with this thesis. Figures and Table numbers have been amended for continuity, and differ from the journal format. The paper was submitted in December 2017 and accepted in February 2018: monetary amounts are therefore accurate for that time.

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Pathways to school completion for young mothers: Are we winning the fight?

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Background. Policy initiatives in South Africa are directed at promoting the educational and developmental outcomes of girls and young women (age 15 - 24 years). These include decreasing the incidence of HIV infection, teenage pregnancy and gender-based violence, and increasing school attendance and economic empowerment. This article explores the contexts of pregnancy, motherhood and schooling in a sample of young mothers in an urban area in Johannesburg, South Africa.
Methods. This ethnographic study, based in a poor urban area in Johannesburg, South Africa, recruited 30 young mothers aged 18 - 20 years with whom open-ended interviews were conducted. Each mother was contacted 3 months after the first interview, and again 3 months later. In addition to the first round of 30 interviews, 9 young mothers were interviewed in the second round, and 6 young mothers in a third round. A total of 45 interviews were conducted.
Results. The findings illustrate how young mothers mediate constraints and challenges to continue and complete their schooling when confronted with a mistimed and unintended pregnancy. A combination of factors converge to facilitate or impede school continuation and completion. Key barriers include school policy and discrimination against pregnant learners, limited options for childcare, and high levels of poverty and unemployment that strain existing scarce family resources.
Conclusions. The pathway to school completion is complex and non-linear. Three particular interventions that support school attendance and completion for young mothers have value: the child support grant, the availability of crèches in the community, and a school policy that upholds the principle of inclusivity for pregnant learners and young mothers.

S Afr J Child Health 2018;12(2 Suppl 1):S15-S18. DOI:10.7196/SAJCH.2018.v12i2.1530

The National Development Plan (NDP) 2030, South Africa's blueprint for socioeconomic growth and achieving the country's Sustainable Development Goals (SDGs), identifies education as one of 14 priority goals.[1] In elaborating on this aim, current policy aims to promote the educational and developmental outcomes of girls and young women by decreasing the incidence HIV, teenage pregnancy and gender-based violence, and increasing school attendance and economic empowerment.[2,3] The present article explores pregnancy, motherhood and schooling in a sample of young mothers (aged 18 - 20 years) in a resource-poor urban area in Johannesburg, South Africa. Understandings of the barriers to school continuation, completion and further education are contextualised, and attention is given to the factors that facilitate school completion for young mothers.

There is a paucity of recent age-disaggregated data on teenage pregnancy. Census 2001 reported that 1% of girls aged 14 years had given birth to at least 1 child; increasing to 2.8% at age 15; 6.5% at 16; 13.1% at 17; 21.9% at 18; and 30.5% at age 19.[4] Birth rates increase significantly among older teenagers, many of whom are in their final year of school or have just started post-secondary education.[5-7] The focus of this study was therefore on mothers aged 18 to 20.

The reasons for and consequences of teenage pregnancy, particularly as it relates to educational outcomes, are well understood.[8-10] Barriers to school completion for young mothers are exacerbated by higher levels of grade repetition and dropping out, and lower levels of school completion.[11,12] The dominant discourse around early motherhood is pejorative, with messages of shame and blame and experiences of discrimination.[13-15] Nevertheless, pregnancy and schooling co-exist in South Africa more than in other countries with high teenage pregnancy rates.[16,17] Progressive policy and legislation such as the South African Schools Act No. 84 of 1996[18] endorses the rights of pregnant learners to continue with formal education.

Madhavan and Thomas[16] argue that the main factors that determine whether young mothers complete their schooling are availability of financial support and childcare. These factors include childcare facilities, social welfare and removal of the stigma associated with early motherhood.[9,16] Less clear is the sequencing of events and causal relationships between poor performance, pregnancy, school withdrawal, low further education enrolment and limited capacity to access available employment opportunities.[17] The present article aims to shed light on the sequence of events from conception to school attendance and completion in a sample of young mothers in Johannesburg, South Africa.

Methods

This ethnographic study, based in a resource-poor urban area in Johannesburg, was conducted as a doctoral research project. Ethics clearance was received from the University of the Witwatersrand Human Research Ethics Committee (Medical; M160535). Permission for the study was granted by the Johannesburg Health District Research Committee and is registered on the South African National Health Research Database.

Between September 2016 and September 2017, 30 young mothers (18 - 20 years), recruited through a local community health centre, participated in open-ended interviews of approximately 30 - 60 minutes. In the course of the year, contact with the participants was maintained via WhatsApp and SMS, with the aim of interviewing them 2 - 3 times. In total, 45 interviews were conducted, including an initial interview with 30 young mothers, a second interview with 9, and a third interview with 6 (total interviews 45). Respondents received ZAR40 at each interview to contribute to cellphone costs in order to keep in contact with the researcher.

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An in-depth, open-ended interview guide was used to elicit narratives to explore three main areas of inquiry: pregnancy and birth; education and continuing education; and support networks. The approach drew on the meanings that young mothers gave to their reality, emphasising their direct experience, as is common in ethnographic research (Bernard, 2006). The length and pace of each interview was determined by the young mother, and the ease with which she was able to participate in the interview while caring for her baby. Interviews were conducted in English; the mothers were offered a translator but in all instances refused.

Data collection and data analysis were conducted simultaneously and iteratively. All interviews were transcribed verbatim. Thematic analysis was conducted using MaxQDA, through line-by-line coding to ensure a comprehensive review of the data, and then to identify primary themes and subthemes. Excel was used for simple statistical analysis to show trends in the thematic data.

Results

Ethnographic fieldwork does not aim to quantify data, and this study does not claim to be representative nationally or provincially. However, the data provide some opportunities for simple quantitative analysis. The results show trends in the data, complemented by young mothers' narratives of why and how school completion was facilitated and challenged. The quantitative results are based on data from the first interview, and information gained during subsequent interviews was not included. The term 'young mother' instead of 'teenage mother' is used in the results as an inclusive term for all mothers between 18 and 20 years of age. The age of the mother in parentheses is the age at first interview. Pseudonyms have been used for all mothers quoted in the article to ensure anonymity. In the sample, 18 mothers were in a relationship with the father of the baby at the time of first interview, and 19 mothers were receiving the state child support grant. Table 7.1 summarises the findings from this study in terms of school completion, school withdrawal and matriculation.

Table 7. 1: Summary of school-related data at pregnancy

Variables	**Age**						
	15	**16**	**17**	**18**	**19**	**20**	**Total**
School completed	0	0	0	1	3	2	6
In school	2	2	5	9	4	2	24
Remained at school during pregnancy and after	0	1	5	6	2	0	13
Withdrew from school during pregnancy	2	1	1	3	2	2	11
Returned to school after pregnancy and birth	1	1	1	2	1	0	6
Did not return to school	1	0	0	1	1	2	5

The results indicate that the pathways to school completion for mothers who were in school at the time of pregnancy are complex, and that numerous factors influence the trajectory to school completion or dropping out.

Remaining at school

Various factors converge to facilitate young mothers remaining at school during pregnancy and after the birth. Reactions to their pregnancies ranged across schools from support for the young mother, not acknowledging the pregnancy and simply treating her like any other learner, to attempts to dismiss her from school because of the pregnancy. Support included advice, encouragement and kindness from teachers. Andiswa (18) related the following act of kindness from teachers:

> Sometime if I don't have lunch then they [teacher] will buy me lunch. "How is the baby," asking, and I will say "Ja, he is doing Ok." "Ok, I will come and see the baby when I've got time," he said.

At the other end of the spectrum, Sesi (19), who was in her matriculation year in 2015 when she conceived, was asked by the school principal to leave school when her pregnancy was made known. Her mother, Queen, would not accept this, and advocated for Sesi's right to remain at school. When the school principal argued that they did not want to be responsible for the health of pregnant learners, Queen arranged for her sister, Sesi's aunt, to accompany Sesi to school daily for the duration of the pregnancy. Nine out of 13 young mothers who continued their education attended schools in the study setting where pregnancy did not affect their access.

Childcare is critical for young mothers who remain at school. For many mothers, the child support grant enabled them to pay for caregiving. Linda (18), for example, said that she used RZAR300 for crèche for her child, and the remaining amount to buy things for her child. However, some young mothers did not trust crèches, because of the limited number of trained staff to care for large numbers of babies, and they opted instead to find paid caregivers. For example, Kheti (18) usually lived with her sister, but she had no experience with infants. After giving birth, Kheti stayed with and received care from the infant's paternal grandmother for two months; the grandmother provided financial and personal support, including paying for a caregiver when Kheti returned to school.

Many participants who remained at school said that they felt under pressure to complete schooling so as not to disappoint their parents and waste their parent's investment in their education. However, despite remaining at school, young mothers achieved different levels of school completion, with only 6 of the 13 mothers in school at the time of conception completing their matriculation year.

Temporarily withdrawing from school

Young mothers who temporarily withdrew from school, but returned after the birth, cited school policy as the primary reason for the temporary break; this was closely linked with personal shame and embarrassment in attending school while pregnant. On the other hand, some young mothers came to Johannesburg to pursue their education after they had experienced discrimination at schools elsewhere in the country. Dzuvha (20) left Limpopo Province because the school in Venda "did not want anyone who was pregnant." Once the baby was born, Dzuvha moved to Johannesburg to join her mother and continue her schooling.

In some instances, young mothers anticipated a negative reaction from school, and dropped out temporarily to avoid possible embarrassment and shame. For example, Boitumelo (18) left school assuming she would be excluded, although she later realised this was unnecessary:

> They [school] were like, why did you not come back [to school], do you attend [school] elsewhere? I was like, no, I have a child. Then they were like, on January we need you here, this school is empty without you, and that gave me the confidence of saying, oh I must go back to school.

Negotiating a new role as a pregnant learner is onerous, and some young mothers temporarily take a break because they cannot cope with caring for their infant and studying. In these instances, the decision was made by the young mother, and school, family and peers had little influence. In other instances, decisions around temporary withdrawal were made by other family members because of their concern for the health and wellbeing of the young mother. Lerato (19) described her grandmother's concern:

> My granny didn't want me to go to school because she thinks that, she thought like, I will get sick at school you know. Because sometimes at school I was getting dizzy, not feeling well and so she told me to stop going to school because she doesn't know what will happen to me…

Although Lerato was unhappy with this absence, she felt unable to assert herself as she was dependent on her grandmother and felt she had already burdened her by falling pregnant.

Permanent withdrawal from school

School policy, the inability to manage the dual roles of mother and learner, and insufficient support to care for the baby resulted in permanent withdrawal from school for 5 young mothers. Two of these left school when their schools enforced a non-admission policy for pregnant learners. A school principal (in Eastern Cape) refused Fezeka's (20) admission, and shamed and abused her: "The principal just called me to the office and say, I must show her my stomach, then I did so then he [actually she] said to me you are pregnant..." Lindi's (20) school in another poor urban area in Johannesburg also made it clear that pregnant learners were not welcome. Her mother attempted to convince the principal to allow her daughter to continue, but the school administration remained steadfast. Lindi dropped out. Bontle (19) was taught by her mother to take responsibility for her "mistake," she was forced to discontinue her schooling as punishment:

> I couldn't go back [to school] because my mother said I should take care of the baby, no one's going to take care of my baby because it is a choice that I made and I wanted to have a baby while I was still schooling.

Betty (20) was completing Grade 11 when she became pregnant. The school did not ask her to leave, but she did so because she found it difficult to study while pregnant. Pule (18) had three children, and she had left school after her first pregnancy at age 14 because of the combined pressures of poverty, limited support for caregiving, and her subsequent pregnancies.

Further education and employment

Opportunities to pursue further education and employment are limited for young mothers who had their babies after school completion. In this study, 6 mothers had completed their schooling when they discovered they were pregnant. In all cases, the pregnancy led to a temporary pause in further education and employment. Two young mothers had passed their matriculation examinations with bachelor passes, which would have gained them university entrance. Ntokozo (19) was accepted into a nursing college and awarded a scholarship, but she was refused admission by the college because of pregnancy. In this instance, opportunity for further study was directly affected by the unintended and mistimed pregnancy. Two mothers had completed their secondary schooling in Zimbabwe, and remained at home with their babies. The remaining 2 mothers combined some level of further education and training, part-time employment, and infant care.

Discussion

The pathways to school completion are complex and non-linear, as described in the results and summarised in Figure 71. The qualitative nature of the study allowed in-depth exploration of the factors that support continued schooling, and both permanent and temporary school withdrawal, illustrating how personal experiences and circumstances of everyday life both support and disrupt dominant narratives of early motherhood.

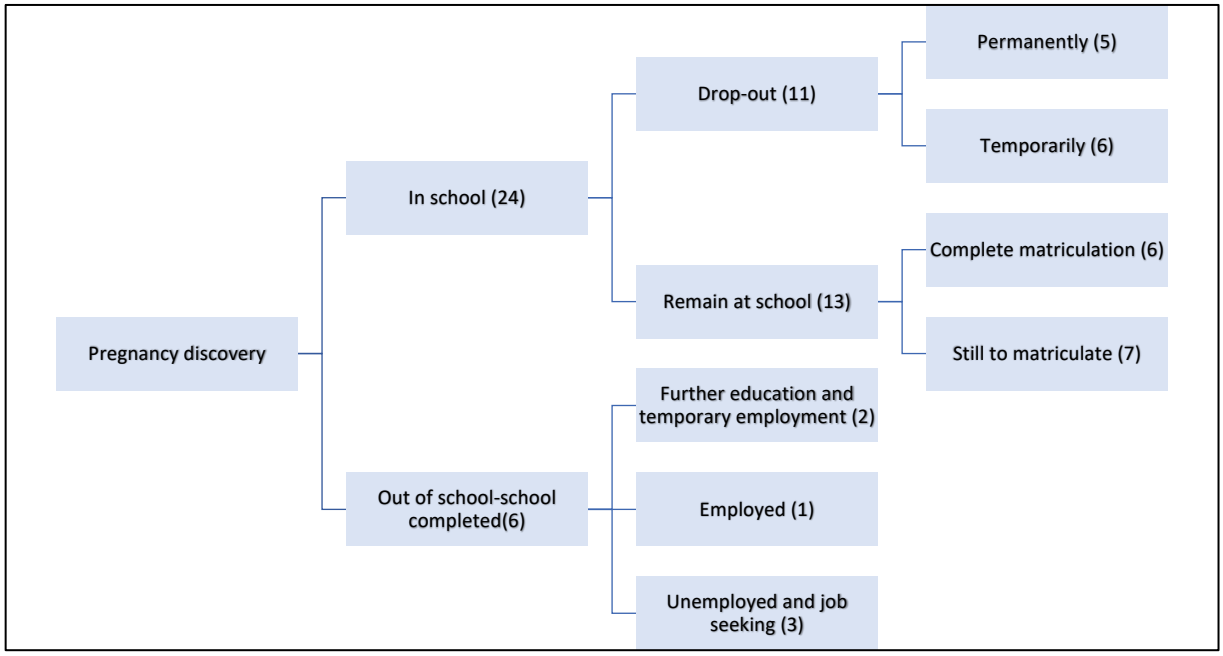


Figure 7. 1: Pathways to school completion after pregnancy

In this study, the permanent drop-out rate (5/24, 20.8%) for young mothers was much lower than the 33% attributed to teenage pregnancy and childbearing by the National Income Dynamic Study (De Lanoy et al., 2015). This finding supports Madhavan's and Thomas's claim that teenage pregnancy and schooling in South Africa are not mutually exclusive (Madhavan and Thomas, 2005). The results illustrate the importance of school policy in facilitating or impeding access to school for young mothers. More than 20 years after the Schools Act No. 84 of 1996 (Republic of South Africa, 2011), the policies of individual schools towards learner pregnancy continue to impede school completion for some young mothers, contravening both the law and the Constitution (Bhana and Mcambi, 2013; Mkhwanazi, 2012; Chigona and Chetty, 2007). While some young mothers who had been attending school in other provinces and elsewhere in Johannesburg were excluded when pregnant, this was not true for any young mother in the study setting, thus removing a significant obstacle to school completion in this community. However, young mothers may

"choose" to withdraw from school on a temporary basis to avoid shame, highlighting the complex interplay between the agency of the young mother to avoid embarrassment, and the power of the school in influencing her education decisions.

Women's agency to challenge the dominant pejorative discourse around young mothers, advocacy for their rights as pregnant learners, and care and support in complex circumstances, significantly facilitated school completion. The woman who challenged school policy exercised agency in advocating and creatively ensuring her daughter's right to be at school while pregnant. The grandmother who decided that her pregnant granddaughter should remain at home during the pregnancy exercised her agency and did what she believed would protect her grandchild from unnecessary danger and difficulty, so prioritising health and wellbeing over education. In this instance, the young pregnant woman had not been excluded by the school, and her temporary withdrawal related to perceptions of pregnancy health and wellbeing. The paternal grandmother who supported and cared for the young mother, illustrated her agency through her support, thereby fulfilling her family's and her sons' duty to mother and baby. Thus, the dominant idea of the absent and irresponsible father and his family is challenged (Richter and Morrell, 2006). These cases illustrate the agency exercised by primary caregivers, who were all women, to support young mothers, reflecting the pervasive gendered nature of care.

The availability of crèches and opportunities for paid caregivers in the community enhanced women's chances of school completion. The child support grant allows young mothers to exercise agency in relation to the independent care and support of their babies, thereby increasing their opportunity to attend school. This is important in resource-poor urban areas where primary caregivers of young mothers are the only employed members of households and so are unavailable for childcare. Use of the child support grant to pay for caregiving challenges the dominant idea of a perverse relationship between early childbearing and the grant – that the grant incentivises young motherhood, and is abused by young mothers for their social and personal needs (Mkhwanazi, 2012; Makiwane et al., 2016; Patel, 2012).

Decisions by young mothers to seek private caregivers for their babies where there are overcrowded local crèches, further illustrates agency in caregiving decisions, and again disrupts perceptions of the irresponsible young mother (Mkhwanazi, 2012). Aspiration for school completion and further education is high, but is tempered by challenges to matriculation completion, results, economic constraints, limited knowledge around further

education and training, and early motherhood. Although young mothers articulated clear educational aspirations, they knew little about entry requirements, application procedures, and the associated costs and funding opportunities for further education. This behaviour mirrors national data that only 6.2% of South Africans under 24 attend post-school educational institutions (Statistics South Africa, 2012).

Conclusion

The present study illustrates that the pathway to school completion is complex and non-linear for some young mothers, affecting their education outcomes. The findings illustrate lower drop-out rates for young mothers than the national average, but further research is required to explore variations nationally, across rural and urban areas, and their relationship to a progressive policy environment and targeted campaigns that focus on improving educational outcomes for girls and young women. It illustrates the value of three particular interventions that policy addresses at a societal level and that benefit young mothers. These are the child support grant, the availability of crèches in the community, and school policy that upholds the principle of inclusivity for pregnant learners and young mothers.

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CHAPTER 8: CONFLICT AND CARE

PAPER FOUR

Pillay, N., Manderson, L., Mkhwanazi, N. 2019. Conflict and care in sexual and reproductive health services for young mothers in urban South Africa. *Culture, Health and Sexuality*. DOI:10.1080/13691058.2019.1606282

Introduction

This paper addresses the following objectives of the study:

Objective 4 - To describe and analyse how and why young mothers make decisions around their sexual and reproductive health before and after the birth of the baby.

In addressing the study objectives, in this paper I explored decision-making around sexual and reproductive health from before conception to after the birth. Drawing on the narratives of young mothers and interviews with health care providers, I elaborate on the complexity inherent in receiving and providing care. The study context of the health centre provided an ideal space to explore this objective, providing me with the opportunity over the year for observation and relationship building with health care providers. This allowed me insight into the lived context of the health system to deliver appropriate, sensitive sexual and reproductive health care to young pregnant and parenting women. Termination of pregnancy was examined, drawing attention to the unmet need for termination services, as well as the continued barriers to accessing termination for young women in South Africa. The article highlights the complexity of care and conflict in health services from the position of young women and health care providers.

The format and referencing style has been amended to comply with this thesis. Figures and Table numbers have been amended for continuity, and differ from the journal format.



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Conflict and care in sexual and reproductive health services for young mothers in urban South Africa

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Abstract

In South Africa, sexual and reproductive health services aim to facilitate access to and utilisation of care to young people. We draw on narrative interviews with 45 young mothers, and six health care providers delivering sexual and reproductive health services at an urban health centre, to understand how young mothers experienced services in relation to ante- and post-natal care, including termination services. Although health care providers emphasised what they considered young women's 'ignorance' and 'irresponsibility' as central to early and unintended pregnancy; they also expressed their sympathy and concern. In a resource limited health care setting, with health system inefficiencies and lack of specialised training, there was little opportunity to deliver high quality care to young women. We draw attention to the need to prioritise the training of health care providers, to expand early pregnancy testing and termination services, and to deliver patient-centred family planning services to young women.
Keywords: early motherhood, termination of pregnancy, youth friendly services, South Africa.

Introduction

South Africa's National Strategic Plan for HIV, TB and other STIs 2017-2022 identifies adolescent girls and young women aged 15-24 as vulnerable because of high rates of HIV infection, teenage pregnancy and gender-based violence (South African National AIDS Council 2017a). In the light of international and South African evidence on the need for Adolescent and Youth Friendly Services to address these issues, we examine young women's and health care providers' experiences of sexual and reproductive health services. Drawing on the experiences of young mothers under 20 years of age in urban South Africa, we examine the relational aspects of health service delivery, paying attention to whether health care providers are sensitive to the needs of young pregnant and parenting women.

In this paper, we use the term 'young mothers' to refer to women under 20 years of age who have had an early, unintended, ex-nuptial (not married) birth. For clarity, we use the World Health Organization's (WHO) (2012) definition of 'adolescents' to refer to those in the age range 10-19 years, and the term 'adolescent girls and young women,' as used in current South African policy, to refer to those aged 15-24 years (South African National AIDS Council, 2017b, p. 4).

Sexual and reproductive health services lie at the intersection of health services and rights. Internationally, the delivery of accessible, acceptable, equitable, appropriate, and effective services is key to supporting young people realise their sexual and reproductive health and rights (World Health Organization, 2012, pp. 7–8). Improved access is dependent on addressing structural barriers, such as gender and age discrimination (Jewkes et al., 2009). Access to such services endorses young women's rights to make informed choices on fertility, termination and appropriate contraception, to have a safe and healthy pregnancy and birth, and a healthy and fulfilling sex life (African Union, 2013; Bearinger et al., 2007).

In South Africa, young women are disproportionately affected by unsafe and/or coercive sex associated with gender-based violence, and at times resulting in unintended pregnancy, STIs and HIV (South African National AIDS Council, 2017a). In 2016, 12.4% women aged 15-19 and 15.6% women aged 20-24 had ever given birth (Statistics South Africa, 2017a). HIV prevalence among young women is higher than for young men, increasing with age; for women aged 15-19 it is 5.8% and for men 4.7%, while for women aged 20-24 it is 15.6% and for men, 4.8% (Human Sciences Research Council, 2018). Intimate partner violence is estimated to be between 17% and 34%, and 35% of rape cases reported to the police in 2013

were young women aged 16-24 (South African National AIDS Council, 2017b). In the light of these figures, access to appropriate sexual and reproductive health services for young women is critical.

In response to international policy and the local context, the Government of South Africa has developed an adolescent and youth friendly essential service package aligned to the WHO tool, 'Making Health Services Adolescent Friendly' (2012b). The guidelines stipulate that service provision for adolescents include education; counselling; treatment; care and support in all areas of sexual and reproductive health, including sexuality, STIs, HIV and tuberculosis (TB); contraception; pregnancy-related services including termination; mental health services and voluntary medical male circumcision (Children HIV Africa (CHIVA) South Africa, n.d.; South African National AIDS Council, 2017a). In addition, South Africa has a strong rights-based, legal framework to contraception and fertility planning for children and youth. The Children's Act, 2005, guarantees the right of children to access contraception from age 12, without parental consent, with required medical advice and examination to assess whether any specific contraceptives should not be given to the child (Republic of South Africa, 2006, p. 94). Termination services are available to all young women under the age of 18, accompanied by advice to consult with 'parents, guardian, family members or friends.' However, termination cannot be denied if a woman resists this consultation (South African Government Gazette, 1996, p. 6).

Although the policy and legal environment is progressive, structural and social barriers such as unequal gender power relations, poverty and low levels of knowledge about services continue to limit service utilisation by young women (Tylee et al. 2007; Ambresin, Bennet and Patton 2013; Christofides et al. 2014; Krugu et al. 2017). Sexual and reproductive health services for adolescents are constrained by the lack of dedicated Adolescent and Youth Friendly Services, human resource shortages, inadequate staff training, and health care providers' attitudes (Wood and Jewkes 2006; Alli, Maharaj and Vawda 2013; Willan 2013; Miller et al. 2017). These factors draw on broader social and political discourses that stigmatise young people's sexuality (Wood and Jewkes, 2006; Department of Health South Africa, 2012, p. 18). Quality care is also inhibited by a history of patient-nurse conflict in the public health system, including obstetric violence – verbal abuse, poor rapport, discrimination, physical abuse, failure to meet professional standards of care and health system conditions (Jewkes, Abrahams and Mvo 1998; Jewkes and Penn-Kekana 2015; Castro and Savage 2019).

Barriers to services are often amplified for girls and young women (Jewkes, Abrahams and Mvo 1998; Chadwick 2016). The provision of contraception and termination is particularly influenced by moral beliefs of health providers, and young women are subject to judgemental attitudes, and incorrect and inadequate information. Nurses' attitudes are an established barrier to young women seeking contraceptive advice, particularly where nurses ignore the rights and agency of young women to make choices. Nurses routinely dispense injectables or implants as the most reliable method, on the basis of their preconceptions of what is best for young people (Wood and Jewkes 2006; Holt et al. 2012; Alli, Maharaj and Vawda 2013; Willan 2013). Assumptions about risky behaviour are rooted in dominant framings of adolescence (Macleod 2009, 2011), and compromise the delivery of patient-centred approaches to contraception provision (Brown, 2015, p. 314).

Barriers to safe termination within health services include inadequate numbers of facilities providing termination, and nurses' attitudes which obstruct access (Macleod 2011; Willan 2013). Drawing on their Constitutional rights, health care providers are allowed to conscientiously object to termination (McQuoid-Mason, 2010), but they are not allowed to prevent or obstruct access to termination; if found guilty, they may be liable to a fine or imprisonment for up to 10 years (South African Government Gazette, 1996, p. 8). Young women are often unaware of their rights regarding termination in the first trimester, explaining their resort to illegal and unsafe abortions (Mkhwanazi, 2014). Women's experiences contribute to community narratives that discourage the use of sexual and reproductive health services. In this article, we explore how services were experienced by 30 young mothers, and how health care providers influenced their experience, drawing on their perceptions of young pregnant and parenting women.

Study setting

The study on which we draw was conducted in a township in Johannesburg, South Africa. The term 'township' is used to describe historically black African areas, established to accommodate labourers employed in urban Johannesburg under Apartheid. Almost 25 years after the first democratic elections, most townships, including the study site, still experience uneven development, concentrated poverty, high levels of unemployment, inadequate housing and poor service delivery.

The township has five health facilities serving an estimated population of around 200,000. There are no hospitals, and of the five facilities, four are primary health care centres and one a community health centre. The community health centre offers 24-hour service and provides full antenatal and postnatal care, with a midwifery and obstetric unit, family planning, paediatric and immunisation services. The primary health care centres offer a smaller package of services during daytime and have no midwifery and obstetric services. Some community health centres offer termination services, but at this centre, women were referred elsewhere. This centre was characterised by large numbers of patients, long queues, limited space for private consultation and poor environmental health; during fieldwork, there was a visible chronic rat infestation.

Methods

The findings reported on here derive from a larger ethnographic study conducted by the first author on agency and decision-making of young mothers after an unintended, ex-nuptial birth. Fieldwork was conducted between September 2016 and September 2017 at the community health centre, following ethics approval by the University of the Witwatersrand Human Research Ethics Committee.

Young mothers aged 18 to 20 were recruited from the immunisation unit of the community health centre, to which they had brought their babies for check-ups and immunisation. Young mothers were purposively sampled, with ten recruited each from ages 18, 19 and 20 (n=30) to ensure maximum variability. Over the year, thirty women were interviewed once, nine twice, and six three times (n=45). All young women and health care providers were black African. In contrast, the first author was an older, Indian, middle class South African woman, leading to concern initially that young women might be uncomfortable discussing with her their private lives, sexual relationships and family planning needs. Attempts to overcome this included the first author highlighting her position as researcher (objectivity, trust), and woman and mother (elements of shared identity). Her interactions with the babies also perhaps contributed to levels of trust and comfortableness. Women reported positive experiences of the interviews, arguably for these reasons and because she was interested in their stories; many interviewees had never discussed their experiences before. Themes explored in interviews with young mothers included decision-making around termination and other sexual and reproductive health services, and factors influencing access to and experiences of care.

Six health care providers who delivered sexual and reproductive health services, including two community health workers, one auxiliary nurse and three professional nurses, were also interviewed. Not all health care providers were trained nurses, but hereafter we refer to them as 'nurses', reflecting that at health centres, little distinction is made between nurses and health care providers not formally trained as nurses. Nurses worked on a rotational basis, moving between units to accommodate patient numbers. No nurses interviewed had received specialised training in Adolescent and Youth Friendly Services. However, all nurses had received some training in maternal and child health, and family planning, and all had been advised of plans for sexual and reproductive health training, with no identified timeframe.

In establishing whether sexual and reproductive health services were sensitive to the needs of young mothers, we explored training, experience and challenges of service delivery, and nurses' perceptions of the lived experiences of these young women. Over the year, the first author developed personal relationships with nurses, enabling extensive probing during formal interviews of their personal life stories and how this influenced their roles as providers.

Young mothers and nurses were offered translation for the dominant local language (isiZulu). All declined and interviews were conducted in English by the first author. All interviews were audio-recorded, then transcribed verbatim by a professional transcription service. All transcripts were reviewed for accuracy while listening to audio-recorded interviews. The data presented below derive from transcripts, participant observation, and field notes. Data collection and data analysis were conducted simultaneously and iteratively. Transcripts were imported into MaxQDA for thematic analysis, allowing for the efficient identification of a priori and emergent themes, through constant comparison during fieldwork and subsequently. Coding was iterative and on-going as new areas of inquiry emerged from the data, with merging themes identified, noted and discussed by all authors. At the conclusion of data collection, codes were finalised after comprehensive review and discussion with all authors. Pseudonyms and age at first interview are used to identify young women and nurses. Where relevant, we add the young mother's age at pregnancy discovery.

Findings

In the following, we explore the narratives of young mothers and nurses. In presenting the voices of those who receive and those who provide care, we seek to go beyond the existing

discourse of judgemental provider versus reluctant user (Wood and Jewkes, 2006; Willan, 2013). We attempt to reflect the complex positions of both, drawing on how personal narratives intersect with health care system challenges and contextual discourses.

Health service delivery to young pregnant and parenting women

Termination

For almost all young women (28 of 30), the pregnancy was unintended and pregnancy discovery was met with fear and disappointment. Twelve of these 28 young women had considered termination, one declined to comment and 15 had decided at the outset not to terminate. The eventual decision of young women not to terminate was because of lack of access to termination either within or outside the public health service; or because family and/or friends convinced them not to terminate. In some cases, more than one of these factors contributed to the failure to terminate, along with fears of immorality, inner turmoil about the pregnancy, fear associated with disappointing members of the family and the practical challenges of accessing termination services.

Young women who sought termination outside the public health service feared judgemental comments from nurses and feared complications as a result of the poor training of nurses. Often, young women attempted to induce termination by taking over-the-counter medications recommended by friends or family. Mbali (19), age 17 at first pregnancy, described drinking a remedy provided by a friend:

> Participant: Jo! I was scared, I don't know about aborting a baby, I just do it. Like my friend – 'drink something, drink this' – I just drink. But nothing is going on.
> Interviewer: And what made you not come to the clinic?
> Participant: Because I feel like they will cheek [tease] me, like 'you are still young, now you want to abort the baby, why did you do it?' Ja.
> Interviewer: Why did you think they would say that?
> Participant: Because I'm still young. And to get a baby (when) you are still young and at school.

When Nolu (19) found out she was pregnant at age 17, she was afraid of her mother's reaction and sought a termination. A private doctor referred her to a hospital, but there, she was refused a termination:

> They were very rude and impatient with me…They told me that how could I want to, um, get rid of a baby when I don't, when they are protections there. So, I tried …

> talking to them about what happened so they didn't want to listen to me. They told me that I just have to keep the baby.

Nolu tried one last attempt to terminate from a traditional healer, but he too refused without the consent from her mother.

Women also faced inefficiencies in the public health system, as Lerato (19), age 18 at first pregnancy, described:

> I went to [clinic] … they gave me a letter to [hospital] because that clinic was full. And then they told me to go on Monday because I went there on Friday … I stayed there [delayed going] maybe two weeks [before going to the clinic] and then I decided to go there because my granny knew that I'm pregnant, so she asked that what am I planning to do. I'm planning to keep the baby or what? So, I told her that no, I wanted to do an abortion, so she asked me that am I sure or what and I told her, so then she said it was okay. When I went to [hospital], they told me that no, it's too late, I can't do an abortion, so.

Lerato attributed the delays to her ambivalence about termination, time constraints because of school attendance, and fear of the health service due to negative experiences of a close friend. Although she had her grandmother's support to terminate, she was unable to do so. She presented to the appropriate facility too late, reflecting a broader finding that young women were also refused termination because they presented when the pregnancy was advanced and well into the second semester.

In addition, nurses asked for permission from parents. Bertha (18) discovered she was pregnant at age 17. When she tried to terminate, her boyfriend refused to give her 'permission' and would not help her pay for a private termination. She was then confronted with another hurdle from the public health system:

> They want a signature – I called and asked, here in this [clinic]. I called and asked, 'if I want to have an abortion, what do you need?' – all that kind of stuff, and then they said I should come with my mother for her signature, because I was still young.

A nurse at the community health centre confirmed that she requested letters of permission from young women's mothers, despite this being illegal (South African Government Gazette, 1996). This nurse was acting on the basis of her own moral beliefs. Another nurse alluded to possible moral resistance, describing a 'friend who used to work at the abortion clinic, at night she would hear these children crying' (Nurse Vanessa, 50). Other nurses knew the legal course of action and wrote letters of referral after counselling women.

Advice from family, friends and nurses played a central role in influencing young women's decisions in relation to termination. Pumla (19) was 18 at first pregnancy, and both her mother and her boyfriend's mother advised her against termination:

> Ai, I was shocked, I thought that maybe the whole world was gonna stop or something, I even thought of killing myself and then when I told my mother she said that it's fine but then we not going to have an abortion, then even Joseph [father of baby] mother that's what she said, there's no abortions so we will carry on with the child.

Charmaine (19), age 18 at first pregnancy, was persuaded by a nurse that termination was wrong, although in any case she was well advanced in her pregnancy:

> The nurse that I found gave me advice and disadvantages of terminating the pregnancy … So I listened to her advice and I understood that my, that, that the child that I wanted to terminate is actually innocent. It's all my fault so I had a twice thought. I thought twice about the thing I wanted to do so then I ended up accepting that all would be well.

As a result of these barriers within and outside the public health service, none of the young women had been able to terminate their pregnancies.

Ante-natal to post-natal care

Young women often attended multiple facilities as a result of their migration in and out of South African townships, return to their natal home and other travel. In addition, young women reported differences in ante- and post-natal care between provinces and health centres. In the study setting, women reported negative experiences of nurses primarily at their first ante-natal booking, when they were reprimanded, with nurses suggesting that 'there is too much teenage pregnancy' (Sine, 19), and that they were ruining their lives by having a baby at a young age. Nurses also reprimanded young women that they needed to take responsibility:

> They used to say, 'Ja, today you are not with your mother, you are all alone, so you should start doing things on your own,' because my mother would come and stand in the queue for me and I would come later on. Ja, they said, 'you should start learning because you are gonna soon be a parent you know,' telling me stuff like that…Like why didn't I use a condom and … then they also said who is going to take care of your child, they also said that I should not have another child again (Pumla, 19, age 18 at first pregnancy).

Fezeka (20), aged 15 when she discovered she was pregnant, recalled a nurse taking her to a private room. The nurse explained that she did not want to shout at her in front of other people, but that it was wrong for her to be pregnant at such a young age. Yet she also assured Fezeka that she would care for her, and that Fezeka should seek her help and advice whenever needed. As this suggests, not all nurses were unilaterally censoring; some were ambivalent and reflected this in their interactions towards young women.

There is no specific protocol for the care of young mothers in the midwifery and obstetric units of community health centres. Nurses adhere to a general protocol associated with maternal age and potential birth complications, and young women with signs of complication were transferred to a hospital. Young women who delivered at the community health centre were perceived to be 'better' patients than older women because they were assumed to better tolerate pain compared with older women, and listened to the nurses: 'I think if you don't know anything, you co-operate' (Nurse Nikki, 59). In contrast to other research in South Africa (Jewkes, Abrahams and Mvo 1998; Jewkes and Penn-Kekana 2015; Chadwick 2016), no young woman reported poor treatment by nurses during labour and delivery. Rather, they emphasised that they were well treated and noted the particular kindnesses of individual nurses:

> There was this nurturing lady there [delivery room], ja she was very good, she was like if you hear something anything just tell me and then okay, like I told her everything like how I feel and all of that. And then she was like, okay, relax a bit or walk round because you still a little bit far… (Ayanda, 19).

Castro and Savage (2019, pp. 125–126) argue that "health system conditions" such as refusal to allow family members to be present during childbirth is one dimension of obstetric violence. Only one young mother was allowed to have her mother with her at a community health centre in a province outside of the study area; the other women were not allowed to have significant others (family members, friends or partners) accompany them but also, they expressed no expectation of this. Nurses, too, accepted this as policy, and did not question the value of a birth companion. Nurse Bongi (43), however, argued that fathers should be present at delivery, so they are 'put off' the idea of having children at a young age:

> Also allow the fathers, the younger fathers to come in and witness the delivery. Maybe teenage pregnancy will go down. If they witness how difficult it is for these girls to have children. I think maybe they will think about using protective measures, measures when indulging in sex.

Family planning services were provided during the six-week post-natal routine examination. The injectable contraceptive Implanon was routinely dispensed, with little or no discussion of other contraceptive options available, or of the woman's future plans in relation to sexuality and reproduction. Young mothers were frequently told not to have sex post-partum for the health of the baby, and to 'choose' Implanon as the safest contraceptive method.

> Then with these teenagers, most of them we do advise on implant. At least implant, with the, with the pills they won't cope. The stress of the baby. The, the books if she's a student, the books she won't cope. Then once you miss a pill you will fall pregnant. Then we advise all on some, at least they are standing for long, Implanon is for three years (Nurse Nikki, age 59).

Health service providers perceptions of young pregnant and parenting women

Ante-natal care in the community health centre was provided by community health workers in the ante-natal waiting room, in which context they gave young women information on pregnancy care, childbirth and infant care. Although young women often first presented late because they either discovered their pregnancy late or had tried to hide being pregnant for as long as possible, once they registered, they accessed regular ante-natal care. Nurses complained that young women often did not turn up for ante-natal care appointments because these times conflicted with school attendance.

Nurses' perceptions of the causes of early, unintended pregnancy were nuanced and contradictory:

> Most of these young ones, I think, eh, they know about HIV. They know about family planning. But they are just ignorant. Most of them. …They come after they are pregnant. They come after saying no, I didn't use a condom and the condom or, or sometimes they say, the condom burst. So, they just come for, for morning after pill…And others, I think it's maybe from poverty. Maybe ah, they don't have enough money you know. To, to, to go to school or maybe to buy other things. So, they normally go with these adults. They need men…Yes older men to maintain them. So not to say they don't know. They just ignorant that they must use condoms. After pregnant then they come to the clinic and just want an abortion (Nurse Mary, age 57).

In the above extract, Nurse Mary (57) began by citing ignorance as a cause of early, unintended pregnancy. She then framed this by suggested that poverty is the root cause, and that unintended pregnancy was a consequence of young women having relationships with wealthier, older men, in order to escape this poverty. In her account, young women living in

the township needed material things and saw older men as a means to achieve this. So, health care providers like Nurse Mary (57) invoked the common trope of 'sugar daddy' as a cause of early, unintended pregnancy. All nurses were aware of the lived realities of young pregnant and parenting women, citing structural and social constraints like poverty, lack of support from extended family, challenges associated with access to the Child Support Grant (CSG), and social isolation.

Nurses also referred to poor parenting and the failure (of parents) to teach young women the consequences of teenage pregnancy, accepted norms around early childbearing, young women 'copying' friends and lax school policy that allowed pregnant women to continue to attend school.

> They must tell them [young mothers] to, ja to stop [going to school] and then they must rest [take a break from school to be with their babies] with their kids for at least one year. So that he [she] can feel a pinch [understand the consequences] (Nurse Elmien, 64).

Personal life stories further shaped nurses' perceptions of, and responses to, early motherhood. Nurse Mary (57) and Nurse Bongi (43) both reflected on their own experiences of early, unintended pregnancy, and the challenges they had faced in disappointing their families. They were sympathetic that young women had to juggle the roles of mother and student, but framed this as a teaching moment:

> Go to school then everything will be okay. So that you can now take care of your child and teach your child when they grow up, that this [teenage pregnancy] is wrong. Because you have already seen (Nurse Mary, age 57).

Nurses regarded broader health care system challenges as a barrier to delivering caring and sensitive sexual and reproductive health services; new policies and mandates were constantly being implemented nationally, with little regard for limited staff capacity and inadequate training at the community health system level. They described being 'worn thin' by workload and distress. Nurse Bongi (43), in commenting on seeing "a lot of difficult things … who will debrief us?" reflected on the pain of delivering the news of intrauterine foetal death to a young woman after a sonogram. The public health system did not provide any counselling to nurses for the multiple psychosocial stressors they experienced daily.

Discussion

Findings from this study suggest that both nurses and young women negotiate a complex mix of personal circumstances, health care system challenges, and structural and contextual factors impacting on health service delivery and experience. The themes discussed below reflect this complexity.

Risk and Punishment

Sexual and reproductive health policy and legislation in South Africa is progressive and recognises the need for Adolescent and Youth Friendly Services (Department of Health South Africa, 2017), but there is evidence that the attitudes of nurses hamper the delivery of services to young people (Wood and Jewkes 2006; Macleod 2011; Holt et al. 2012; Alli, Maharaj and Vawda 2013; Willan 2013).

Nurses in this study characterised young women as irresponsible, immature and ignorant, echoing pervasive negative narratives concerning 'teenage pregnancy' (Mkhwanazi, 2012; Hodes, 2017). Prevailing ideas about young women as risk takers, unable to make good choices, led nurses to believe they needed guidance, as evident in the way they delivered family planning services post-natally. Nurses therefore dispensed Implanon and prior to its availability, injectables (Holt et al. 2012), without counselling young women and offering them a choice of contraception. By not informing women about the range of contraceptives, their side effects and what may be appropriate for each individual, nurses missed the opportunity to address negative perceptions of contraception (Evens et al., 2015). This approach to family planning also perpetuated dominant ideas of hypersexualised, risk-taking adolescents and ignored the individual needs of young parenting women. Thus, the health service undermines the agency of young women to make informed contraceptive choices.

Nurses consistently reflected on the need to punish young women for early motherhood, and in some instances, the fathers of their babies too. Thus, having the father of the baby attend delivery was not seen as an opportunity to improve young women's birthing experiences (Chadwick, 2016), but as a means to punish or teach young men the about risk taking and its consequences. Yet while nurses were often judgemental, they could also be kind and compassionate, as illustrated by the nurse who assured 15-year-old Fezeka that she would care for her, and by the nurse who supported Ayanda (19) during labour when she was in pain, alone and vulnerable.

Knowledge and Ignorance

Nurses repeatedly referred to young women as 'ignorant', and attributed unintended pregnancy to this 'ignorance,' resonating with other studies of health care providers and young patients (Holt et al., 2012). Yet they simultaneously described young women as having more knowledge than older women about HIV, sex and pregnancy. They also observed that even if registering late, young women complied with expectations of attending antenatal care at clinics. As noted above, young women were considered to be easier to manage than older women, because they had no prior experience and relied on nurses, through their age, experience and moral authority, for guidance.

Reported difficulties by young women in accessing termination highlight problems related to delivering sexual and reproductive health care. A primary objective of comprehensive sexuality education is to increase knowledge and enable young people to make informed decisions related to sexuality and reproduction, thereby increasing their appropriate utilisation of services (Pretorius et al. 2015). A critical decision-making moment for young women occurs early in pregnancy in relation to terminating or continuing with the pregnancy. In South Africa, unless there are special circumstances, termination is only legally available till 12 weeks of gestation (South African Government Gazette, 1996). The decision therefore has to be made within a limited time frame, when young women are especially vulnerable – immediately after pregnancy discovery and before they may have shared the news with loved ones, when fear, disappointment and shame are dominant, and when they may be most isolated from their social and kinship networks. At this time, young women have limited agency and poor access to potentially supportive others to mediate on their behalf.

Consistent with the existing literature (Dickson-Tetteh, Pettifor and Moleko 2001; Macleod 2011; Mkhwanazi 2014), study findings highlight that when young women negotiated this complex decision-making moment and sought legal health service termination, they were unable to challenge providers in either public or private centres. Thus although young women had the requisite knowledge about termination, they had little agency to assert their rights. This challenges the assumption that knowledge and rights are sufficient to ensure access to services. In settings where young women have limited power, knowledge and rights become irrelevant.

Conflict and Care

There is an extensive literature on discord in the relationship between nurses and patients, particularly young women, and the barriers to sexual and reproductive health services this presents (Wood and Jewkes 2006; Holt et al. 2012; Alli, Maharaj and Vawda 2013; Geary et al. 2015). In their initial interaction with the health service to confirm pregnancy or seek termination, young women anticipated sanctions from nurses, reflecting community attitudes towards early, unintended pregnancy. Stigma, discrimination, personal beliefs, and health system challenges, including overcrowding and limited capacity, provided fertile ground for these attitudes to flourish and become deeply entrenched. However, in this study, we found no dominant narrative of young pregnant women being treated poorly. A few women reported negative attitudes and judgement from nurses at the first ante-natal booking or when seeking termination, but this decreased once they were embedded in the ante-natal care system. Although nurses and young women expressed negative opinions about each other, their accounts of clinical interactions did not always reflect this.

Nurses reflected their complex position by the often-contradictory ways in which they described their opinions about and experiences working with young women. Although they stated that teenage pregnancy indicated irresponsibility and ignorance, requiring punishment, they were also sympathetic and concerned for the young women, and acknowledged structural factors such as poverty, inequality and gender norms that make young women vulnerable (Edin et al., 2016; Ibis Reproductive Health, 2011; Pretorius et al., 2015). However, inadequate training on Adolescent and Youth Friendly Services, and inadequate support provided to them, inhibits nurses' capacity to deal with issues affecting young women.

Conclusion

The tensions and contradictions discussed above indicate areas of conflict and care in how nurses and young mothers experience each other. Although young women and nurses often began their interviews with negative accounts, they then expressed insight and understanding of the position of the other. Both young women and nurses demonstrated their awareness of the complexities surrounding unintended pregnancy and appropriate services, in the context of extensive health system challenges.

Young women's experiences of sexual and reproductive health services in this urban setting suggest that there is little targeted support for young pregnant and parenting women. There

are no guidelines or protocols of care to provide services to them. Young women's agency with regard to sexual and reproductive health is compromised by barriers to access and good quality care. Almost twenty years after the need for Adolescent and Youth Friendly Services was identified, work is needed to prioritise the training of health care providers, expand termination services, provide early pregnancy testing and encourage women to present for care early, and deliver patient-centred family planning services to young pregnant and parenting women.

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SECTION C
INTEGRATED NARRATIVE



Image 4: “Teenage pregnancy on the rise in Limpopo” (Shipalana, 2018)

CHAPTER 9: AGENCY IN EARLY MOTHERHOOD

INTEGRATED DISCUSSION

In this chapter, I provide an overview of the findings of the study, and revisit these against the literature as they relate to the specific study objectives. I do not repeat what is in the papers, but rather, I draw on the conceptual frameworks in Figure 1.1 and Figure 1.2, to situate these findings against the evidence and the theoretical framework in which they are positioned.

This study expands on how young women confronted with early, unintended, ex-nuptial motherhood negotiate decision-making around pregnancy and parenting vis-a-vis three structures in which they are embedded. These are: the family, characterised as extended over several households and wider kinship networks (Chapter 5 and 6); the education system, as a structural facilitator of future opportunities for young mothers (Chapter 7); and the health service, as guardian and gatekeeper of health and wellbeing for the young mother and her baby (Chapter 8). How these different structures work is in part determined by their context, stability and how actors mediate their functioning. Families and kinship networks, as I illustrate, are dynamic, fluid , fragile, and malleable to changing conditions and circumstances. Education and health services are less fluid, are formally regulated by state policy and legislation, so enabling interventions and structural changes, but they are also informally regulated by the dominant discourse of early motherhood.

Decision-making moments around early, unintended pregnancy represent "vital conjunctures," as theorised by Jennifer Johnson-Hanks (2006, p. 3), which is the horizon surrounding a particular event where the social actor envisions a possible future and acts depending on how she imagines that future. Vital conjunctures for young women are mediated by distal and proximate forms of support, as reflected in Bronfennbrenner's (1994) social-ecological framework (Figure 1.1). The concept of support varies, and draws on the literature on social support and social networks to define the most important forms of support, namely material, informational, emotional and caregiving. Kinship capital, a theoretical concept arising from this study and elaborated on in Chapter 6, is a form of support that is mediated by kinship networks and which young mothers draw on at various decision-making moments surrounding pregnancy, birth and after. Discourse remains ever present in the lives of young mothers and influences their responses; however, young pregnant and parenting women remain active in both disrupting *and* perpetuating these discourses. I understand

discourse to mean the way in which knowledge is incorporated into belief systems, particularly as it relates to scientific biomedical knowledge where "data" and "evidence" are used to discipline agents to become moral and honourable citizens (Foucault, 1973; Graham, 2005). I pay attention to the way power produces discourse (Foucault, 1984b; Lupton, 1997), but also to how discourses are constantly being reproduced and disrupted in complex ways.

Three intersecting themes emerge when exploring the relationship between structure and the agency of young pregnant and parenting women. First, discourse is pervasive across all contexts in the lives of young women and plays a powerful role in mediating the relationship between structure and agency. Second, young women exercise agency along a continuum that is influenced by power inherent and manifest in structures like families, schools and health service and the levels of support that are available through these structures. Third, young mothers have multiple aspirations in relation to themselves and their babies, which they need to adjust at the onset of pregnancy and thereafter. These are further expanded in this chapter. Although described as discrete headings, discourse, aspiration and agency are contingent and are interwoven through each section.

Some issues raised in the discussion that follows are not in the papers and reflect some of the broader findings of the study, and remain potential future publications. These were emergent themes. Where appropriate, I provide stories and quotes to highlight the discussion, and situate the discussion within the broader literature, unless already fully explored in Chapter 2.

Disrupting and disseminating discourse

As I have illustrated, among the young women in Johannesburg with whom I spoke, the dominant discourse of early motherhood was deeply internalised and present in their narratives and in understandings of others in the community: in homes, schools and health services. I draw attention to active and passive forms of resistance to these discourses, as well as the way young mothers and others in their network perpetuate the dominant discourse in their words and actions, highlighting how discourse is internalised and enacted in multiple ways. There is no single position in relation to discourse, and acts of disruption or dissemination would be what Giddens (1984) called "passive" agency, the embodiment of habitus and practice. In other words, although young women may have acted with agency, they were not doing so with the intention of disrupting or disseminating any particular discourse.

Intended pregnancy

The study aims were to explore early, unintended pregnancy. In inviting young mothers to participate in the study, I assumed that all cases of early motherhood were unintentional. This was not so: two young mothers intentionally fell pregnant. Here I explore the case of Sine (19) because of her active decision to fall pregnant, and the reasons for this. Sine's baby daughter Amo was three months old at the time of the interview. Sine conceived in her matriculation year at age 18. She was in a long-term relationship with Joe (22), who she had dated since 2014 and with who she had been in a sexual relationship since late 2015. Sine lived in Limpopo with her mother's two sisters and their children, and Sine and Joe had been in school together until matric. Sine had passed matric with an "F" (grade) while Joe had failed. She was in Alexandra visiting her mum and step-siblings at the time of the interview.

Sine's story of intended pregnancy is as follows: In early 2016, Sine visited a traditional healer after years of struggle with crippling dysmenorrhea and a constant period.

> I was sick then they took me to a traditional healer, then they told us that I am being bewitched. That I cannot have babies, ja, something like that then he give me something to drink [medicine]. And to bath with it. Then after that it's where I started having this thing of having a baby. Like to try and see if I can have a baby.

The traditional healer's diagnosis shocked Sine and she was determined to prove him wrong. She stopped using contraception and tried to conceive, and Joe supported her decision. Sine and Joe were delighted when she conceived. Although Joe was supportive and present as a prospective father, and committed to her and their unborn baby, Sine ended her relationship with him. She refused him any access to herself or Amo despite his pleas. She was unable to explain why.

Sine actively sought motherhood to demonstrate her fertility and placed this uppermost as an aspiration, thus affirming studies that illustrate that demonstrating fertility is an important element of performing womanhood (McQuillan et al., 2015). Sine's story is a counter-narrative of intention and choice, of active decision-making and adjusting aspiration. She exercised agency in a number of ways. Through pregnancy she discarded a script handed to her by a traditional healer, and asserted her agency over her body and its reproductive potential. However, in doing so she simultaneously created and perpetuated the dominant discourse of the absent young father, even though that did not truly represent Joe or his intentions. In this instance, Joe's agency and power was curbed in resisting that discourse, and Sine played maternal gatekeeper to Joe's desire to father Amo (Madhavan et al., 2014b, p.

459). Sine thus perpetuated the narrative of absent fathers. Yet simultaneously she described her own sadness at not being acknowledged by her own biological father and the trauma of being poorly treated by her stepfather. In choosing not to make a claim on Joe's paternity through a fine or "damages" paid to the young woman's family for the ex-nuptial birth, or *inhlawulo*, she asserted her agency to have exclusive claim over Amo and undermined the paternal family claim over Amo. This echoes other studies that highlight the increased agency of women and their families over deciding the nature and involvement of fathers in their children's lives (Mkhwanazi and Block, 2016, p. 282).

Responsible motherhood

The idea of the good mother is ubiquitous across all contexts and stages of motherhood, and young mothers have not escaped this ideology: the result of a deeply embedded patriarchal approach to raising families. The term "good enough mother" was coined in response to the discourse of responsibility and self-sacrifice that are embedded in this notion of motherhood (Winnicot, 2005; Koffman, 2012). Young mothers experience a heightened pressure to perform as good/responsible mothers because of the pejorative narrative of early motherhood. They are continually under surveillance: young mothers judge themselves and they are judged by the wider community – to take responsibility for their actions in defying the course of "normal" adolescent development and entering the realm of childbearing prematurely (Rolfe, 2008; Macleod, 2009; Shefer et al., 2012, 2013; Bhana and Mcambi, 2013).

Early motherhood is framed as a teachable moment, where young women must learn from the "mistake" of early motherhood – the punishment of enduring hardship and taking responsibility for early, unprotected, ex-nuptial sex. These views include "teaching them [young mothers and in some cases fathers] a lesson" and "showing them their mistake" (Pillay et al., 2019). In this framing, good mothers take responsibility and learn their lesson; they make good of this teachable moment and need to make reparation for it. This is not unique to South Africa. Christian moral welfare workers in the United Kingdom from the 1950s adopted a similar approach, where raising a child, taking responsibility, and self-sacrifice were understood as a way of rehabilitating young women. The burden of looking after a baby is therefore a transformative act of learning their lesson: "it could make them give up their careless way of life and become dutiful subjects" (Koffman, 2012, p. 124). More recently in the United States of America, Bute and Russell (2012) raise the example of Britney Spears' (actress and singer) sister and Sarah Palin's (Republican politician) daughter, both of who were pregnant in their teenage years. In both instances, the young mothers and their mothers

seek to show the American public that they are taking responsibility for the mistake, and are learning from this lesson by taking care of their children, as demanded by the public discourse.

In this study, many young mothers adopted this punitive stance towards themselves. For example, Ayanda (19) did not seek any form of acknowledgement of paternity or support from the father Sipho (22) when he left her after she found out she was pregnant. Another young mother, Pumla (19) suggested the absence of the genitor was "teaching me a lesson…[about] "responsibility you know, like even though he is not around I should take care of my kids." Charmaine (19) remains in a relationship with Funani (28), father of her 6 week old son Sipho, even though she doesn't love him, they are no longer sexually involved and he hasn't paid *inhlawulo*. When asked why, she says: "It's not that much about love actually." In elaborating on this, Charmaine undermines her own needs and aspirations and instead chooses what she believes is expected of her. Some young mothers accepted infidelity because they felt they were being taught a lesson; they believed that being pregnant meant that they were not seen as sexual partners any longer, and that their lack of sexual interest was a reason for their partners' infidelity. These beliefs further demonstrate how young women accept and enact the punitive discourse, and further perpetuate discourses of hegemonic masculinity and men's sexual prowess performed through infidelity and having multiple sexual partners (Shefer and Strebel, 2012, p. 60; Mlotshwa et al., 2017).

Learning lessons about life, men, relationships and love, were a consistent theme in the pursuit of being a responsible mother. The ultimate lesson learnt is to delay future childbearing: "I learnt [a] lesson about having a baby, ja, I was young but now I told myself that now I am going to wait for a long time to have another one" (Fezeka, 16 at first birth). Rates of repeat pregnancies among young women in South Africa are lower than in other countries with a high incidence of early first pregnancy (Kaufman et al., 2001; Panday et al., 2009):

> I don't want a boyfriend now, and 'cause I see it's not good to be in love to [with] the people who don't care about you. It's better to stay [without a boyfriend] and then to finish my school. My work at [is], to finish at school (Linda, 17 at first birth).

The idea of responsibility is spread intergenerationally among women kin, where mothers, grandmothers and other female kin absorb, express and reiterate ideas of shame, guilt and disappointment and perform good motherhood. This also represents the expression of

aspiration for future generations, enduring and taking responsibility for the range of sacrifices to make this happen. This was further described in Chapters 5 and 6, where women across kinship networks absorbed the responsibility of caring for and supporting young mothers and their babies.

Responsible fatherhood

Two important points preface this section. First, understanding fathering and fatherhood was not a central objective of the study and was raised only in relation to support offered to young pregnant and parenting women. Second, fathers in this study are represented through the narratives of young mothers, therefore their representation is limited. Although I attempted to speak to fathers, especially those *in* relationships with the young mother, I only interviewed one father who was not in a relationship with the mother but was present and supporting his baby, reflecting a difficulty with interviewing men in research studies, particularly qualitative ones (Mlotshwa et al., 2018). Nonetheless, this interview was important because it adds to the limited data or understandings of non-resident fathers and their involvement with children, particularly in relation to early motherhood (Hosegood and Madhavan, 2012, p. 270).

Fathering and fatherhood in Africa, and South Africa specifically, are subject to the same moralising discourse of Developmental Idealism and traditional nuclear families discussed in Chapter 2. This discourse does not recognise the value of social fathering, fatherhood that is constituted by networks of social relationships between adult men and children who may or may not be their biological children (Makusha, 2013; Madhavan et al., 2014b). In South Africa, fathering and fatherhood are dominated by narratives of fathers as irresponsible, exploitative and absent, a social problem that has its roots in colonialism, apartheid enforced labour migration, urbanisation and continued circular labour migration (Hosegood and Madhavan, 2012, p. 265). This is particularly so when the mother is young. Furthermore, a "sugar daddy"/"blessor" narrative in relation to adolescent girls and young women dominates current discourse, as discussed further below in the section on *Young families*.

The study findings reflect both disruptions to the dominant narrative of the absent and irresponsible (young) father, yet simultaneously affirms the idea of the "deadbeat dad" through genitors who deny paternity and/or do not offer any support (Madhavan et al., 2014b, p. 452). Eighteen fathers were in a relationship with the young mother, nine were not and one young mother declined to comment on her relationship status. Of the 18 fathers in a relationship with the young mother (Table 4.1), 14 were non-residential fathers as expected in

unintended, ex-nuptial parenthood and in South Africa (Sikweyiya et al., 2017). Twenty fathers were providing some source of support to the young mother and/or his baby, and hence taking responsibility for the unintended pregnancy (Sikweyiya et al., 2017). Two fathers were not involved with the mother but provided some form of support to her and their baby. Provision of material support to children is an important indicator of long-term support from fathers (Madhavan et al., 2008).

Junior (27), the only father I interviewed, was aware that he had not treated Betty (20) well, and that he had created uncertainty, heartache and stress with persistent infidelity at a time when life was already complicated and challenging for her. He ended their fraught relationship and decided to concentrate his efforts to support their son Mpho (6 months): "No, actually I don't want to be friends with Betty, she must stay there and I can stay away. It's alright, I will go only to support the baby" (Junior, 27). I interviewed Betty three times between September 2016 and May 2017 and Junior remained committed in his support through their personal difficulties, with regular visits to Mpho, and irregular but consistent material support as discussed further in Chapter 6. Here, Betty demonstrates her role as maternal gatekeeper but also her agency in facilitating and supporting Junior's access to his baby (Madhavan et al., 2014b, p. 454).

In this study, support from fathers was mainly material, and was inconsistent and varying. This reflects wider social and structural conditions in South Africa, particularly in urban environments, where precarious livelihoods, persistent poverty and movement into and out of urban areas are influenced by constantly changing family circumstances and need. This mirrors other studies in South Africa that show that the agency of fathers in relation to parenting practices is socially and economically constrained. Cultural practices like *ilobola* (bridewealth) and *inhlawulo* (damages) further undermine the agency of fathers because of the economic element required to embrace fatherhood (Richter and Morrell, 2006; Swartz and Bhana, 2009; Madhavan et al., 2014b; Bhana and Nkani, 2014). The current unemployment rate of 27,6% – with 3,4 million of the 10,3 million young people aged 15-24 (33.2%) not in employment, education or training (NEET) – highlights the structural realities of young people in South Africa (Statistics South Africa, 2019b). This is reflected in Nobuhle's (18) patience and sympathy in waiting for the baby's father, Solly (23) to pay *inhlawulo*:

> But there are certain things that needs to be done with family but they can't do them because they haven't paid damage, like they have to take her to KwaZulu Natal…

> Yes. So [to] her grandfather's grave, to tell him that there is a new child in the family, such things they won't be able to do that until they paid. But then to see her they can come and see her at my place, I can't take her to their home…he said that they are going to pay, he just doesn't know when, because he is not working at the moment but then he would like to pay…Yes he is trying to find a job at the moment.

Where fathers (of young mothers) were present, their support was occasional, mostly material and rarely involving any responsibility for caregiving, reinforcing the idea of "provider masculinity" (Hunter, 2010; Bhana and Nkani, 2014). Two young mothers only were living in a household with both biological mother and biological father present, consistent with low levels of nuclear family formation in South Africa (Rabe and Naidoo, 2015; Mlotshwa et al., 2017). One young mother lived with her father who was the primary caregiver and provided support at all levels to the young mother and his grandchild. How fathers are involved in the care of their daughter and grandchild needs to be understood in the context of the wide variety of family and kin formation, households, and the complex and multiple ways that fathering and fatherhood is practiced in South Africa (Hosegood and Madhavan, 2012, p. 259). Simultaneously, this must be understood as a reflection of gendered caregiving practices within patriarchal systems.

Young families

In this study, young couples who remained together did so in various ways, through different living and care arrangements. This draws on the work of Nolwazi Mkhwanazi and Deevia Bhana's (2017). In *Young Families: Sexuality, Gender and Care*, they define young families as *young* because they are comprised of young children, young parents and young grandparents. I deviate somewhat from this definition and use the term "young" primarily because of the age of the mother, as in many instances the fathers were significantly older. There were no married couples, consistent with the South African context where early marriage is rare (Amoateng and Heaton, 2015; Rabe and Naidoo, 2015; Mlotshwa et al., 2017). Four couples co-habited (Figure 4.4) with marriage in the horizon, and operated as young families. Two young families were from Zimbabwe, and had limited family support in Johannesburg – both fathers were consistent income providers and the main source of support for the young mother. In total, three of the four fathers embedded in young families were the main material providers, confirming other studies that show that residential fatherhood is a "hard-won status…particularly economic and social achievements which make them able to marry and co-reside with their children" (Makusha, 2013, p. ii). Here again, the idea of

provider masculinity is highlighted, which is pervasive in this study in relation to material support. One of the couples lived under dire economic circumstances with both of them unemployed, living in a shack and relying on material support from family, who themselves had minimal resources.

The cases of young families raised two emergent themes: age disparate relationships (framed as a blessor/blessee relationship) and intimate partner violence (IPV). Neither of these were objectives of the study, but are pervasive within the evidence and discourse of early motherhood in South Africa. Below, I present the story of a young family embedded in an age disparate relationship to elaborate on the concept of blessors and blessees. Age disparate relationships are defined as relationships where men are at least five years older than women (Toska et al., 2015; South African National AIDS Council, 2017b). Sugar daddies are framed within this narrative. A sugar daddy is a man who is ten or more years older than the woman (Ott et al., 2011, p. 2): it is assumed that the younger women enters into a relationship with the sugar daddy in exchange for economic or material gain. Sugar daddies are understood as men who abuse their social and economic position to attract younger women who may be particularly susceptible in the materialistic context of globalisation (Masenya and Mphahlele, 2017, pp. 120–121).

The age range of fathers varied widely in the study, and the ages of two fathers remain unknown. Of the 28 fathers, one was under 20 years of age. Nine fathers (32%) were more than five years older than the young mother (age disparate), and three of these were more than ten years (11%) older (Table 4.1). These data are drawn from this small sample for the purpose of simple description, but it bears noting that this is not dissimilar from that which Harling and colleagues (2014, pp. 5–6) found from a rural based longitudinal study, where 37.7% of partners were more than five years older, and 9.1% were more than ten years older. Age disparate relationship levels are generally high in South Africa.

The narrative surrounding age-disparate relationships has increasingly gained purchase with the biomedical evidence on the transmission pathway of HIV, with transmission of HIV from older men to younger women, and that having older sexual partners is associated with increased sexual risk behaviour and adolescent pregnancy (Toska et al., 2015). In 2016, South Africa's former Minister of Health, Dr Aaron Motsoaledi, stated that health policy and intervention should focus on "increasing economic opportunities for young women to try and wean them away from sugar daddies" (Gqirana, 2016). This idea of "weaning young women"

became the framework for the She Conquers campaign for adolescent girls and young women: an ironic name where one of the core messages infantilises young women and positions them as having no agency, much like President Zuma did in 2009 and 2015.

An emerging body of evidence contests this framing of women as victims and as powerless in age disparate relationships. Much has been written about the transactional nature of love and relationships, with increased attention on the agency of women within relationships understood to be materially motivated or driven by the "commodities of modernity" (Leclerc-Madlala, 2003, p. 213, 2008; Hunter, 2002, 2010; Bhana and Pattman, 2011; Groes-Green, 2013; Stoebenau et al., 2016). Far from seeing women as victims who need to be "weaned" off blessors, some studies show that young women have agency and may choose transactional relationships for status and access to material goods and actively participate in these relationships (Shefer and Strebel, 2012; Potgieter et al., 2012, p. 193). They show that notwithstanding many power differentials in age disparate relationships, women often control the formation and dissolution of partnerships (Harling et al., 2014, p. 7; Leclerc-Madlala, 2008), and receive emotional intimacy that is otherwise absent from their lives (Shefer and Strebel, 2012, p. 59). The following case contributes to this idea of women as agents, able to make their own choice. However, in presenting this case as inter-generational, I have not interpreted this relationship as one of transaction; rather, I seek to disrupt this idea.

Mpho (19) and Samuel (40) co-habit in what could be called a "blessor-blessee" relationship: Mpho is aware of the gossip – emanating from discourse – around their relationship, but is confident that she is loved, cared for and has a future with Samuel who is a good father, partner and provider.

> Blessors, sugar daddies and all that, but to me he didn't come as a blessor, I loved him you see, I knew afterwards, he's forty [laughs], even his body doesn't show that he is forty because he's slim you see, but I did not care what people would say because I loved him and I still love him.

I interviewed Mpho twice during the year of fieldwork. In this family, Samuel was a consistent provider, had met Mpho's family and had begun paying *inhlawulo* and *inhl* as a marker of his commitment to their future. Mpho said she loved Samuel, had faith in his ability to care for her and their baby, and believed that her aspiration to be a nurse would be met with Samuel's support. Although she aspired to be a nurse, she began a course in office administration to kick-start her income generation: as with other young women in this study,

she adjusted her aspiration to meet her changed circumstances. She planned to pursue nursing once they had enough money.

Analysing this case within the discourse of "blessor-blessee" relationships highlights that there is no absolute measure of what constitutes a legitimate relationship, or if material considerations are present or absent in any relationship irrespective of age. Mpho shares an emotional intimacy with Samuel that she does not get with her family; her mother is dead, her sister and father live in another province, and she has little contact with other kin. This raises the concept of emotional intimacy that is scarcely raised in the discourse of age disparate relationships (Potgieter et al., 2012; Stoebenau et al., 2016). Furthermore, as Ott and colleagues (2011) argue, we need to move the discourse beyond age gaps in sexual partnerships which then requires seeing beyond the sugar daddy narrative. The case also reminds us to continue to explore broader definitions of exchange that are not inherently exploitative, and to seek a more nuanced and complex understanding of transaction in relationships (Shefer and Strebel, 2012, p. 61), to understand the interplay of transactionality *with* socio-economic factors and gender (Dunkle et al., 2007).

In troubling issues of transactionality and age-disparate relationships, I do not mean to neglect the deeply gendered inequality that is present and manifest in all relationships, particularly so when there are significant age differences. Nor do I wish to neglect the impact of hegemonic masculinity which drives violence in South Africa, particularly gender-based violence. The power of men in relationships illustrates a further reality of South Africa where gender imbalances are pervasive and often reflected through intimate partner violence (IPV).

IPV involves behaviours within a relationship that cause physical, psychological and sexual harm (Mason-Jones et al., 2016, p. 502). IPV is associated with increased incidence of STI and HIV infection (Jewkes et al., 2010), with younger mothers (under 15) at higher risk (Christofides et al., 2014a). Exploring IPV was not a study objective, and not explicitly addressed in interviews; but violence in all forms in South Africa is unrelenting, particularly gender based violence, and was anticipated to be part of young women's experiences. When issues of violence were raised by a young mother, I probed further if she was comfortable discussing it with me. There were two cases of IPV in this study: these young mothers were referred to an NGO for counselling and support. In one case, the young mother sought legal protection; described further in Chapter 5. The second case of Connie (20) and her partner Miracle (24), was discussed in Chapter 6, but is presented here again, to expand on how a

young women's vulnerability to IPV is heightened and to show how agency is constrained when kinship capital is not easily available. Connie did not seek any legal protection.

Connie and Miracle are a young Zimbabwean couple living in Alexandra. Although Connie described Miracle as materially supportive, she describes his temper as follows:

> If you keep on doing like that, he will end up beating you. So sometimes I realise eh, I don't like to be beaten. Sometimes I just keep quiet if I see something is going bad like that, he's going quiet like that. If I'm talking, talking, I will say let me keep my voice, keep quiet, for then and there I will say I'm sorry then everything will be okay.

In this case, Connie, who I interviewed three times over the year, never explicitly describes violence, but described her fear of Miracle's temper, her loneliness and general isolation. As a Zimbabwean migrant, she has limited kinship capital and is isolated from her family and kinship network. She feels isolated from community structures that can offer potential support. She is more passive in her relationship with Miracle and accepts the gendered power hierarchy that characterises their relationship, strongly influenced by the informal support she receives from the church, "because they [church] used to tell us that the husband is the head of the house" (Connie, 20). Connie's case highlights the complexity of young women's vulnerability to IPV, how isolation and economic dependence increases vulnerability, and the way agency is constrained by these forces. It also tells us about the enduring power of structural forces like religion (church) and migration which reproduces the patriarchal system that disempowers young women.

Exercising Agency

The preceding discussion interrogated the way young mothers, intentionally or not, disrupt *and* disseminate existing discourses. In doing so, they illustrate the complexity of exercising agency, and the barriers they face. In this section, I further examine this complexity, and seek to show the dynamic movement between structure and agency, and the range of factors that support or hinder them. I highlight three areas aligned to the study objectives: considering care (health and wellbeing of mother and baby), reconciling education and motherhood, and navigating the pervasive power of biomedicine. I emphasise agency through using the verbs 'considering,' 'reconciling' and 'navigating' to reflect agency and engagement. I expand on themes that were emergent or outside the scope of the papers, and need to be further explored to better understand the articulation between agency and structure.

In each of the areas discussed, the impact of deeply entrenched structural inequality which characterise urban townships and influence the articulation between urban and rural areas, must be acknowledged. The location, Alexandra, in which young mothers reside, played a critical role in mediating the challenges of early childbearing. The idea of "living in" Alexandra is an anomaly for most young mothers in this study: only nine young mothers had lived in Alexandra for five years or more, highlighting the nature of Alexandra as a township of movement and limited stability. This is illustrated in Figure 4.3. The study findings highlight the effects of widespread unemployment, the challenges of living in a township that is overcrowded and underserved, and the level of family disruption due to constant movement of kin between Alexandra and other areas in South Africa and beyond. However, the urban township also offered a space for young mothers to escape to and become "invisible" after experiences of stigma and discrimination in other areas in South Africa where they were known and "visible." As shown in all four papers, these factors resulted in households that are fluid, and the future of young people within them was fragile and insecure. Constant disruptions in households had the effect of mediating the agency of young women and their families, and affected each of the domains discussed below. Furthermore, decision-making for young pregnant and parenting women is strongly gendered and mediates all acts of agency.

Considering care

In considering care, two issues were uppermost in the minds of young mothers in this study: material support and caregiving support. Material support was critical for young mothers and their babies while they were young, often still at school or unemployed and in families that were resource poor. The Child Support Grant was the main income source for 19 young mothers (see Table 4.1), providing them with some autonomy in relation to care decisions, and reducing anxiety around food insecurity. Food insecurity is associated with increasing vulnerability to IPV (Gibbs et al., 2018). Thus, material and caregiving support are intimately connected. The Child Support Grant was a critical enabler for young mothers to access paid care for their babies outside of families, through crèches and other community child carers, illustrating the value of cash plus care as shown in other studies (Mkhwanazi et al., 2018; Hill, 2019). This was very important in Alexandra where the location and neighbourhood context meant that caregiving options through kinship networks were not always available because women kin were involved in income generation. Furthermore, practical considerations like physical space and number of residents per household impacted on decisions of care.

As noted in the literature review and Chapter 7, material and caregiving support mediates future aspiration for education with early motherhood (Madhavan and Thomas, 2005; Marteleto et al., 2008; Pillay, 2018). However, some young mothers made decisions to leave school to take care of their babies when they were unhappy with the quality of care in community crèches, demonstrating agency about the kind of care they wanted for their babies. This raises a further conundrum in performing responsible motherhood: should a good mother prioritise care of her baby or complete her education? And, what happens when these requirements are irreconcilable?

The study confirms that caregiving is strongly gendered, with women and their families shouldering the bulk of caregiving (Mkhwanazi and Bhana, 2017; Ngabaza and Shefer, 2017; Richter et al., 2018). Within families, women kin were most involved in supporting and caring for young mothers and their babies, with mothers, grandmothers, aunts, and sisters playing a central role in supporting young mothers mediate care decisions, varying from material and emotional support to facilitating care arrangements. As described in Chapter 7, 22 young mothers identified a woman (mothers, grandmothers, sisters, aunts and friends) as the most significant source of support. One identified her father, and six young women identified the father of the baby. Consistent with other studies, mother-daughter dyads were the most common significant relationships (Pillay, 2020). However, the data also showed family and care were shaped by roles and not biology, nor confined by geography.

The impact of early motherhood on family relational dynamics, particularly the mother-daughter relationship, is different across contexts and circumstances, the literature showing weakened (Jacobs and Mollborn, 2012; Wamoyi and Wight, 2014) and stronger mother-daughter bonds (Mkhwanazi, 2014; Ngum Chi Watts et al., 2015; White et al., 2018). Mothers were always disappointed when their daughters fell pregnant, in spite of historically high levels of early childbearing and the culturally recognised value of motherhood. Charmaine (19) recalled her mother's reaction:

> I did not tell her myself; I asked my sister to tell her for me. Ja ja so she was so angry. She took something like maybe a month without talking to me without calling me, without taking my calls but she, she ended up calming down and then she spoke to me…I was feeling bad and I was feeling abandoned sort of, but I understood that it was my fault. Just that when she was she was not talking to me, I did not know when it was going to end you see, so I was stressed. Right, left and right because somehow I was doing matric and then I had to cope with the stress too. You see the stress of my

mother not talking to me, my family being angry at me, so things were so difficult by that time.

In almost all instances mothers overcame their disappointment to provide care to their daughter and grandchild. This was not the case for Bontle (19): her mother's reaction was perhaps the most extreme example of maternal punishment, forcing her to leave school with feelings of shame and disappointment to learn a lesson from the unintended pregnancy (see Chapter 7). Even though young mothers were often protected by kinship capital, they internalised the initial disappointment of their families and adopted a punitive stance towards themselves. They too believed that taking the bulk of responsibility for the unintended pregnancy, or making amends by completing school or finding employment, was a way of learning a lesson for transgressing childbearing expectations. Young mothers' sense of appreciation was further complicated by role confusion of who the "mother" really was; where claiming motherhood was understood as a sign of disrespect and ingratitude. This was described by Nolu (18):

But ah, when I look at him with my mom, I think he is going to call my mom, mom because he really likes my mom. He loves her.

Okay. And how do you feel about that?

Well it's fine but not fine.[laughs]

Tell me more, why is it fine but not fine?

Because he has to know that I'm his mother then my mother is his grandmother.

The role of gender was not fixed nor did it always impact negatively on young women. Fathers and paternal kin were also involved in caregiving, with women often acting as agents mediating this, operationalised through the practice of maternal gatekeeping (Mkhwanazi and Block, 2016, p. 285). Here culture, in particular the practice of *ilobola* and *inhlawulo,* facilitated and constrained agency for both young mothers and fathers. For fathers, economic constraints linked to the practices restricted them from enacting new forms of masculinity that encourage healthy family relationships. For example, genitors who wanted to take up their role of fathers were sometimes hindered from establishing fathering practices early on. However restrictive for fathers, *ilobola* and *inhlawulo* offer an opportunity of maternal gatekeeping to young mothers and increase their agency; they and their kin decide if they want to "report the pregnancy," as demonstrated by Ayanda (19):

We had some conflict with his parents ja because like they wanted us to go to Soweto, this thing, this traditional thing of reporting you're pregnant, when a girl is pregnant.

> They wanted us to go to Soweto and my grandmother was like no, because this baby was made here in Alex, he [genitor] has a family, a [paternal] grandmother here so we are going and report to the [paternal] grandmother, we are not going to Soweto. So we had a conflict about that, that is where we ended up breaking up because I was like no, you and your family, you have to understand I am staying with my grandmother, my grandmother cannot be travelling, coming to Soweto to report that I'm pregnant, no.

Reconciling education and motherhood

Jennifer Johnson-Hanks (2006, p. 2) posits that to be educated means to practice disciplined reproduction. Young women with an early, unintended pregnancy have failed in this expectation of disciplined reproduction. Reconciling the right to education while pregnant and parenting is a right earned through the struggles and pain of many women and is a significant policy and legislative victory. Responsible mothers simultaneously must complete schooling or post-school education while caring for their infant and failure to achieve this is perceived as irresponsible, demonstrating disrespect to the wider social and economic investment in young women.

As discussed in Chapter 7, "The pathway to school completion is complex and non-linear" (Pillay, 2018). The paper highlights the value of three interventions that support school attendance and completion for young mothers which include: the child support grant; the availability of créches in the community; and school policy of inclusivity for pregnant and parent learners. This section draws attention to two themes that require further exploration from the data; first, the importance of support in mediating the challenges of reconciling early motherhood with school (also discussed in Chapter 6 but not specifically with reference to education), and second, the continued challenges of young mothers to discard the discourse of shame associated with being a pregnant or parenting learner.

Notwithstanding progressive policy and legislation, reconciling education with motherhood is difficult to achieve and requires a level of tenacity and determination to withstand the shame that still permeates early motherhood, as illustrated in Chapter 7 and many other studies (Bhana and Mcambi, 2013; Mkhwanazi, 2012, 2014). It also requires emotional and physical strength as young mothers take on the concomitant demands of learner with caregiver. For example, Nolu (19) wrote her matriculation examination three weeks after giving birth:

> I normally went to school at the time when, when we were going to write. Not early in the morning, um and like when we were writing at two, at two o'clock, I was going at one so that I can feed the baby.

Nolu passed her matriculation but did not get the requisite Bachelor pass to study for a degree in transport management – she missed a Bachelor pass by 4 marks! Of the 11 young mothers who proceeded to complete matriculation after having a baby, only two passed with a Bachelor pass which is the requirement for tertiary level education and to which most young mothers in the study aspired.

Ayanda (19) described her juggling the roles of mother and student as she studied Human Resource Management at a community college, as an interim plan before she could upgrade her matriculation to pursue tertiary studies:

> They give you sixty days in between to write your assignments and then you have to send them out. So, maybe when they started giving me the assignment I will take the book and when she is sleeping I will study, study, study and then on the day that I want to write I will take her to my aunt and then I will tell her I want to write my assignment today I have studied and then I write on that day, I finish my assignment and then tomorrow I give it to my grandmother to email it at work.

Nolu and Ayanda's cases illustrate the difficulties of reconciling education with motherhood, particularly the early period, when breastfeeding is being established and decisions around care are being contemplated and negotiated in an effort to continue with school.

In addition to school policy that protects the right of pregnant and parenting women to remain at school, young mothers experienced support from the school environment as strong motivators in continuing with school and overcoming the multiple barriers they faced physically and emotionally. Support described was often meagre, inconsistent, ad hoc or not particularly aimed at pregnant and parenting learners, but was nevertheless described by young mothers as important in keeping them at school. These included individual teachers, who offered emotional support by demonstrating interest and care, as well as information support through offering advice and information particularly in relation to health services. Some young mothers referred to these teachers as mentors.

> They [teachers] were always supporting me, telling me when you are pregnant, don't feel so ashamed of yourself ya its part of life, you will get through it and those give me some stuffs like apples to make me smile because I was always so shy to walk, feeling like all the learners are watching me (Tebogo, 19).

Discarding the discourse of shame is a challenge faced by all young women who were in school through their pregnancies. There is a wide body of literature that describes this at school level (see Chapter 7). This experience of shame was at multiple levels and from multiple actors, and suggests that failing in disciplined reproduction was internalised and articulated as deserving of punishment. Family, particularly maternal kin, identified as the most significant sources of support, were simultaneously the source of most shame in the eyes of young mothers. Not disappointing their families was a strong motivator to continue school. As Bertha (18) explained:

> No the thing is at home my sisters don't have matric, and my parents are unemployed, so I am the only person that had a chance to be in matric. And they are all looking up on me… I want to pass my matric so that maybe I will get a bursary and go to school so that I can support my family. So I don't have a choice, I have to study very hard because they are all depending on me. I am the only that had a chance to go to matric.

The shame of being pregnant and in school was perpetuated by young mothers too; performing what Foucault (Rabinow, 1984, p. 11) called "subjectification", or the "way a human being turns him- or her-self into a subject," thus themselves disseminating the discourse surrounding early motherhood. For example, Ayanda (19) emphasises, "I told my grandmother, NO, I am not going to go to school with a big belly…I'm not." Here, Ayanda asserts her agency over her grandmother and chooses not to be shamed, yet also acts against her own and her family's aspirations for further education. In one extreme case, Mbali (19) described pregnant learners:

> Oh, ai, Hey, they're [pregnant learners] very disgusting, ai, like when you are pregnant at school, it is very… eish, like wearing a uniform and being pregnant – it doesn't sound…
>
> *So it is disgusting when learners come to school when they are pregnant?*
>
> Yes. [emphatic]
>
> *But you were a pregnant learner?*
>
> But I was not showing. I was not showing. If you show like in uniform, in a shirt like this – no.

Three months later I met Mbali at the health centre, in a school uniform and pregnant with her second child.

These findings show that support and shame work together to inhibit and encourage agency. They further illustrate how inescapable the discourse of early motherhood continues to be, even in contexts where education and motherhood is not uncommon.

Navigating the pervasive power of biomedicine

I draw here on Foucault's theory of the medicalisation of society and the role of biomedicine in social regulation (Foucault, 1973), where biomedicine has disciplinary power with "guidelines about how patients should understand, regulate and experience their bodies" (Lupton, 1997, p. 99). The pervasive power of biomedicine is ever present in the lived experiences of young mothers, and plays a critical role in perpetuating and disseminating the discourse of early motherhood (SmithBattle, 2009). This is experienced through health services which are a structural constraint to the agency of young mothers. The dominant discourse of early motherhood is deeply embedded in the health system, and requires "active" agency to navigate. Responsible motherhood is powerfully framed by medical determinism and the public health agenda, and is contingent on whether and how young mothers access health care for themselves and their babies. Young pregnant and parenting women are urged to heed the advice of medical experts rather than family and community, even when they are poorly treated and shamed by the same experts. Public health requires adherence and responsibility during pregnancy and after; to book early at community health centres, take ante-natal vitamins and eat well, exercise, and attend routine ante-natal care including HIV testing and treatment if necessary. After birth, responsible motherhood is demonstrated through feeding, regular health visits and immunisation for the infant. Breastfeeding is the ultimate goal, although being in school or employed is one of the greatest barriers to exclusive breastfeeding (Nieuwoudt, 2018, p. 61).

A key finding of this study is related to decision-making when a young woman discovers she is pregnant. At this vital conjuncture one of the choices available to the young woman is to terminate the pregnancy. When twelve young women in this study considered termination, they were unable to exercise their right because of health system challenges and community narratives around termination. Thus, their rights in relation to reproductive choice were denied, and they were forced to enter the world of early childbearing and responsible motherhood. In this example, their agency was constrained by wider structural and system level barriers (Varga, 2002).

Avoiding repeat pregnancy is a public health goal, and contraception after birth is critical. This is the priority of health care providers, and they actively pursue this through dispensing Implanon or the three-month injection (Depo Provera) to young mothers at the six-week post-natal visit. Health care providers rarely consider the personal family planning needs of young mothers (Pillay et al., 2019). The danger of not providing sensitive family planning services and its effect on adherence – leading to unintended pregnancy – recently received attention at the June 2019 South African AIDS Conference. The Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial was that there is no link between the injection and HIV (Ahmed et al., 2019): the relevance of this for my study is that it confirms the need to provide alternative and more contraceptive choices to women, and to prevent the one-size-fits all approach used for "for too many black and brown women who want choices, dislike side effects and deserve equity with high-quality contraceptive programmes in high-income countries" ("#SAAIDS2019," 2019; Pilane et al., 2019).

Breastfeeding as a medico-moral discourse (Seidel, 1993) is associated with public health messages like "breast is best" and "breast is free" (Seidel, 1998, p. 69). Here, motherhood is biomedically constructed, paying scant attention to the social and gendered construction of motherhood, and the realities women face like the nutritional needs of a feeding mother, the need for paid employment (Seidel, 2000) and in the case of young mothers, the aspiration to complete school. The slogan "breastfeed for a healthy nation" (Seidel, 2000, p506) is illustrative of how a biomedical public health message becomes a political one. Breastfeeding is therefore synonymous with being a good mother (Marshall et al., 2007; Nieuwoudt, 2018). More recently, the focus on the first thousand days in a child life, between conception to age two, adds to this biomedical discourse with a focus on nutrition (Pentecost and Ross, 2019). Young mothers were aware of this discourse, and often felt pressure because financial resources for other feeding options were not available. For parenting mothers, this meant managing the dual demands of breastfeeding while schooling, and enduring the associated stigma and practical challenges of this. Here breastfeeding was both an act of good motherhood *and* deviant adolescence and required that the young mother actively discarded the discourse of shame, as illustrated in other studies (Shefer et al., 2013). Pursuing education and/or employment meant that many mothers needed to engage in forms of co-operative caregiving, relying on the help and support from family or community, or in Alexandra through more formal structures of caregiving like crèches, to achieve this. This simultaneously eroded a young mother's agency in relation to feeding decisions for her baby,

putting her in a position of making impossible choices between being a good mother and a good citizen (going to school and/or finding a job).

The power of biomedicine was further present in the way young mothers expressed ideas of sex and sexuality. The idea of pleasure was absent from their narratives. Questions of sex, sexuality and pleasure were not directly addressed and may have been difficult to raise with a middle-aged woman. Young mothers discussed sex biomedically rather than as a social concept, with a focus on the risks associated with unprotected sex, pregnancy and HIV. Having already transgressed the rules of safe and responsible sex, young mothers had "failed" in relation to public health messages of safe sexual practices. However, there remained a disjuncture between their understanding of safe sex in relation to pregnancy and in relation to HIV. Understanding HIV risk and prevention was not an objective of the study, yet this remained present in the narratives of young mothers in relation to safe sexual practice, as they tried to express their responsible behaviour when it came to HIV prevention. When asked about contraception after pregnancy particularly in relation to protection from HIV infection, many young women claimed that they ensured they were safe from HIV because they "tested" all the time. Conflating testing with prevention was common: reflecting how the science of testing has been shaped using "vernacular science" language and knowledge of testing in everyday talk (Jensen and Blumling, 2018, p. 326). This raises concern whether the public health drive to increase access to testing is dominating messages of prevention; possibly an unintended consequence of increased access to HIV testing.

Aspirations before and after early motherhood

In this study, aspirations for young mothers presented as three related themes: young mothers and their families' aspirations for their daughters' post-school education and careers were high prior to pregnancy; these were adjusted at the onset of pregnancy and after; and opportunities to match aspirations of any kind, high or low, were limited in this urban context in South Africa.

At the vital conjuncture of conception, most young mothers had dreams of careers that required post-school education. Their career aspirations prior to pregnancy included, among others, becoming a pilot, social worker, lawyer, or training in nursing or geomorphology. In most cases, these aspirations were poorly matched to support from schools, academic results or financial reality. Families' aspirations for young women before pregnancy were linked to

hopes and dreams for education, a better life, and upward socio-economic mobility. Edin and Kefalas (2005, p. 65), describing Black and Latina families' disappointment when young women transitioned to early, unintended motherhood in Philadelphia, United States, wrote:

> …the realization that one's child will not be the rare exception to the neighborhood rule - the one who avoids early pregnancy, finishes high school, completes college, gets married, moves to the suburbs, and has children - in that order.

This is equally true in South Africa, reflecting the disappointment in families when young women fail to achieve the ideal life course trajectory and are seen to perpetuate early reproduction across generations, and with it, limited opportunity, unemployment and poverty. This is so even though ideal life course trajectories are not the social norm in South Africa.

Ayanda's (19) pre-pregnancy dream was to study further: at school she had shown potential and won a scholarship to a local private school. Having raised Ayanda after her mother died, Ayanda's grandmother Faith (62) was disappointed that her financial investment in Ayanda, and the sacrifices she had made, did not pay off:

> Since 2012 I was thinking to drop down to [resign from] work. I said 'No, I want Ayanda to see [achieve] the best, the matric, and then I see if …' I was just walking. I'm limping, I'm not right, I'm not well. So, I was just force myself to see [continue at work]. That's why I was so hurt when she's get pregnant and didn't pass that matric I was fighting for.

Faith's disappointment did not diminish her support for Ayanda and her baby, and she too adjusted her aspirations and focussed on supporting Ayanda to find work as a prelude to further education. Ayanda felt this disappointment sharply, and translated this into determination to become economically independent so she could support her baby and her grandmother.

The idea of letting family down, of failing in achieving "ideal" personal and family development, was experienced as shame and regret for many young mothers.

> When I found out I was pregnant it was a bad thing, mostly embarrassment and disappointment, because it wasn't my intention. I had good thoughts of myself and I had good wishes, like dreams, you see. So, that kept me or held me from pursuing with my dreams because this year I am staying [unemployed and not at school] and I wish to be at college or university after matriculating. So I couldn't go further because of being pregnant and having the son, so it was a bad thing actually (Charmaine, 19).

Aspirations were tailored to consider financial independence and material support for the baby as a primary goal, driven by the onus to take responsibility, to repair the "damage" of the unanticipated birth and to make good with their families. Adjusting aspirations was strongly gendered – it is the young mother, not the genitor, that adjusts her aspirations around education or employment, to be the "good mother" performing what society deems as responsible motherhood. This is seen in other studies as well (Shefer et al., 2012, p. 136).

In considering the aspirations of young mothers, I found that school results, knowledge about post-school opportunities, entrance requirements and funding limited young mother's access to these opportunities and illustrated that there were multiple hurdles to achieving their dreams. This was discussed in Chapter 7. Of the 24 mothers in school at the point of pregnancy, only two passed their matriculation with the required Bachelors pass for university entrance. Those who didn't had plans to upgrade their matric but the opportunities were limited because of funding, the pressure to work and not study, and to find caregivers for their babies. The financial pressure on households meant that young women needed economic independence before they could pursue education. My data supports national data on youth unemployment in South Africa and illustrates that the barriers to education completion are substantial for young South Africans, and opportunity for post-school education and/or jobs is limited. Thus, the official discourse of education as a pathway out of poverty holds little promise for young people and young mothers in particular.

Notwithstanding personal barriers to further education and employment, opportunities were rarely available for young mothers in Johannesburg. Even though young mothers adjusted their aspirations (down) after motherhood and recognised the need for economic independence before education and careers, early motherhood was only one obstacle, and paths to school completion and post-school education were circuitous and fraught with uncertainty. The social and economic position of young mothers, as well as their schooling experiences, suggested that there would be limited opportunities even if they had not fallen pregnant, reflecting the reality of unemployment in South Africa and the disillusion experienced by young people. This is more so for young women than young men – they have a lower likelihood of finding employment after school, even though levels of school achievement and completion are higher amongst young women (Woolard et al., 2014). This is borne out by the literature in other countries as well (Edin and Kefalas, 2005; Stapleton, 2010; Edin et al., 2016; Sniekers and van den Brink, 2019).

In spite of limited opportunities and the plethora of obstacles facing young mothers, having an unintended pregnancy in contexts of severe socio-economic disadvantage can serve to increase aspiration in an environment where reality kills aspiration, first discussed by Preston-Whyte and Zondi (1989) three decades ago. As described earlier, the desire for socio-economic mobility is cyclical, and young mothers too, aspire for their babies to have more than they have. In this study, I found that aspirations for their babies to have more was often accompanied by guilt; that this may be interpreted by their families and kin as a lack of gratitude for the support that they have provided. This was expressed by Andiswa (18) "I do appreciate what they are buying for her but I want more [for the baby]." The achievement of aspirations or the longer term impact of motherhood was not possible to assess in this study, given the limited exposure to young mothers over a relatively short period of time. However, young women did express a greater sense of responsibility and drive, akin to what Ngum Chi Watts (2015, p. 5) found in Melbourne, Australia amongst young, African mothers:

> For some young women, motherhood brought with it a sense of maturity, elevated responsibility and purpose. They began to regard themselves as adult and more mature. Becoming a mother meant they had to behave like responsible adults. Motherhood offered them an immediate family structure, and gave them a person they could truly love. For some, it brought an increased sense of self-worth.

With respect to aspirations for marriage and families, some young mothers in relationships with the fathers of their babies aspired to these "ideal" family goals, but here too, the flexible cultural system separating motherhood (*inhlawulo*) and marriage (*ilobola*) meant young women did not necessarily see having a baby as a reason to cede their aspirations for education and/or employment to early marriage. This cultural context is particularly valuable when women are young and may be economically vulnerable; they do not feel pressured into long term relationships with men they still need to build relationships with.

The neighbourhood context played an important role as a barrier to future aspirations, especially in this urban, highly mobile township where livelihoods were precarious: kinship caregiving was not always easily available and young mothers needed financial security to procure caregiving for their babies if they want to continue their education or seek employment. This echoes the findings of Woodward and colleagues (2013, p. 307) in New Zealand where they argued that early motherhood today can be a greater disadvantage than in the past because young mothers are more dependent on social assistance than previous generations, with contextual factors altering family and kinship systems, placing young

mothers in a precarious position. In this study, young mothers in Alexandra who were isolated from their kinship networks, because of distance or loss, were most vulnerable. Economic security and independence remained uppermost in the minds of young mothers: "I want to work, I want to support my child on my own, I don't want asking for money, for Pampers, for a lot of things… I wanna support my child for myself and my own, and support myself, and buy myself a chance" (Betty 20).

The case of Fezeka

In conclusion, I present the case of the Fezeka (20), to illustrate and summarise the main arguments of this section. I use a kinship network map, Figure 9.1, adapted from my field notes, to visually represent this.

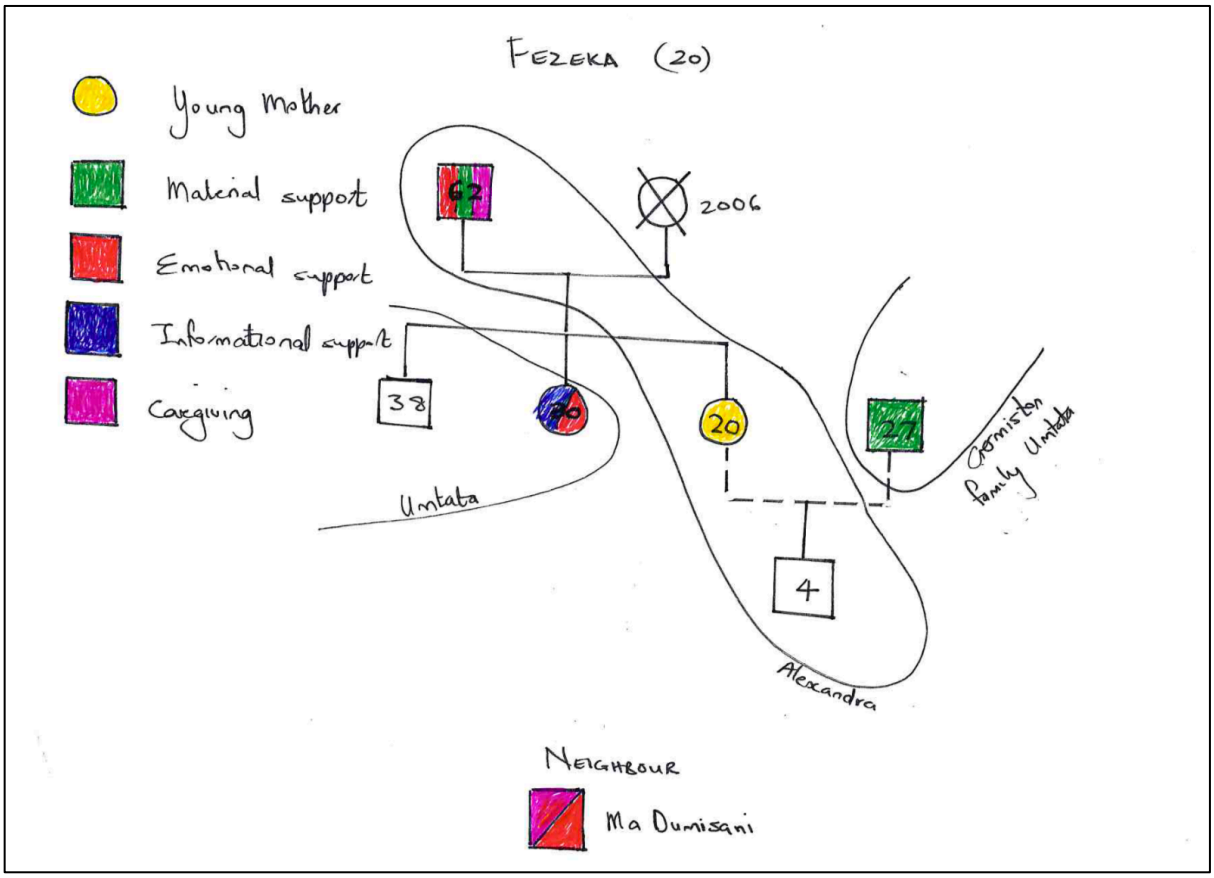


Figure 9. 1: Kinship network map of Fezeka (20 years old)

At the time of the first interview, Fezeka (20) was in a relationship with Bongani (27) and their son Isipho was four years old. Fezeka was 15 when she conceived, 16 when she gave birth, and she was living in Umtata, Eastern Cape, with her brother and sister. Her mother had died in 2006 and her father lived in Alexandra. Fezeka had been dating Bongani for two

months when she conceived. The negative reaction of school teachers and fellow learners to Fezeka's pregnancy forced her to leave school:

> I was still young and people were laughing, gossiping, every day at school they would call me for a meeting.
>
> *How did they find out?*
>
> The principal just called me to the office and say I must show her my stomach, then I did so then he said to me you are pregnant.
>
> *Is this a male principal or a female?*
>
> Female, I said no I'm not and she kept on saying that, then she called my sister and my brother. I went to a clinic for the test and the test confirmed that I was pregnant.

When Fezeka's father found out about the pregnancy, and heard of the schools reaction, he encouraged her to leave Umtata to live with him in Alexandra, which she did. Bongani's father asked Bongani to relocate to Johannesburg to find work when their family heard the news. After Isipho was born, Fezeka went to a college in Johannesburg to do a course in motor mechanics, which she successfully completed, but at the time of the interview, she had not been able to find a job despite many attempts. She described her father as the most significant person in her life, providing her with material, emotional and caregiving support. Bongani and Fezeka's relationship had been tumultuous, they had split up initially but had reunited in the last year. Fezeka was not sure whether she loved Bongani, but "I was thinking that no one would want me with another baby, with another man's child so I decided to go back to him." Bongani (27) provided some material support and his family had paid R10 000 for inhlawulo. Fezeka's neighbour, Ma Dumisani also provided Fezeka with support especially in the early days of motherhood, teaching her to bath and feed Isisipho as well as helping out with short-term care if Fezeka needed help.

Fezeka's story highlights a few themes that are germane to this study. It illustrates the fluidity and adaptability of families to unanticipated life events, and the movement of people between Alexandra and other parts of South Africa. Here, Johannesburg represents a safe-haven of anonymity after Fezeka's hyper-visibility in Umtata, where the gossip and shaming continued even after Fezeka had left. The school's reaction – illegal and unethical – and its consequent effect on Fezeka's future, is an example of policy failure. The case also provides an alternative narrative of fatherhood: Fezeka's father was the only father in the study to provide the main support to the young mother, and his support was consistent, allowing her to find an alternate path to school completion. Bongani remained present in their lives even though he

was inconsistent as a provider; and Bongani's father was instrumental in urging him to find work in Johannesburg so that he could support his child. The paternal kin had paid *inhlawulo*, and were further involved with caregiving when Isisipho visited them in the Eastern Cape during holidays. Fezeka's inability to find employment remained her biggest challenge: in spite of adjusting aspirations from completing secondary school to study law *to* studying motor mechanics at a technical college as a faster and a more realistic path to economic independence and security, she remained unemployed.

Limitations

This discussion must be interpreted within the limitations of the study, which represents early motherhood through the lens of thirty young mothers. This is a small sample and any statistical data presented is for description only. The depth of data from the nine young mothers interviewed twice and the six young mothers interviewed three times illustrated how rapidly things changed for them in the period following the birth of their babies, and cautions against reading too much into the data. The expanded understanding of the lived experiences of young mothers was evident in cases where interviews were with both young mothers and significant others, illustrating the value of ethnographic data. Most notable was the issue of IPV, which arose only in third interviews, illustrating the time needed to build relationships of trust to share painful stories. Second and third interviews also revealed the changing nature of romantic and family relationships, household disruptions and changing patterns of kinship networks. The genograms (Appendix 16) elucidated this and were expanded to kinship network maps to include support networks and family movement into and out of Alexandra during second and third interviews. Furthermore, even where young mothers were engaged with me over the course of the year, one year is a short period of time in the life of a new mother.

CHAPTER 10: ADJUSTING ASPIRATIONS

CONCLUSION AND RECOMMENDATIONS

The aim of this study was to understand how young mothers (18 to 20 years) exercise agency in early, unintended motherhood in an urban area in Johannesburg, South Africa. I explore the intersection of individual agency and the structural context in which it is exercised. My data illustrates how the flexibility of the social and cultural system in which young mothers are embedded allows them to navigate early motherhood in multiple and complex ways. Young mothers practice "malleable motherhood" (Johnson-Hanks, 2006, p. 205); agency is enacted and constrained in different ways. There is no single story of how this is experienced (Adichie, 2009; Mkhwanazi, 2015). Their ambitions for education and employment are mediated by structures – fixed and fluid – which determine whether they adjust their aspirations up or down; their agency is contingent on this.

As a contribution to scholarship on reproduction and kinship, I examine the experiences of young mothers through the timeline of early motherhood throughout pregnancy and after birth, and offer a lens into social support, education and health, exploring how these systems work separately and together to enable and constrain agency. I show how the agency of young mothers is constrained by the power invested in structural institutions like schools and health services, so confirming how human action is mediated by structure and agency (Giddens, 1984). Even where young women are constitutionally and legally protected, when pregnant they experienced discrimination and hostility, and they were sometimes refused access to services, including termination of pregnancy and continued school attendance. I also show how women's agency challenge and resist the pejorative discourse around early motherhood in a patriarchal context, and how they actively and passively advocate for their rights to services.

I highlight the power inherent in discourse, operationalised and enacted through structure, and the ways that this works to limit the agency and aspirations of young mothers. The aspirations of young mothers are in a constant state of flux, mediated by their social networks, the availability of kinship capital and structural constraints. The kinship network maps, that used genograms as the basis for mapping kinship networks and other social support, were a methodological contribution to the scholarship of kinship and families. They were a compelling conceptual tool in understanding the multiple forms of family, households,

kinship networks and social support, and the way they articulate with each other, illustrating how this works to alleviate or amplify some of the negative consequences of early motherhood. Thus, I add to a growing body of literature on the importance of understanding the social and cultural context of early motherhood, and the value of social support in mitigating some of the negative consequence associated with this (Sax, 2010; Brand et al., 2014a, 2014b).

In paying attention to the social address (Bronfenbrenner, 1986, p. 724) of young mothers in this study, the kinship network maps add texture and deepen the meaning of the social context in which young women live. They illuminate how movement between rural, peri-urban and urban areas which began during the early years of apartheid has endured over time. The articulation between Alexandra and other areas in South Africa reveal the dynamics of a constantly changing labour market, and the promise of socio-economic opportunity in an urban hub, even in the context of severe unemployment and underdevelopment. While I emphasise the value of these networks and kinship capital, I am cautious not to overstate their value and create overly romanticised notions of family and kin, which understate the strain on families and households in resource poor contexts, and serve to allow the state to default on the role it should and must play (Manderson et al., 2016a).

The agency of young mothers is constrained by pervasive socio-economic disadvantage and gender discrimination. The Child Support Grant plays a critical role in mediating this, providing young mothers with income for childcare which is a major facilitator of school continuation and completion. In negotiating gender mediated power imbalances, young women in this study enacted “modern” and more “conservative” forms of feminism; illustrating varying levels of agency in their relationships with genitors and their families (Jewkes and Morrell, 2012). Here too, kinship capital and other forms of social support, as well as the Child Support Grant, were protective in empowering women to mediate these relationships. While the central objectives of the study did not include understanding fatherhood, age disparate relationships, or intimate partner violence; the data highlights that these issues are woven into the fabric of young women’s lives.

I add to an emergent literature that honors the diverse forms of families in South Africa (Rabe and Naidoo, 2015; Mkhwanazi and Bhana, 2017; Hall and Richter, 2018), paying attention to the complex way in which young families in this study were constituted, and the multiple configurations of household and kinship networks wherein young mothers and their babies

were embedded. The findings from this study are not generalisable to the wider population; however, they contribute to this emergent literature. The study findings provide contextual nuances and narratives that offer a magnified view into the lives of young mothers in urban South Africa; these complement national studies and data that track changes in early motherhood over time, and the implementation and impact of policies in protecting development outcomes for young mothers and their children.

In this thesis, I argue that the South African policy framework is progressive in relation to international good practice, but falls short in implementation. The study highlights the unintended consequences of policy; it illustrates how policy to improve the lives of adolescent girls and young women creates a pernicious discourse around young mothers, who represent the failure of policy implementation. This thesis elucidates the latent power in public health messages and the impact this power – experienced as discourse – has on the everyday lives of young women.

Policy embraces a biomedical framing of cause and consequence that is short-sighted: it fails to adequately consider the intersection of multiple factors that influence experiences of early motherhood; race, gender, socio-economic status, culture, neighbourhood context, migration and movement, social support, kinship capital and aspiration. This points to the widely acknowledged importance of addressing the social and structural context: failure to address these factors with serious intent means that the opportunity cost of early childbearing is not significant in contexts of severe socio-economic disadvantage, crippling unemployment, limited opportunities for education especially at a post-school level, and a health system that fails to deliver youth sensitive sexual and reproductive health services. It also shows that South African policy needs to be more attuned to the local context, especially in relation to family and households, honouring indigenous social structures, systems and practices (Wood, 2012, p. s20) and their value in social reproduction.

Recommendations for Policy and Programmes

In this study, I presented the range of policies, international and national, that serve to protect the rights of young mothers and their children. At a super-structural level, the Sustainable Development Goals (United Nations, 2015) target health, education, economics and social protection for young women and their children, with a focus on Early Childhood Development as a growing area for intervention to improve child development outcomes. In

South Africa, the National Development Plan 2030 (National Planning Commission, 2012) and sector specific policies serve to address this. There is increasing awareness of the importance of the first thousand days of life in a child's life – from pre-conception to age two – in relation to child development and health, in the shorter and longer term (United Nations, 2015). In early childbearing, this is when young mothers are especially vulnerable, when they would most benefit from targeted interventions and support to ensure they achieve their aspirations for themselves and their babies.

In considering *how* to support young mothers during pregnancy and after the birth of their babies, the recommendations are organised within the three focus areas of the study: social support (protection), education and health. However, there are no clear boundaries, and the three fields are interdependent; interventions for young mothers require an integrated approach. In the language of HIV and AIDS implementation science, they require considering the health and wellbeing of young mothers and their babies as something to "mainstream" into all interventions.

Social support

In this thesis, I have presented the value of social support and kinship capital to mitigate the consequences of early childbearing, especially in relation to caregiving, material, emotional and informational support. These are informal and organic and not always available in urban contexts. The psychosocial wellbeing of mothers and the associated outcomes for young children is well documented (World Health Organization, n.d.; Britto et al., 2017; Chan et al., 2017; Daelmans et al., 2017; Lo et al., 2017). Furthermore, the value of the Child Support Grant as a pathway to economic security (particularly food security for the baby), increased independence and childcare was a key finding of the study.

I recommend the following interventions to improve social support for young mothers:

Removing all barriers to access the Child Support Grant. The current requirements to access the Child Support Grant include Identity Documents, birth and death certificates, and were found to be barriers to access the Child Support Grant because young women do not always have these documents. The Department of Social Development and the South African Social Security Agency must heighten efforts to remove these barriers. In addition, efforts must include linking all child caregivers to the Child Support Grant, paying attention to the number of children who live in kinship care arrangements (Proudlock and Rohrs, 2018, p. 19). Early

Childhood Development centres, schools and health services must play a role in identifying young women eligible for the Child Support Grant and refer appropriately; public sector workers must understand their responsibility to do this.

Provision of social assistance during pregnancy. The study findings add to the evidence on the importance of wellbeing during pregnancy as a critical time in the first thousand days of life (Scorgie et al., 2015). I support the call to extend the Child Support Grant, or create a new grant mechanism, to provide social assistance during pregnancy. Food security is essential to meet the additional nutritional demands required during pregnancy and while breastfeeding, and has been found to be critical in protecting women from intimate partner violence (Gibbs et al., 2018). Furthermore, social assistance during pregnancy will alleviate the stress of travel costs in getting to and from health services; this will ensure access to health services, and contribute to improved maternal and child health outcomes in South Africa.

Developing the capacity of all practitioners (teachers, nurses, community workers) to provide basic psychosocial support to young pregnant and parenting women. The emotional and mental health of young pregnant and parenting women must be prioritised. This study highlighted the value of "thin" support or "weak ties" (Granovetter, 1973, 2005), which played an important role in making young mothers feel visible and supported. Unintended pregnancy is associated with emotional distress, depression, and poor mental health (Jacobs and Mollborn, 2012) indicating the need for more support during pregnancy (Mlotshwa et al., 2017); this is exacerbated when women are young and subject to heightened stigma and discrimination. It is therefore important to remove the existing barriers to care and improve their experience of service providers with whom they are forced to interact for their health, education and wellbeing.

Create networks of support through forums or meeting groups for young pregnant and parenting women. Young pregnant and parenting women in urban areas have relatively little support and become isolated from their peer and community networks, and they have increased economic and care commitments and responsibility. Some countries have responded to this by creating opportunities for young mothers to network and meet with each other face-to-face or through virtual communities – for advice, companionship and solidarity. This should be considered in South Africa; groups can be convened at health centres, schools or the community, and can be facilitated or supported by health care providers, teachers, community or social workers. Current programmes to improve maternal and child health

outcomes are an opportune space to hone in to the needs of young mothers; for example, mothers2mothers – addressing paediatric AIDS ("mothers2mothers," n.d.) , Philani Maternal, Child Health and Nutrition Project – a programme of Mentor Mothers ("Philani," n.d.), and MomConnect – a government based web based platform providing key maternal and child health messages ("MomConnect," n.d.).

Improve Early Childhood Development (ECD) services. Access to ECD services, including crèches, is important for young mothers, particularly in urban areas where more traditional forms of caregiving, through family, may not be available. It is important that these services provide quality care – in this study many young women removed their babies from crèches because of perceived sub-standard care and over-crowding.

Education

Interventions in the education sector, specifically schools, must strike a balance between treating pregnant and parent learners without discrimination (as any other learner), yet simultaneously recognising and accommodating their particular experiences, to facilitate school continuation and completion. Schools need to address the educational *and* social exclusion experienced by pregnant and parenting learners (Harden et al., 2009, p. 9). The value and limitations of Life Orientation (Comprehensive Sexuality Education) continues to be a barrier for parents, teachers and learners (Lan Anh Thi Do et al., 2017). However, young women in this study were aware of prevention, especially as related to HIV. The Integrated School Health Programme was not discussed by young women in this study, although as schools were not visited, this does not mean that the programme was absent.

I recommend the following interventions for the education sector to prevent early childbearing, as well as to encourage school continuation and completion for pregnant and parenting learners:

Schools provide integrated services for young people. The secondary school should be reconceptualised as a space where adolescents and young people access a range of services, in addition to schooling. This requires a broader vision of education as a vehicle to address structural inequality in its embedded social context, supporting young people to plan realistically for their futures given the range of structural and social deterrents. For example, schools should be a space in the community where NGOs and other service providers offer skills development, mentorship programmes, CV writing workshops, post-school education

and bursary application support; acknowledging the barriers young people face in accessing these services. ECD centres should be set up in or alongside schools, so that in-school and out-of-school parenting young people, teachers and the broader community can access these services thereby removing a major barrier for young parenting women. This must be addressed in a socially sensitive manner, paying attention to removing the stigma young parent learners currently face. In addition, the potential for schools to offer sport and recreational activities after school and at weekends must be considered: the study highlighted the absence of such spaces for young people in this urban community. These services will address the education system in total *including* ECD; thereby improving the value and experience gained from school, raising hope, ambition and aspiration, and providing social support and skills.

Developing the capacity of teachers to provide basic psychosocial support to young pregnant and parenting learners. This involves training ALL teachers (not just Life Orientation teachers) to offer counselling to young pregnant and parenting women, as part of the broad package of care and support offered at schools. Periodic assessments or informal check-ins will ensure that any young pregnant or parent learner in need of support to remain at school, to manage her studies through the birth and after, to manage the dual demands of breastfeeding and schooling, or needing caregiving support for her baby is assisted within the school context or referred appropriately. In addition, teachers must consider how to provide on-going education support to pregnant and parent learners if school attendance is compromised, for example, in the period after childbirth, or when health services are required.

Life Orientation (Comprehensive Sexuality Education) must address structural inequality, especially gender norms. The Life Orientation programme in South Africa must pay greater attention to the context in which adolescent sexuality grows and develops. Addressing gender norms is as important as messages about prevention and the current focus on condoms and testing. Sexuality education must be framed as a rights-based, empowering conversation, paying attention to equality in sexual relationships with a focus on healthy sexual development, sexuality and sexual pleasure, steering away from current heteronormative, risk-based discourse.

Male and female condoms, as well as pregnancy testing kits, should be provided at all secondary schools in South Africa. The Integrated School Health Programme is currently the vehicle for the provision of basic Sexual and Reproductive Health (SRH) services to schools;

yet South Africa's limited resource capacity, human and financial, means that this programme is still being rolled out across South Africa. Basic SRH services, like providing condoms and pregnancy tests, should be mainstreamed into schools, recognising schools as important points of contact with young people, and therefore an ideal space to provide basic prevention services. Testing early for pregnancy is imperative for women who may seek termination services, and to encourage early booking for maternal health care.

Health

In this study, I have identified three important areas for intervention in the health sector. The first is to remove the punitive stance of health care providers in the provision of services. This requires removing all obstacles to service access, including contraception before pregnancy and all areas of maternal and infant care. Second, there is a need to specifically remove the social and structural barriers to abortion (Varga, 2002; Ngwena, 2003; Jewkes et al., 2005; McQuoid-Mason, 2010; Macleod, 2011a; Sanger, 2016; Mosley et al., 2017) and to minimise women's vulnerability to seeking termination outside health facilities. Third, there is a need to ensure adequate staffing and training of health care providers to enable the government to realise its commitment to Adolescent and Youth Friendly Services (AYFS). In general, improving the quality of maternity care is critical to impacting on young women and their babies (Allen et al., 2012).

I recommend the following interventions to improve access to and delivery of health services to young pregnant and parenting women and their children:

Training health care providers in basic psychosocial counselling skills, to provide support to young mothers as well as to each other. This would serve to heighten health care provider's sensitivity to the needs of young pregnant and parenting women, as well as provide psychosocial support to health care providers who are confronted with the difficult realities of peoples' lives. ALL nurses working in any area of maternal and child health should receive this training, irrespective of whether they are providing adolescent and youth services or not. This is especially so in the South African primary health care context where health care providers work across departments to manage patient numbers and other health system challenges. Providing nurses with basic psychosocial support skills is a way to mitigate the lack of capacity in the healthcare system, and to create a system of peer support within the health service, with benefits to each other as well as patients.

Pregnancy testing kits should be easily available and accessible in health care centres without requiring interacting with a health care provider. This would ensure that young women are able to test for pregnancy early and can seek termination services in a timely manner if they choose to do so, without fearing intimidation or discrimination from health care provider because of their age. This will also facilitate early booking for maternal health care, particularly important for young women under 17 years.

Improve access to, and communication on, termination services. All facilities should provide basic information about termination services including legal parameters, timelines, referrals, and contact details for facilities where termination services are available. This could be through print materials, posters, billboards, or using technology-based media.

Improve contraception and family planning services. When young women seek SRH services before or after pregnancy, it is a window of opportunity for personal contact and the opportunity to deliver targeted advice to individual young women. This has been found to provide young women with greater agency which is associated with lower exposure to gender based violence (Heidari and Moreno, 2016, p. 2). Nurses must be trained to recognise the needs of young mothers, and provide sensitive family planning services that consider their age, relationships, sexuality and future family planning needs. A one size fits all approach of the injectable or implant contraceptive is not appropriate and serves to alienate women from health services further, and discourage adherence (Sheeder et al., 2009, p. 302). Furthermore, individual and targeted contraception counselling decreases rates of repeat adolescent pregnancy (Rowlands, 2010).

Birthing companion during labour. All women should be allowed a birthing companion. Birthing companions are recognised as international good practice in preventing obstetric violence. Birthing companions in the South African public health service would ensure that the rights of (young) women are protected and would provide them with support through the birth. They would also support health care providers who are often overwhelmed by patient numbers and unable to provide quality care and support to women during labour, birth and after; thereby decreasing a health system challenge and the heightened risk of obstetric violence.

Extend sexual and reproductive health and maternal and child health services to Saturdays. Adolescents and young people; in school, out-of-school, employed and job

seeking; struggle to attend routine health services during weekdays. Most public health centres require attendance from 7am to access immunisation and other services. This adds to the pressure of young pregnant and parenting women: extending hours of service will facilitate women to achieve greater independence and control over decisions that affect their health and wellbeing, as well as that of their children. It would ensure improved adherence to ante-natal, immunisation and family planning guidelines.

Recommendations for future research

There is a wide body of literature globally and in South Africa on early childbearing: most of this is situated within the dominant framework of cause and consequence. An emergent body of literature complicates this framing, but remains under-represented in research and writing. There is a need for an expansion of longitudinal studies, across a variety of contexts, to better understand the needs of young pregnant and parenting women, young parenting men and young families, to understand how to mitigate the disadvantage associated with them.

Plans for further publication from this study include:

1. "Policy and practice: do the lived experiences of young mothers in an urban area in Johannesburg, South Africa reflect the intended rationale of policy aimed at adolescent girls and young women in South Africa." This paper will address three broad policy imperatives that seek to achieve improved outcomes for adolescent girls and young women in South Africa; namely, keeping girls in school, improving sexual and reproductive health services to adolescents, and decreasing HIV and teenage pregnancy.
2. "Barriers to termination services for young pregnant women in urban South Africa." This paper will explore the barriers twelve young women in this study faced when seeking termination services. The paper will attend to the disjuncture between policy and practice.
3. "Not all fathers are absent: exploring how fathers offer care and support to young mothers in Alexandra, Johannesburg." This paper will elaborate on all forms of fatherhood presented in the data – genitors, fathers and grandfathers – represented through the eyes of young mothers. The paper will seek to complicate current representations of fathers as absent in the context of unintended, ex-nuptial pregnancy and parenthood.

Concluding comment

Developmental Idealism is persuasive as a cultural framework, and has influenced the framing of adolescent and family development in South Africa. In this study, I have shown how this is present in policy and discourse, and subsequently in the lived experiences of young mothers after an unintended, ex-nuptial birth in urban South Africa. The pervasive effects of this discourse have been a recurring theme: the dominant discourse of early motherhood in South Africa is embedded within Developmental Idealism. Young mothers' aspirations align with this. Young mothers aspire for higher levels of education, nuclear families and economic independence from their families and kin. Their aspirations for these ideals remain despite the social, cultural and structural constraints of their personal, family and community contexts, and the disadvantages conferred to them by not practicing disciplined reproduction. Young mothers adjust their aspirations and exercise agency in nuanced ways along a continuum influenced by the social and structural context: they show that unintended pregnancy is not irreconcilable with future aspirations.

> "There is no more future for me? Like really, are you kidding? A baby is not the end of the world." (Sesi, 18)

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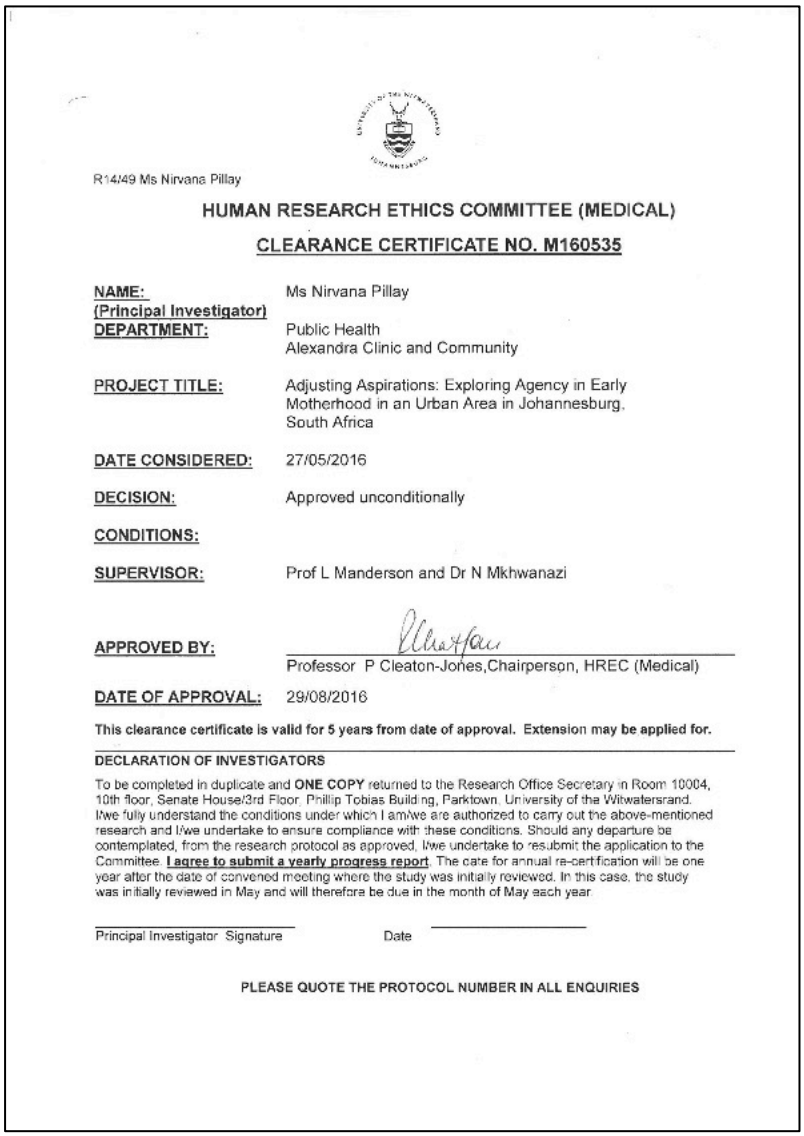
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APPENDICES

APPENDIX 1: HUMAN RESEARCH ETHICS COMMITTEE CERTIFICATE



R14/49 Ms Nirvana Pillay

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M160535

NAME: (Principal Investigator)	Ms Nirvana Pillay
DEPARTMENT:	Public Health Alexandra Clinic and Community
PROJECT TITLE:	Adjusting Aspirations: Exploring Agency in Early Motherhood in an Urban Area in Johannesburg, South Africa
DATE CONSIDERED:	27/05/2016
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Prof L Manderson and Dr N Mkhwanazi
APPROVED BY:	Professor P Cleaton-Jones,Chairperson, HREC (Medical)
DATE OF APPROVAL:	29/08/2016

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

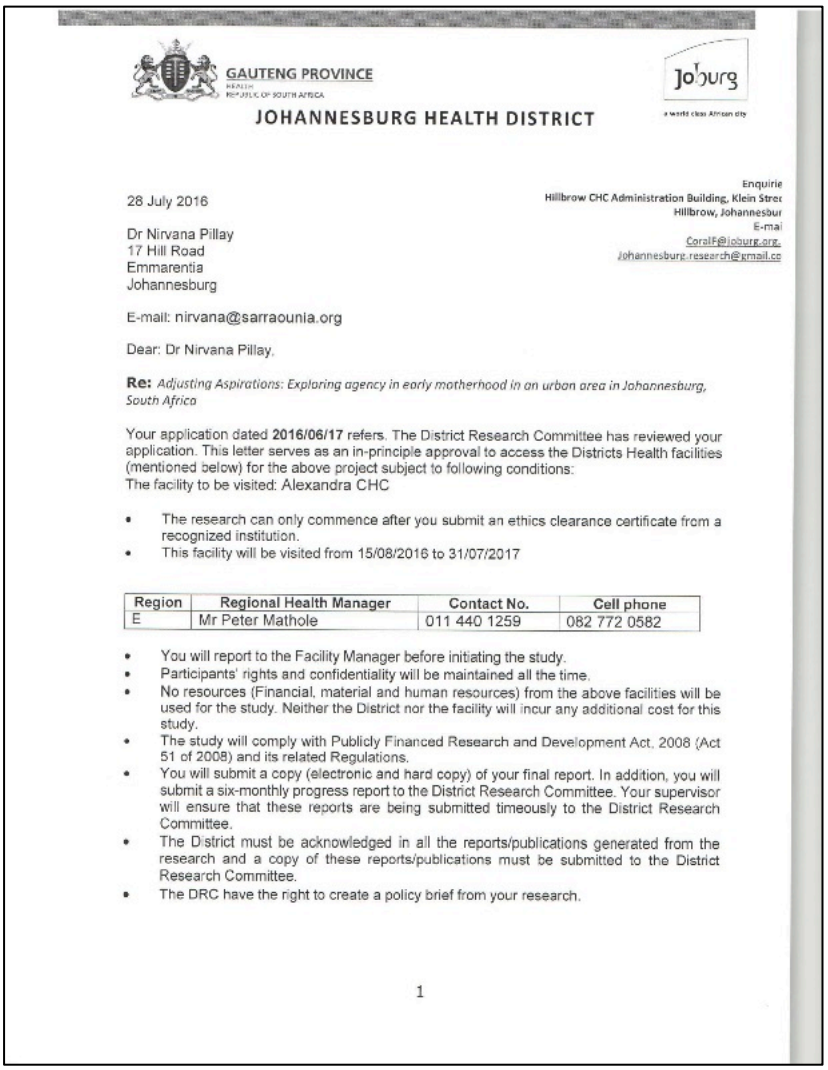
DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004, 10th floor, Senate House/3rd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in May and will therefore be due in the month of May each year.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX 2: JOHANNESBURG HEALTH DISTRICT RESEARCH APPROVAL



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

JOHANNESBURG HEALTH DISTRICT

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a world class African city

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28 July 2016

Dr Nirvana Pillay
17 Hill Road
Emmarentia
Johannesburg

E-mail: nirvana@sarraounia.org

Dear: Dr Nirvana Pillay,

Re: *Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa*

Your application dated **2016/06/17** refers. The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project subject to following conditions:
The facility to be visited: Alexandra CHC

- The research can only commence after you submit an ethics clearance certificate from a recognized institution.
- This facility will be visited from 15/08/2016 to 31/07/2017

Region	Regional Health Manager	Contact No.	Cell phone
E	Mr Peter Mathole	011 440 1259	082 772 0582

- You will report to the Facility Manager before initiating the study.
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee. Your supervisor will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.
- The DRC have the right to create a policy brief from your research.

1

APPENDIX 3: ETHICS COMMITTEE ACKNOWLEDGEMENT OF THEFT REPORT



UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

13 October 2017

Ms Nirvana Pillay
17 Hill Road
Emmarentia
2195

Sent by email to: nirvana@sarraounia.org

Dear Ms Pillay

Re: **Protocol Ref no: M160535**
Protocol Title: Adjusting Aspirations: Exploring Agency in Early Motherhood in an Urban Area in Johannesburg, South Africa
Principal Investigator: Ms Nirvana Pillay
Theft Report

This letter serves to confirm that the Chairman of the Human Research Ethics Committee (Medical) has noted the theft report of the study laptop and documents for the abovementioned protocol, as detailed in your letter dated 02 October 2017.

Thank you for keeping us informed and updated.

Yours Sincerely,

L. Moeng

Mr Lebohang Moeng
Administrative Assistant
Human Research Ethics Committee (Medical)

UNIVERSITY OF THE WITWATERSRAND OFFICE OF THE DEPUTY VICE CHANCELLOR RESEARCH 13 OCT 2017 RESEARCH OFFICE HREC (Medical) JOHANNESBURG

Research Office Secretariat: Faculty of Health Sciences, Phillip Tobias Building, 3rd Floor, Office 302, Corner York Road and 29 Princess of Wales Terrace, Parktown, 2193 Private Bag 3, Wits 2050 | T+27 (0)11-717-1234/2656/2700/1252 E: Lebo.Moeng@wits.ac.za | Office E HREC-Medical.ResearchOffice@wits.ac.za |Website: www.wits.ac.za/research/about-our-research/ethics-and-research-integrity/

APPENDIX 4: ETHICS EXTENSION APPROVAL

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

05 October 2018

Nirvana Pillay
17 Hill Road
Emmarentia
2195

Sent by email to: nirvana@sarraounia.org

Dear Nirvana Pillay

Re: **Protocol Ref no: M160535**
Protocol Title: Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa
Principal Investigator: Nirvana Pillay
Protocol Amendment: Extension of original study to include two further groups of stakeholders

This letter serves to confirm that the Chairman of the Human Research Ethics Committee (Medical) has noted and approved the protocol amendment for the abovementioned protocol, as detailed in your letter, dated 30 August 2018.

The following documents were received:

- Summary Letter
- Protocol
- Consent form
- Interview guides

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
OFFICE OF THE DEPUTY VICE CHANCELLOR (RESEARCH)
05 OCT 2018
RESEARCH OFFICE HREC (Medical)

Thank you for keeping us informed and updated.

Yours Sincerely,

.....
Miss Charmaine Khumalo
Administrative Officer
Human Research Ethics Committee (Medical)

Research Office Secretariat: Faculty of Health Sciences, Phillip Tobias Building, 3rd Floor, Office 304, Corner York Road and 29 Princess of Wales Terrace, Parktown, 2193 Private Bag 3, Wits 2050 I **T**+27 (0)11-717-1234/2656/2700/1252 **E**: Charmaine.khumalo@wits.ac.za I **Office E** HREC-Medical.ResearchOffice@wits.ac.za IWebsite: www.wits.ac.za/research/about-our-research/ethics-and-research-integrity/

APPENDIX 5: INFORMATION SHEET FOR YOUNG MOTHERS

Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa

Contact details of researcher
Name of researcher: Nirvana Pillay
Position: PhD student
Contact details of researcher: cell: 083 55 000 55/email:nirvana@sarraounia.org

My name is Nirvana Pillay. I am doing research to understand the experiences of young mothers aged 18-20 in the Alexandra area. I am doing this study for a PhD in the School of Public Health, the University of the Witwatersrand. This means that I will be writing a thesis, which is like a book.

This information sheet is about the study and what it will involve for you. This information sheet may contain information that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, please feel free to ask me.

As a young mother, I would like you to participate in my research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

The purpose of the study

The study is being conducted in Alexandra with young mothers between the ages of 18 and 20.

I would like to understand:

- how young mothers cope once they have fallen pregnant; how young mothers make decisions about the baby;
- how young mothers keep healthy after the baby is born; and
- how young mothers make decisions about their future.

I would also like to know more about who supports young mothers through their pregnancies, during the birth and after.

Study Procedures

Interviews

If you decide to participate in this study, you will be invited to participate in three private interviews. The interviews can be conducted at the Alexandra clinic, at your home, or anywhere else you would like to be interviewed. The interviews will be conducted over the next 9 months. Each interview is expected to take around an hour, but we can take breaks, or divide the time so that you can attend to your baby too. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question. No one else but me or a translator will be present, unless you would like someone else to be there.

The interview will be conducted in English with me. If you prefer to speak in a local language, a translator will be available to translate during the interview. The interview will be conducted as a conversation so that I can learn more about your experiences of early motherhood.

The following topics will be explored during the interviews:

- The life of young mothers in the 12 months following the birth of the baby
- How and why decisions are made around the care and wellbeing of the baby
- To understand how and why young mothers make decisions around their own health and wellbeing, in particular their sexual and reproductive health
- To understand how early motherhood impacts on plans for the future
- To understand who supports young mothers through the pregnancy, birth and after; how they are able to help and support and the impact of that support.

At the first interview you will be asked for information about yourself, including for instance your relationships, your family, what you do, your health, and about the people in your life who support you. You will be asked about updates of this at every interview. At the end of the third interview, I will ask your permission to speak to someone in your life who has been a major source of support to you during the first year of motherhood. You will be asked for help to set up that interview.

The interviews will be audio-recorded with your permission. The information recorded is confidential, and no one else except me and my academic supervisors will have access to the information documented during your interview. The recordings and transcripts will be kept safely in locked files and will be destroyed after five years.

Possible risks

I am asking you to share personal and confidential information during the interviews. Sometimes you may feel uncomfortable talking about some of these things. You do not have to answer any questions if you do not wish to do so. You do not have to give any reason for this. If you feel sad or emotional or feel you need any kind of support, I will refer you and help you access the Ububele Centre and the Alexandra Clinic where you will be provided with support.

Possible benefits:

You will not benefit directly from participating in this study. However, I hope that the information you provide will be useful to help improve the support offered to young mothers in communities.

Costs to you:

You will not be provided with any incentive to participate in this research. Participating in this research will involve no cost to you. At each interview, you will be given R40 for your transport costs. After the first interview, you will be given airtime of R40 to assist with scheduling the next interviews.

Right to refuse to participate in this research:

You do not have to take part in this research if you do not wish to do so. You have the right to agree or refuse to participate in this research at any point. If you decide to participate and later change your mind, you are free to stop the interview at any time. You can do one or two interviews and decline the next interview. Your refusal to participate will not result in any penalty or loss of benefits to which you are otherwise entitled.

Records of your participation in this research:

You have the right to privacy. The researcher will keep information about your participation in locked files. Any notes or recordings from the interviews will also be kept securely and any information that may identify you will not be shared with anyone. Any information about you will have a number on it instead of your name. Only I will know what your number is.

- Ethical approval: This study protocol has been submitted to the University of the Witwatersrand's, Human Research Ethics Committee (HREC), and written approval has been granted by that committee. Ethics Clearance number: X

Publication of the results of the research: The results of this research may appear in scientific publications, but I will not identify you in any way. Your name will not be used in the reporting. If I quote something you say, I will use a different name, and no details will be included that could potentially identify you.

- As per HPCSA guidelines, we will preserve the audio records for a minimum of two years after the study results have been published or six years if there is no publication.

Your questions:

I am available to answer your questions about this research. You may contact me at any time on the number 083 55 000 55.

If you have any questions or concerns about your rights as a participant, you may contact Professor Peter Cleaton-Jones at the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 2301).

YOU WILL HAVE A COPY OF THIS INFORMATION SHEET TO KEEP

If you agree to participate in the study, you will be asked to read and sign the attached consent form on the day of your interview. This form will confirm your agreement to participate.

Your signature on the consent form will certify the following:

- You have read the information provided in the information sheet
- You have been provided with an opportunity to ask questions about the research and have received answers to your questions
- You understand that you are free not to participate in this study and to withdraw from this study at any point
- You have freely decided to participate in this research
- You understand that you are not giving up any of your legal rights.

APPENDIX 6: IN-DEPTH INTERVIEW GUIDE FOR YOUNG MOTHERS (LONGITUDINAL)

INTERVIEW 1

Good morning/afternoon! My name is Nirvana Pillay. Thank you for agreeing to speak to me and for making this time available for us to speak. I am going to start by asking you for some information about you. I will then move on to ask specifically about the pregnancy and the first few months after the birth.

Details of interview
Date of interview:
Place:
Time:
Interviewer:
Others present:

Details of young mother
Interviewee Name:
Date of Birth:
Age:
Race:
Study code:
Residential address:
Cellphone number:
Alternative number 1:
Alternative number 2 (optional):

Details of baby
Name of baby:
Date of birth of baby:
Current age of baby:

INTERVIEW 1

Note: Probe and follow the story the young mother is telling, without necessarily following the order of questions. Make sure all questions have been asked. Use the names used by the young mother during the interview. Use the baby's name throughout the interview.

Pregnancy

1. Can you tell me about what happened when you first found out you were pregnant?
Probe for: whether the pregnancy was planned, feelings/emotions, decisions around keeping the baby if unplanned or mistimed, support from whom, disclosure, reactions from family and friends, challenges.

2. Can you tell me about your relationship with the father of the baby at the time you found out about the pregnancy, whether you told him you were pregnant and if he supported you in any way?
Probe for nature of relationship, father's reaction if told, support if any with decision to keep the baby, and during the pregnancy; his family involvement and support (if any); status of the relationship at present.

3. Can you tell me about what was happening in your life at the time you found out about the pregnancy?
Probe for whether at school, post school education, work, unemployed; impact of the pregnancy on this, support, challenges.

4. Can you tell me about what kinds of support you received during your pregnancy, and what your challenges were?
Probe different types of support: financial, physical, emotional, information, decision making; from whom.

5. Can you tell me generally about the pregnancy, your health and how you coped?
Probe for antenatal care; care, advice and support from clinic; support with health and care for herself during pregnancy (if any).

Birth

Now I would like to ask you about the birth ….

6. Please tell me about the story of the birth?
Probe for kind of birth, delivery and after, experience of health services, fears.

7. Tell me about ***who*** supported you during the birth and in the initial period after the birth, and ***how*** they supported you?
Probe nature of support: transport, clothes, emotional, baby essentials, advice.

8. Tell me about the time immediately after the birth and how you coped with having a new baby in the first few days and weeks?
Probe for learning to care for an infant (washing, nappies, cuddling, feeding), support, feelings, challenges.

Post Birth to Present

We are now at the last section of this interview. I'd like to ask you about your life at present.

9. Tell me about your daily activities and routine – what does an average day look like for you?
Probe for whether still at school, post school education, work or stay at home; how soon after the baby was born, care for baby, support with care for baby and herself, challenges?

10. Tell me about your social life, what you do on weekends, and what you do in addition to being a mother?
Probe for time for social activities, interaction with friends or family, relationships.

11. Is there anything else you would like to share with me or tell me about?

Thank you for talking with me. That is the end of this interview.

Note: Make an appointment with the young mother for the next interview. Make sure you have all contact details and preferably more than one cellphone number to contact her. Arrange where the next interview will take place. Assess whether she is comfortable with you going to her home for the interview. If she has given you permission to visit her at her home for the next interview, note the address and directions.

THANK YOU!

INTERVIEW 2. THREE MONTHS LATER

Details of interview
Date of interview:
Place:
Time:
Interviewer:
Others present:

Note: These are guide questions that need to be tailored to each young mother. Questions need to relate to and build on Interview 1. Use the names of people referred to in the first interview.

1. How are you and your baby doing since we last spoke?
Probe for relationship with baby, coping with the baby, changes in the baby developmentally (feeding and care) and feelings about her life.

2. Tell me about how you continue to manage the demands on you as a mother and your other daily activities? Have there been any changes since we last spoke?
Probe for any changes in routine, coping with demands, support from whom and how, care of baby.

3. Tell me about your social life and activities, and whether there have been any changes from our last conversation?
Probe for time for social activities, interaction with friends or family, relationships, support to have a social life.

4. Tell me about how you manage and cope with issues around the baby's health and development?
Probe for interactions with the health system (immunisations, support from clinic), feeding decisions, other support.

5. Can you tell me about how you manage and take care of your own health?
Probe for interactions with the health system (particularly sexual health, contraception, check ups), advice and support from clinic.

6. Can you tell me about whether you are in a relationship at the moment, and how that is going?
Probe for who the partner is (baby's father or a new partner), nature of relationship, and for how time is managed and shared between private life with boyfriend/partner and life with the baby, challenges, support.

7. Is there anything else you would like to share with me about the baby or yourself?

Note: Make an appointment with the young mother for the next interview. Make sure you have all contact details and preferably more than one cellphone number to contact her. Arrange where the next interview will take place.

THANK YOU!

INTERVIEW 3. THREE MONTHS LATER

Details of interview
Date of interview:
Place:
Time:
Interviewer:
Others present:

Note: These are guide questions that need to be tailored to each young mother. Questions need to relate to and build on Interview 1 and 2. Use the names of people referred to in the previous interviews.

1. How are you and your baby doing since we last spoke?
Probe for relationship with baby, coping with the baby, changes in the baby developmentally (feeding and care) and feelings about her life, challenges.

2. Tell me about how you continue to manage the demands on you as a mother and your other daily activities? Have there been any changes since we last spoke? Are things any easier or more difficult since our last conversation?
Probe for any changes in routine, coping with new and changing demands, support from whom and how, care of baby.

3. Can you tell me about your social life and activities, and whether there have been any changes from our last conversation? Are you finding time to spend with your friends and in other social activities?
Probe for time for social activities, interaction with friends or family, relationships, support to have a social life.

4. Tell me about how the baby's health has been, what changes have happened with the baby, and how you are managing and coping with this?
Probe for interactions with the health system (immunisations, support from clinic), developmental changes in the baby, any new feeding decisions, support.

5. Can you tell me about your own health at the moment, and whether you are able to take care of your own health? What does this involve?
Probe for interactions with the health system (particularly sexual health, contraception, check ups), advice and support from clinic, general health and wellbeing.

6. *If respondent had indicated she was in a relationship at the last interview*…Tell me whether you are still in a relationship and how that it is going?
Probe for what's going well with the relationship, challenges, coping with baby and relationship.

OR

If respondent had indicated she was not in a relationship at the last interview…Tell me about whether you are in a relationship at the moment, and how that is going?

Probe for who the partner is (baby's father or a new partner), nature of relationship, and for how time is managed and shared between private life with boyfriend/partner and life with the baby, challenges, support.

7. Can you tell me about what your biggest concerns and worries are at present?

8. Can you tell me about the things that bring you joy or happiness at present?

Now I would like to ask you to think ahead a bit, to a time when your baby is older …

9. Tell me about your dreams and hope for your future? What are the challenges for you in achieving this? What support is there for you to achieve this? Do you feel excited about your future?

10. Tell me about your dreams and hopes for the future of your baby? What are the challenges for you in achieving this? What support is there for you to achieve this?

11. Can you tell me about any thoughts you may have about what kinds of support young mothers, like yourself, would benefit from in this community? As a young mother, what kind of support would you have liked to receive?

Probe for support at community level, child care, health care and others.

12. Is there anything else you would like to share with me or tell me about?

This is the end of this interview. I have enjoyed the time we have spent together and am very grateful to you and your baby for all the time you have given me.

Note: thank the young mother for participating in the study. Tell her where you are in the study and remind her of the goals and objectives of the study and how she has contributed.

THANK YOU!

APPENDIX 7: INFORMATION SHEET FOR SIGNIFICANT OTHERS

Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa

Contact details of researcher
Name of researcher: Nirvana Pillay
Position: PhD student
Contact details of researcher: cell: 083 55 000 55/email:nirvana@sarraounia.org

My name is Nirvana Pillay. I am doing research to understand the experiences of young mothers aged 18-20 in the Alexandra area. I am doing this study for a PhD in the School of Public Health, the University of the Witwatersrand. This means that I will be writing a thesis, which is like a book.

This information sheet is about the study and what it will involve for you. This information sheet may contain information that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, please feel free to ask me.

As someone who provides care or support to a young mother, I would like you to participate in my research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

The purpose of the study

The study is being conducted in Alexandra with young mothers between the ages of 18 and 20. I would like to understand:

- how young mothers cope once they have fallen pregnant;
- how young mothers make decisions about the baby;
- how young mothers keep healthy after the baby is born; and
- how young mothers make decisions about their future.

I would also like to know more about who supports young mothers through their pregnancies, during the birth and after.

Study Procedures

Interviews

If you decide to participate in this study, you will be invited to participate in one interview. The interview can be conducted at the Alexandra clinic, at your home or anywhere else you would like to be interviewed. The interview will be conducted over the next 3 months. The interview is expected to take between about an hour. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question. No one else but myself or a translator will be present unless you would like someone else to be there.

The interview will be conducted in English with the researcher, Nirvana Pillay. If you prefer to speak in a local language, a translator will be available to translate during the interview.

The following topics will be explored during the interviews:

- The life of young mothers in the 12 months following the birth of the baby
- How and why decisions are made around the care and wellbeing of the baby
- To understand how and why young mothers make decisions around their own health and wellbeing, in particular their sexual and reproductive health
- To understand how early motherhood impacts on plans for the future
- To understand who supports young mothers through the pregnancy, birth and after; how they are able to help and support and the impact of that support.

The interview will be audio-recorded with your permission. The information recorded is confidential, and no one else except me and my academic supervisors will have access to the information documented during your interview. The recordings and transcripts will be kept safely in locked files and will be destroyed after 5 years.

Possible risks

I am asking you to share personal and confidential information during the interviews. Sometimes you may feel uncomfortable talking about some of these things. You do not have to answer any questions if you do not wish to do so. You do not have to give any reason for this.

Possible benefits:

You will not benefit directly from participating in this study. However, I hope that the information you provide will be useful to help improve the support offered to young mothers in communities.

Costs to you:

You will not be provided with any incentive to participate in this research. Participating in this research will involve no cost to you. You will be given R40 for your transport costs to attend the interview, unless the interview is conducted at your home.

Right to refuse to participate in this research:

You do not have to take part in this research if you do not wish to do so. You have the right to agree or refuse to participate in this research at any point. If you decide to participate and later change your mind, you are free to stop the interview at any time. Your refusal to participate will not result in any penalty or loss of benefits to which you are otherwise entitled.

Records of your participation in this research:

You have the right to privacy. The researcher will keep information about your participation in locked files. Any notes or recordings from the interviews will also be kept securely and any information that may identify you will not be shared with anyone. Any information about you will have a number on it instead of your name. Only the researcher will know what your number is.

- Ethical approval: This study protocol has been submitted to the University of the Witwatersrand's, Human Research Ethics Committee (HREC), and written approval has been granted by that committee. Ethics Clearance number: X

- Publication of the results of the research: The results of this research may appear in scientific publications without identifying you in any way. Your name will not be used in the reporting, and no details will be include that could potential identify you.

- As per HPCSA guidelines, we will preserve the audio records for a minimum of two years after the study results have been published or six years if there is no publication.

Your questions:

I am available to answer your questions about this research. You may contact me at any time on the number 083 55 000 55.

If you have any questions or concerns about your rights as a participant, you may contact Professor Peter Cleaton-Jones at the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 2301).

YOU WILL HAVE A COPY OF THIS INFORMATION SHEET TO KEEP

If you agree to participate in the study, you will be asked to read and sign the attached consent form on the day of your interview. This form will confirm your agreement to participate.

Your signature on the consent form will certify the following:

- You have read the information provided in the information sheet
- You have been provided with an opportunity to ask questions about the research and have received answers to your questions
- You understand that you are free not to participate in this study and to withdraw from this study at any point
- You have freely decided to participate in this research
- You understand that you are not giving up any of your legal rights.

APPENDIX 8: IN-DEPTH INTERVIEW GUIDE FOR SIGNIFICANT OTHER

Good morning/afternoon! My name is Nirvana Pillay. Thank you for agreeing to speak to me and for making this time available. **You were identified by X as being a significant source of support to her and her baby.** I am going to start with some information about you and will then move on to ask specifically about your relationship with X and her baby.

Details of interview
Date of interview:
Place:
Time:
Interviewer:
Others present:

Details of significant other
Interviewee Name:
Date of Birth:
Age:
Race:
Profession:
Study code:
Young Mothers Study code:
Residential address:
Cellphone number:
Alternative number 1:
Alternative number 2 (optional):

Note: Probe and follow the story of the relationship between the significant other and the the young mother, without necessarily following the order of questions. Make sure all questions have been asked, and check that prompts in the probes have been asked. Use the names used as known to you of the young mother (X) and of the baby, and any others you are familiar with from the interviews with the young mother.

1. Can you please tell me about your relationship to X?

Probe for nature of relationship (family, friend), how much time is spent with X.

2. Can you tell me about what happened when X told you she was pregnant? What were your first thoughts, reactions and concerns? How did she cope and what support were you able to offer her?

Probe for how X disclosed the pregnancy, reactions to the pregnancy, how support was offered.

3. Tell me about the birth of X's baby? How did she cope? Were you able to support or help her in any way?

Probe for his or her role during this period and how support was offered.

4. Over the last 6 months, what support have you been able to offer X in relation to caring for her baby? Tell me of a story or an example of a time X needed help and you were there to support her.

Probe for day to day interactions and examples or stories of when help was provided and how.

5. In addition to everything you have already mentioned, do you offer any other kind of support to X? Please tell me about this.

6. Can you tell me about the major challenges faced by X during the last 12 months of the pregnancy, birth and after? What kind of support do you think X needs to support her with all the challenges that she experiences?

Probe for support at the level of family, friends and community, child care, health.

7. Can you tell me about yourself, and any challenges you have had in trying to support X over the past months.

8. Is there anything else you would like to share with me?

This is the end of this interview. I am very grateful to you for making the time to speak to me.

THANK YOU!

APPENDIX 9: INFORMATION SHEET FOR MATERNAL AND CHILD HEALTH NURSES

Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa

Contact details of researcher
Name of researcher: Nirvana Pillay
Position: PhD student
Contact details of researcher: cell: 083 55 000 55/email:nirvana@sarraounia.org

My name is Nirvana Pillay. I am a PhD candidate in the School of Public Health, the University of the Witwatersrand. I am doing research to understand the experiences of young mothers aged 18-20 in the Alexandra area.

This information sheet is about the study and what it will involve for you. This information sheet may contain information that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, please feel free to ask me.

As a maternal and child health nurse, I would like you to participate in my research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

The purpose of the study

The study is being conducted in Alexandra with young mothers between the ages of 18 and 20. I would like to understand:

- how young mothers cope once they have fallen pregnant;
- how young mothers make decisions about the baby;
- how young mothers keep healthy after the baby is born; and
- how young mothers make decisions about their future.

I would also like to know more about who supports young mothers through their pregnancies, during the birth and after.

Study Procedures

<u>Interviews</u>

If you decide to participate in this study, you will be invited to participate in one private interview. The interview will be conducted at a private room at the Alexandria clinic. The interview will be conducted over the next 3 months. Each interview is expected to take between 1 and 1.5 hours. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question.
The interview will be conducted in English with the researcher, Nirvana Pillay. If you prefer to speak in a local language, a translator will be available to translate during the interview.

The following topics will be explored during the interviews:

- The life of young mothers in the 12 months following the birth of the baby
- How and why decisions are made around the care and wellbeing of the baby
- To understand how and why young mothers make decisions around their own health and wellbeing, in particular their sexual and reproductive health
- To understand how early motherhood impacts on plans for the future
- To understand who supports young mothers through the pregnancy, birth and after; how they are able to help and support and the impact of that support.

The interview will be audio-recorded with your permission. The information recorded is confidential, and no one else except me and my academic supervisors will have access to the information documented during your interview. The recordings and transcripts will be kept safely in locked files and will be destroyed after 5 years.

Possible risks

There are no risks in participating in this interview. However, if for any reason you do not wish to answer a question, you do not have do so. You do not have to give any reason for this.

Possible benefits:

You will not benefit directly from participating in this study. However, I hope that the information you provide will be useful to help improve the support offered to young mothers in communities.

Costs to you:

You will not be provided with any incentive to participate in this research. Participating in this research will involve no cost to you.

Right to refuse to participate in this research:

You do not have to take part in this research if you do not wish to do so. You have the right to agree or refuse to participate in this research at any point. If you decide to participate and later change your mind, you are free to stop the interview at any time. Your refusal to participate will not result in any penalty or loss of benefits to which you are otherwise entitled.

Records of your participation in this research:

You have the right to privacy. The researcher will keep information about your participation in locked files. Any notes or recordings from the interviews will also be kept securely and any information that may identify you will not be shared with anyone. Any information about you will have a number on it instead of your name. Only the researcher will know what your number is.

- Ethical approval: This study protocol has been submitted to the University of the Witwatersrand's, Human Research Ethics Committee (HREC), and written approval has been granted by that committee. Ethics Clearance number: X.

- Publication of the results of the research: The results of this research may appear in scientific publications without identifying you in any way. Your name will not be used in the reporting, and no details will be include that could potential identify you.

- As per HPCSA guidelines, we will preserve the audio records for a minimum of two years after the study results have been published or six years if there is no publication.

Your questions:

I am available to answer your questions about this research. You may contact me at any time on the number 083 55 000 55.

If you have any questions or concerns about your rights as a participant, you may contact Professor Peter Cleaton-Jones at the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 2301).

YOU WILL HAVE A COPY OF THIS INFORMATION SHEET TO KEEP

If you agree to participate in the study, you will be asked to read and sign the attached consent form on the day of your interview. This form will confirm your agreement to participate.

Your signature on the consent form will certify the following:

- You have read the information provided in the information sheet
- You have been provided with an opportunity to ask questions about the research and have received answers to your questions
- You understand that you are free not to participate in this study and to withdraw from this study at any point
- You have freely decided to participate in this research
- You understand that you are not giving up any of your legal rights.

APPENDIX 10. IN-DEPTH INTERVIEW GUIDE FOR MCH NURSES

Good morning/afternoon! My name is Nirvana Pillay. Thank you for agreeing to speak to me and for making this time available. I am doing this study to learn more about how young mothers cope once they have fallen pregnant; how they make decisions about the baby; how they keep healthy after the baby is born; and how they make decisions about their future. I would also like to know more about who supports young mothers through their pregnancies, during the birth and after. I would like to learn more from you about what you see in your interactions with young mothers about how they make decisions about their health and the health of their babies.

Details of interview

Date of interview:

Place:

Time:

Interviewer:

Others present:

Details of MCH nurse

Interviewee Name:

Date of Birth:

Age:

Race:

Name of Clinic:

Position at the clinic:

Study code:

1. Can you please tell me about any special training you have received to work with adolescents and young people? Do you think that you have been adequately trained in this area? Are there any difficulties that you experience in this regard?

Probe for details of training, challenges of working with adolescents, other skills and knowledge that may be useful.

2. In your experience, what are the challenges faced by young women when they fall pregnant? Do you offer any specialised help or advice to them during this time?

3. In your experience, what are the challenges faced by young women during the birth? Do you offer any specialised help or advice to them during this time?

4. In your experience, what are the challenges faced by young women in caring for their babies in the first year? Do you offer any specialised help or advice to them during this time?

5. Can you tell me whether young mothers are encouraged to take care of their sexual and reproductive health after the birth of their babies, and how you do this?

6. Can you tell me whether you think the health system offers enough support to young pregnant women and young mothers?

Probe for kinds of support offered and whether this is taken up by young mothers

7. Can you tell me whether there are other kinds of support that you think would benefit young mothers at a community level?

8. Is there anything else you would like to share with me?

THANK YOU

APPENDIX 11: INFORMATION SHEET FOR NGO

Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa

Contact details of researcher
Name of researcher: Nirvana Pillay
Position: PhD student
Contact details of researcher: cell: 083 55 000 55/email:nirvana@sarraounia.org

My name is Nirvana Pillay. I am a PhD candidate in the School of Public Health, the University of the Witwatersrand. I am doing research to understand the experiences of young mothers aged 18-20 in the Alexandra area.

This information sheet is about the study and what it will involve for you. This information sheet may contain information that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, please feel free to ask me.

I would like you to participate in my research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

The purpose of the study

The study is being conducted in Alexandra with young mothers between the ages of 18 and 20. I would like to understand:

- how young mothers cope once they have fallen pregnant;
- how young mothers make decisions about the baby;
- how young mothers keep healthy after the baby is born; and
- how young mothers make decisions about their future.

I would also like to know more about who supports young mothers through their pregnancies, during the birth and after.

Study Procedures

<u>Interviews</u>

If you decide to participate in this study, you will be invited to participate in one private interview. The interview will be conducted at your office or at any other venue suitable for you. Each interview is expected to take approximately 1 hour. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question.

The interview will be conducted in English with the researcher, Nirvana Pillay. If you prefer to speak in a local language, a translator will be available to translate during the interview.

The following topics will be explored during the interviews:

- The experiences and challenges of young pregnant and parenting women;
- The challenges associated with continuing or furthering education after an unplanned pregnancy;
- How and why decisions are made around the care and wellbeing of the baby;
- To understand how early motherhood impacts on plans for the future;
- To understand who supports young mothers through the pregnancy, birth and after; how they are able to help and support and the impact of that support.

The interview will be audio-recorded with your permission. The information recorded is confidential, and no one else except me and my academic supervisors will have access to the information documented during your interview. The recordings and transcripts will be kept safely in locked files and will be destroyed after 5 years.

Possible risks

There are no risks involved in participating in this interview. However, if for any reason you do not wish to answer a question, you do not have do so. You do not have to give any reason for this.

Possible benefits:

You will not benefit directly from participating in this study. However, I hope that the information you provide will be useful to help improve the support offered to young mothers in communities.

Costs to you:

You will not be provided with any incentive to participate in this research. Participating in this research will involve no cost to you.

Right to refuse to participate in this research:

You do not have to take part in this research if you do not wish to do so. You have the right to agree or refuse to participate in this research at any point. If you decide to participate and later change your mind, you are free to stop the interview at any time. Your refusal to participate will not result in any penalty or loss of benefits to which you are otherwise entitled.

Records of your participation in this research:

You have the right to privacy. The researcher will keep information about your participation in locked files. Any notes or recordings from the interviews will also be kept securely and any information that may identify you will not be shared with anyone. Any information about you will have a number on it instead of your name. Only the researcher will know what your number is.

- Ethical approval: This study protocol has been approved by the University of the Witwatersrand's, Human Research Ethics Committee (Medical), and written approval has been granted by that committee. Clearance Certificate Number: M160535

- Publication of the results of the research: The results of this research may appear in scientific publications without identifying you in any way. Your name will not be used in the reporting, and no details will be included that could potentially identify you.

- As per HPCSA guidelines, we will preserve the audio records for a minimum of two years after the study results have been published or six years if there is no publication.

Your questions:

I am available to answer your questions about this research. You may contact me at any time on the number 083 55 000 55.

If you have any questions or concerns about your rights as a participant, you may contact the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 2301).

YOU WILL HAVE A COPY OF THIS INFORMATION SHEET TO KEEP

If you agree to participate in the study, you will be asked to read and sign the attached consent form on the day of your interview. This form will confirm your agreement to participate.

Your signature on the consent form will certify the following:

- You have read the information provided in the information sheet
- You have been provided with an opportunity to ask questions about the research and have received answers to your questions
- You understand that you are free not to participate in this study and to withdraw from this study at any point
- You have freely decided to participate in this research
- You understand that you are not giving up any of your legal rights.

APPENDIX 12: IN-DEPTH INTERVIEW GUIDE FOR NGOs

Good morning/afternoon. My name is Nirvana Pillay. Thank you for agreeing to speak to me and for making this time available. I am doing this study to learn more about how young mothers cope once they have fallen pregnant; how they make decisions about the baby; how they keep healthy after the baby is born; how they negotiate school and motherhood; and how they make decisions about their future. I would also like to know more about who supports young mothers through their pregnancies, during the birth and after. I would like to learn more from you about what this NGO offers to this community, and whether there are any specific interventions or programmes for young pregnant and parenting women.

Details of interview

Date of interview:

Place:

Time:

Interviewer:

Others present:

Details of School Principal/Educator

Age:

Race:

Name of NGO:

(note-will not be quoted by name in reporting unless permission provided to do so)

Position:

Study Number/code:

9. Can you please tell me about this NGO, including the overall aims and objectives?

10. Can you please tell me more specifically about working in the Alexandra area, and what needs of the community this organization addresses? Which other areas does this organization work in?

11. What would you say are the specific challenges experienced by young people, aged 15-24 in Alexandra? And the specific challenges of adolescent girls and young women?

12. Does this organization have any experience working with young pregnant and/or parenting women? Can you please tell me more about this?

13. What would you say are the most significant challenges experienced by young pregnant and parenting women in Alexandra?

14. Can you tell me what kinds of support that you think would benefit young mothers at a community level? And more broadly (at a national or policy level)?

15. Is there anything else you would like to share with me?

THANK YOU

APPENDIX 13: CONSENT FORM FOR ALL STUDY PARTICIPANTS

Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa

Contact details of researcher
Name of researcher: Nirvana Pillay
Position: PhD student
Contact details of researcher: cell: 083 55 000 55/email:nirvana@sarraounia.org

Please Tick Box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. a. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐
3. I agree to take part in the above study. ☐
4. I agree to the interview being audio recorded. ☐
5. I understand that my name will not be used in the study and agree to the use of anonymised quotes in publications. ☐

Interviewee

Printed Name Signature Date and Time

Researcher

Printed Name Signature Date and Time

APPENDIX 14: CONSENT FORM FOR AUDIO RECORDING FOR ALL STUDY PARTICIPANTS

Adjusting Aspirations: Exploring agency in early motherhood in an urban area in Johannesburg, South Africa

Contact details of researcher
Name of researcher: Nirvana Pillay
Position: PhD student
Contact details of researcher: cell: 083 55 000 55/email:nirvana@sarraounia.org

This study involves the audio recording of your face to face interview. The interview will last for between 60 to 90 minutes.

Only the research team will be able to listen to the recordings. The tapes will be translated and transcribed by the research team. The recordings will be stored for two years after publication of the study or six years in the absence of publication. Your identity will be kept confidential. Your name will not appear in the research report.

By signing this form, I give my permission for the researcher to audio tape the interview as part of this research.

Interviewee

Printed Name Signature Date and Time

Researcher

Printed Name Signature Date and Time

APPENDIX 15: A LIST OF USEFUL RESOURCES FOR YOUNG MOTHERS

This resource list is provided to all young mothers who participate in the study, should they require any of the help and support from services in this list.

The Ububele Educational and Psychotherapy Trust: 011 786 5085 or 076 545 4138

Ububele offers counselling and support to mother and infants under 3 years. Moms can find Ububele at Masekani Clinic (Alex Clinic) at the Brown House on Tuesday and Wednesday mornings and Thursday afternoons.

www.ububele.org

Family and Marriage Association of SA: 011 975 7106/7

Supports families through difficult situations and offers counselling and educations to strengthen marriage and other relationships in the family

www.famsa.org.za

Thuthuzela Care Centre Soweto, Chris Hani Baragwanath Hospital: 011 933 1229

One stop care centres for survivors of rape that offers crisis counselling, and professional support and advice.

LifeLine Southern Africa: 0861 322 322

Lifeline provides 24 hour crisis intervention service. Free, confidential, telephone counselling, rape counselling, trauma counselling, AIDS counselling, and other services.

www.lifeline.org.za

National AIDS helpline: 0800 012 322

National toll free helpline for help and advice with HIV and AIDS.

Stop Gender Violence helpline: 0800 150 150

National toll free helpline for survivors, witnesses and perpetrators of gender based violence.

Childline South Africa: 0800 055 555

Assistance and advice from trained counsellors for abused children, young people and their families.

www.childline.org.za

Child Welfare South Africa: 0861 4 24453

Has networks and partnerships throughout South Africa to support vulnerable families and communities.

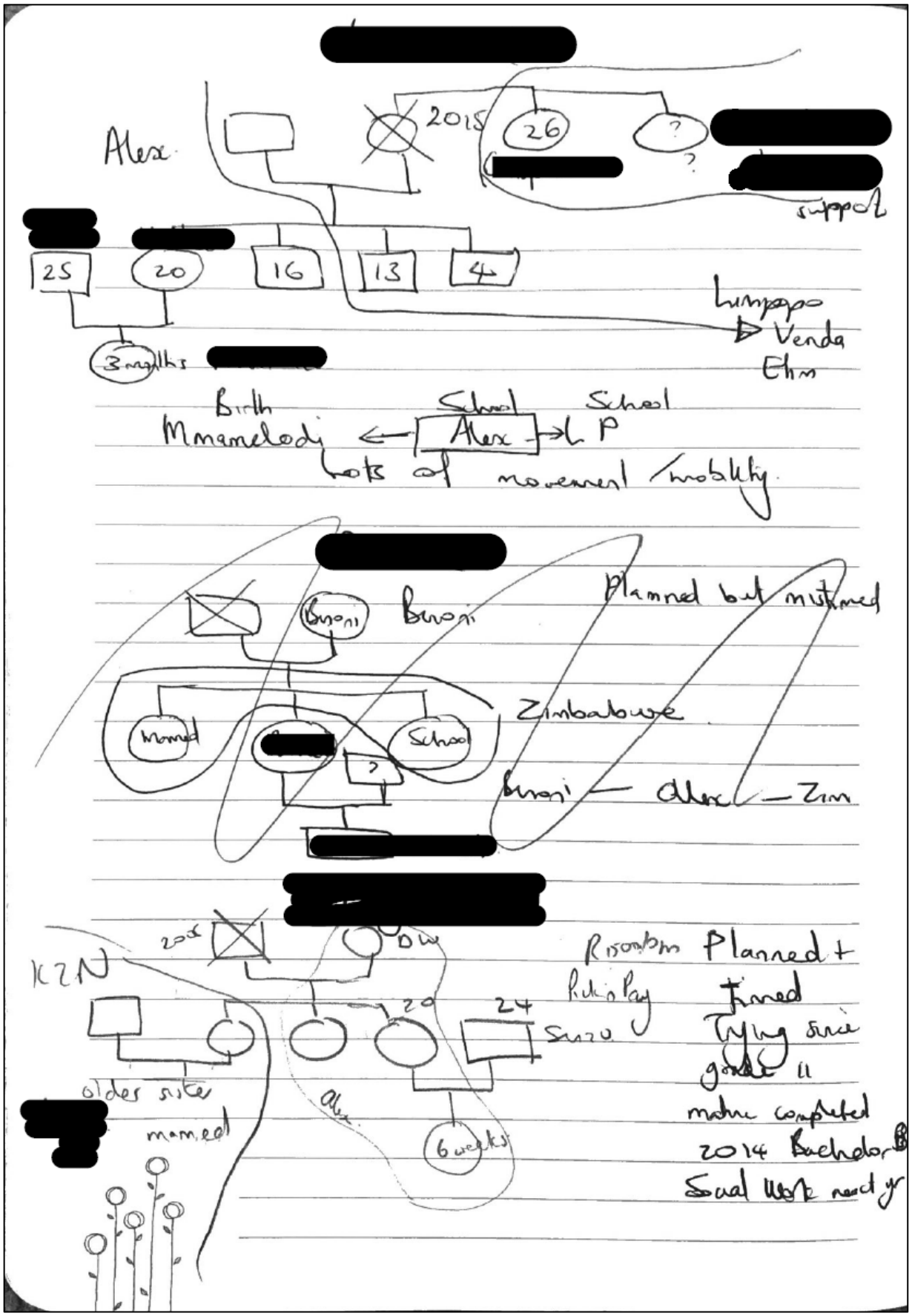
SA Depression and Anxiety Group: 011 262 6396

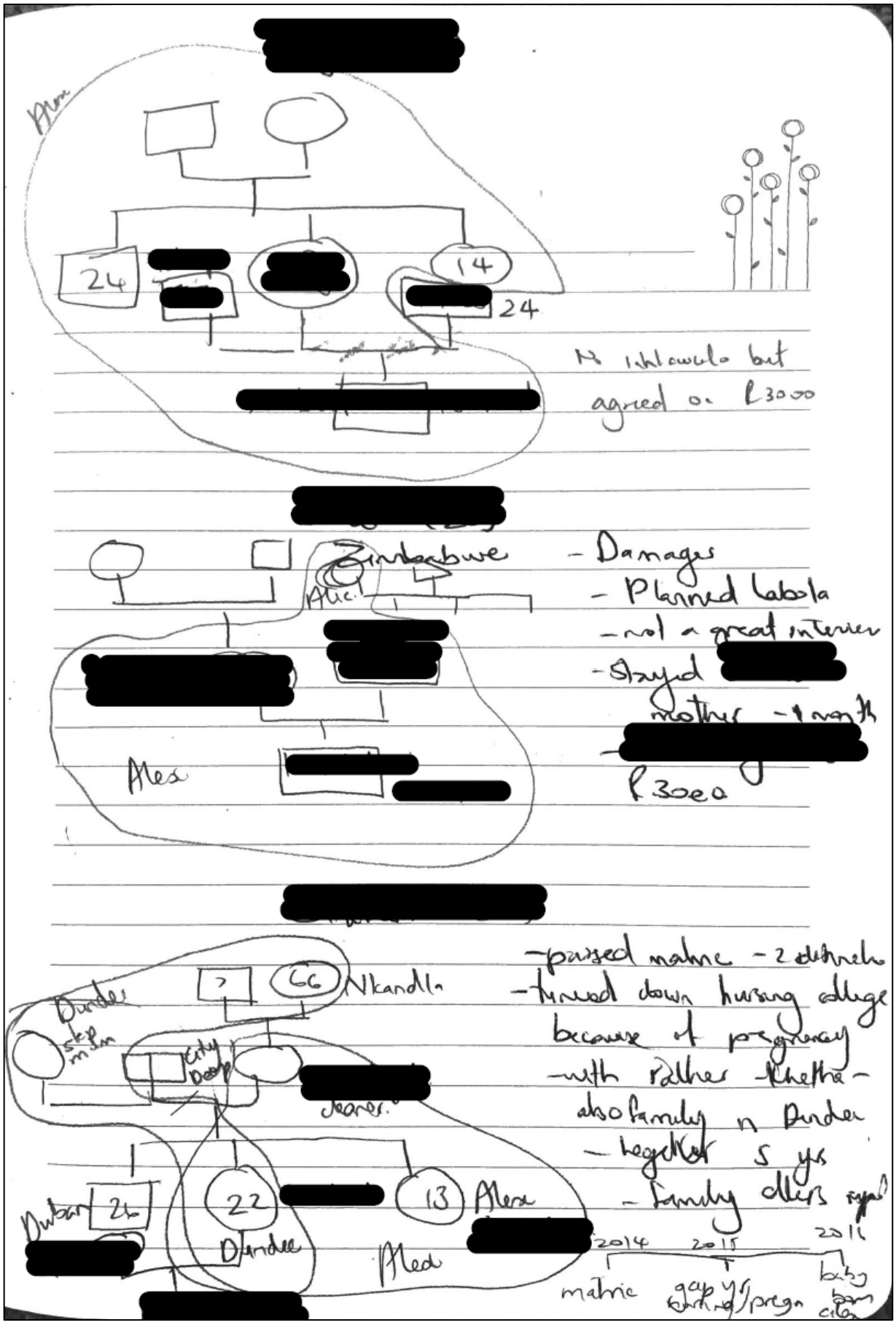
Suicide crisis line 0800 567 567

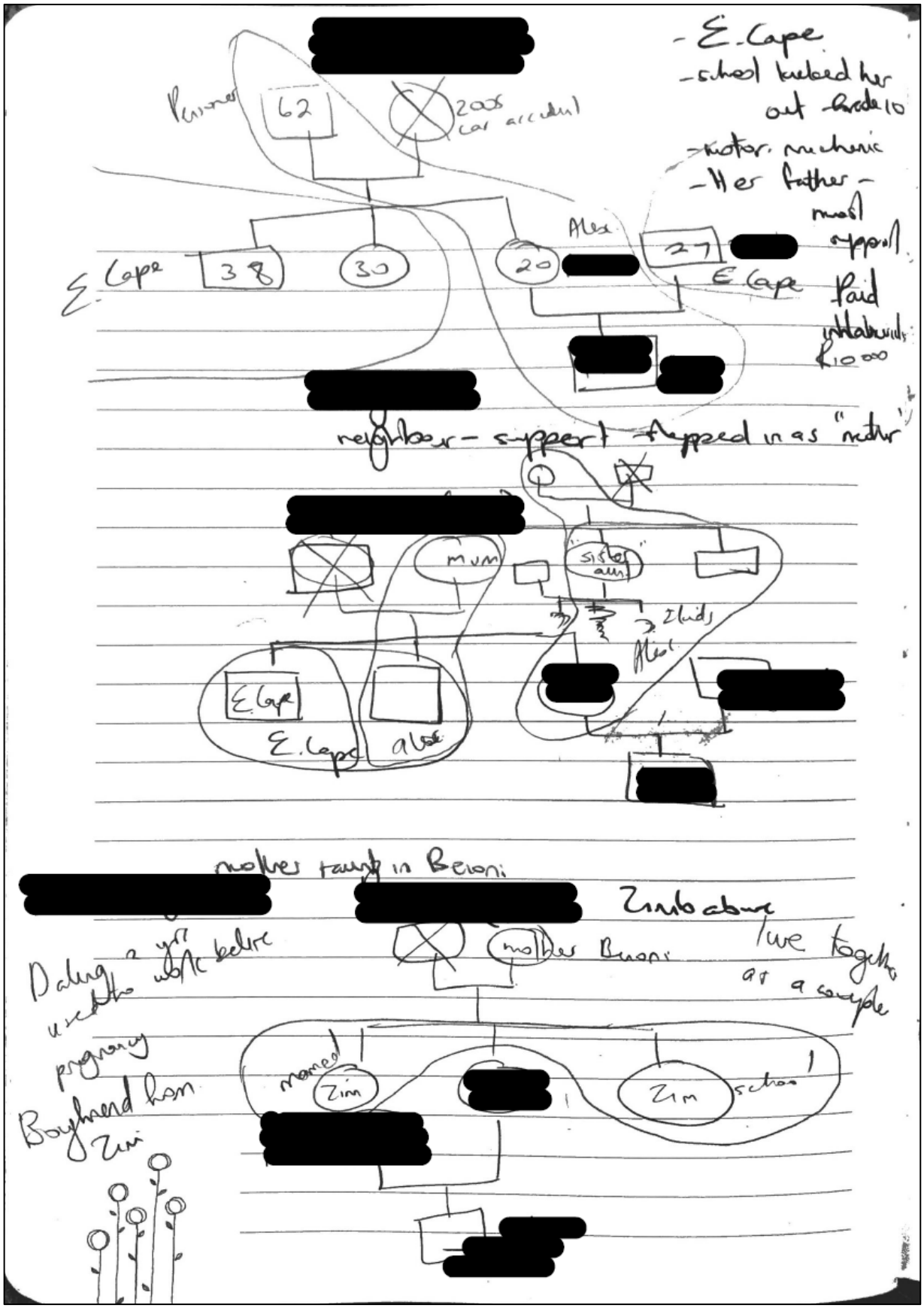
Offers support, education and assistance with mental health problems.

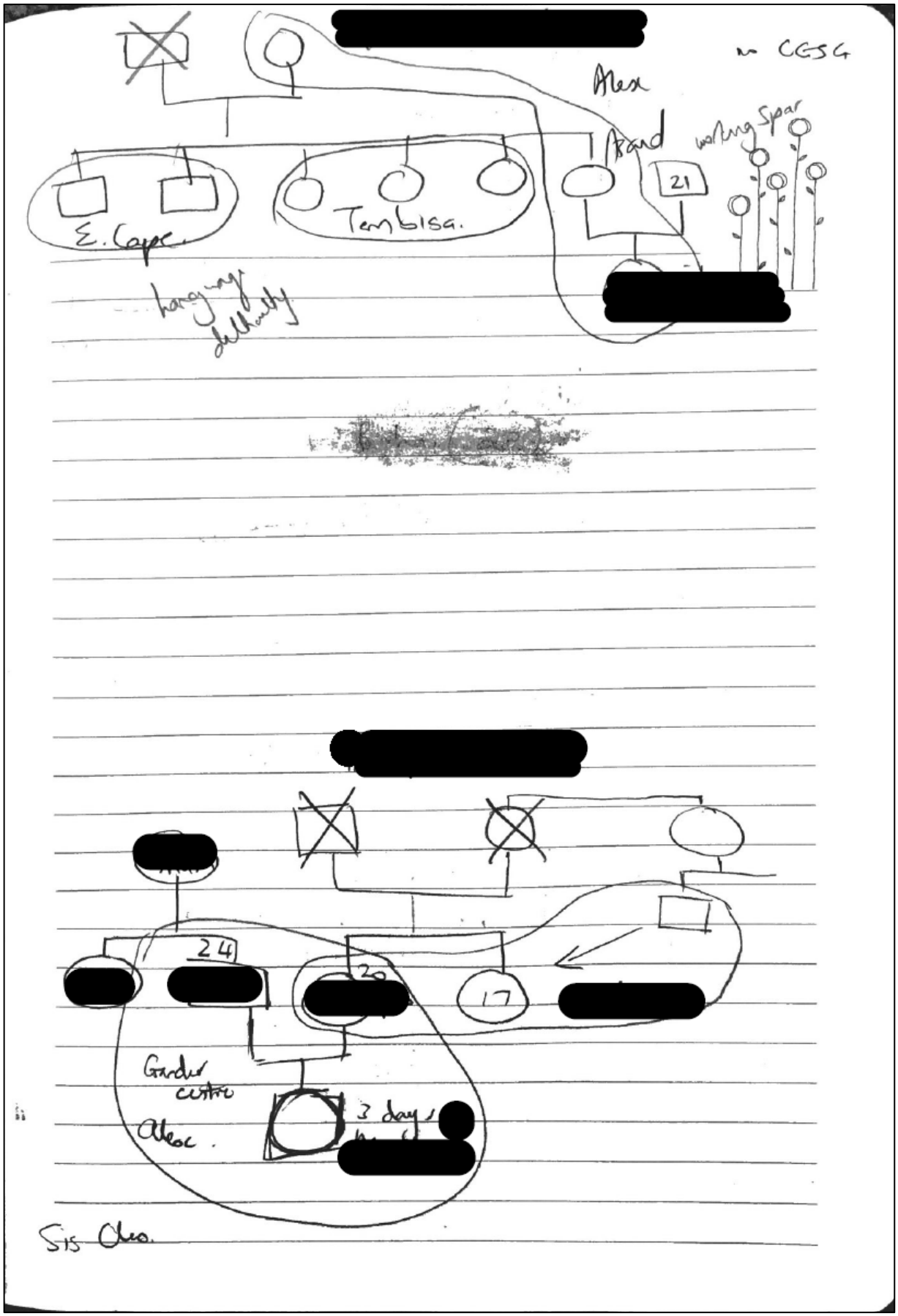
www.sadac.org

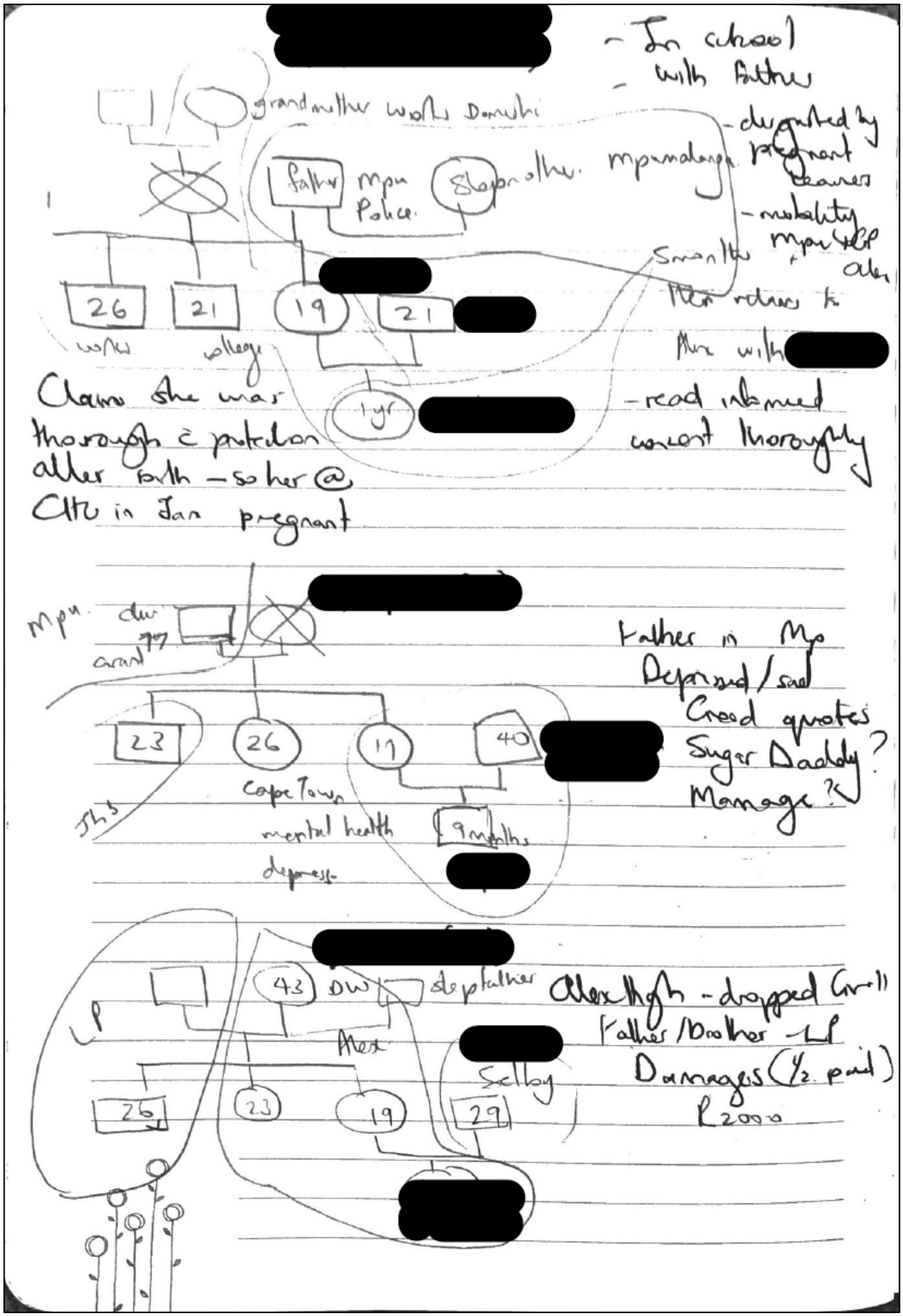
APPENDIX 16: KINSHIP NETWORK MAPS

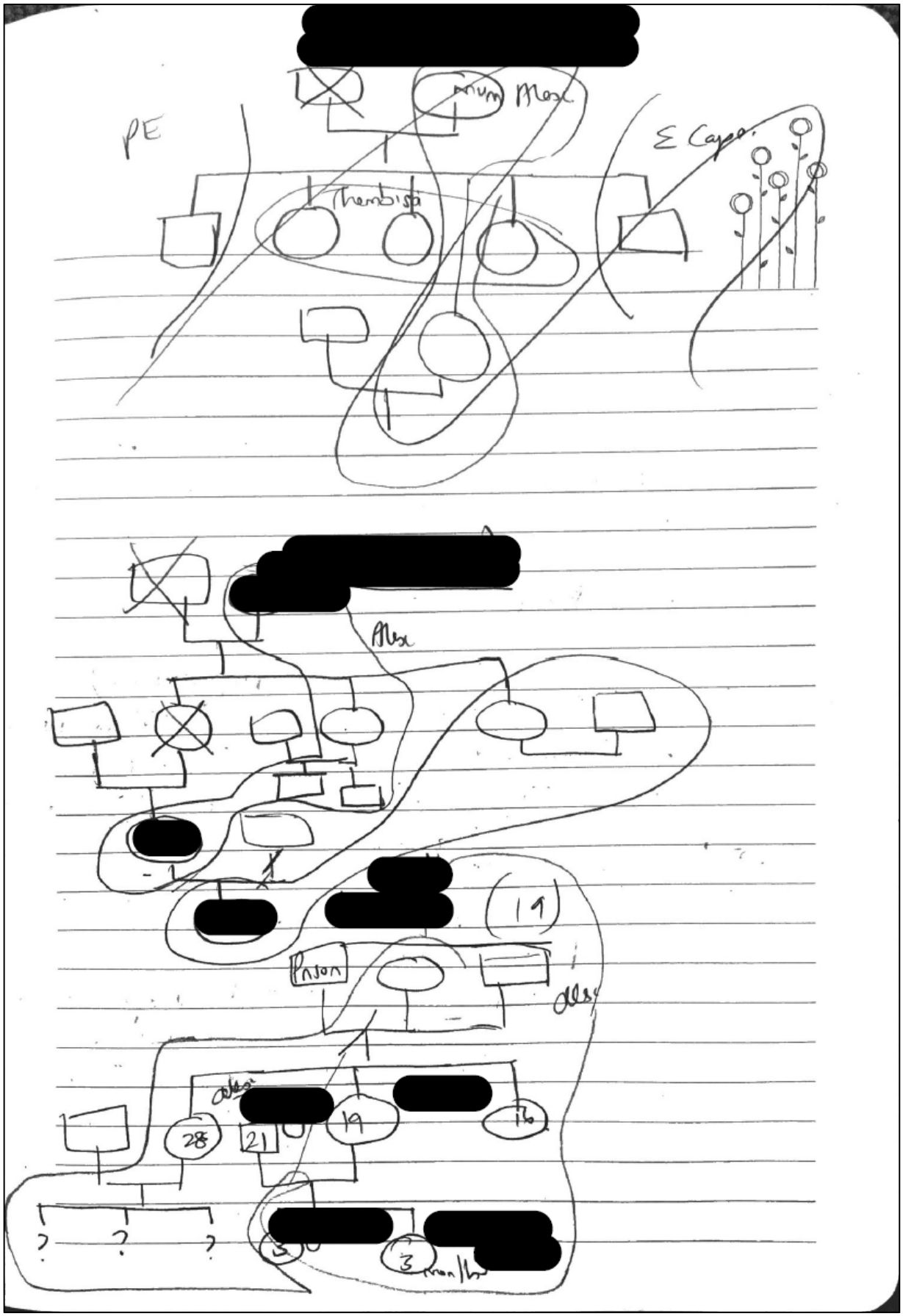


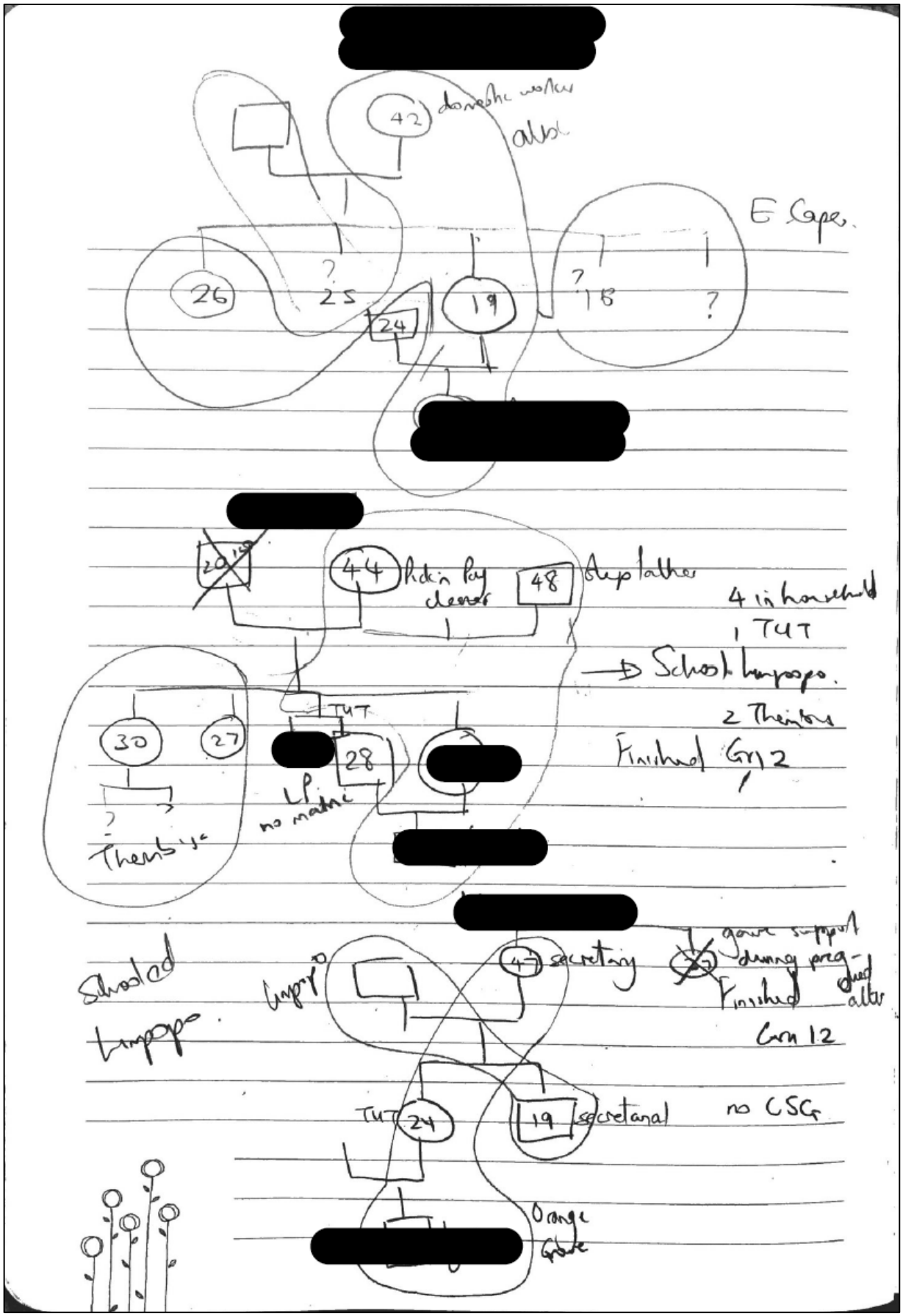

24
14
24
Zimbabwe
- Damages
- Planned labola
- Stayed
mother - 1 month
R3000
66
Nkandla
- passed matric - 2 attempts
- turned down nursing college
because of pregnancy
- with father - Khetha -
- also family in Durban
- legal for 5 yrs
- family differs
22
13
Alex
2014
2015
2016
matric
gap
baby born

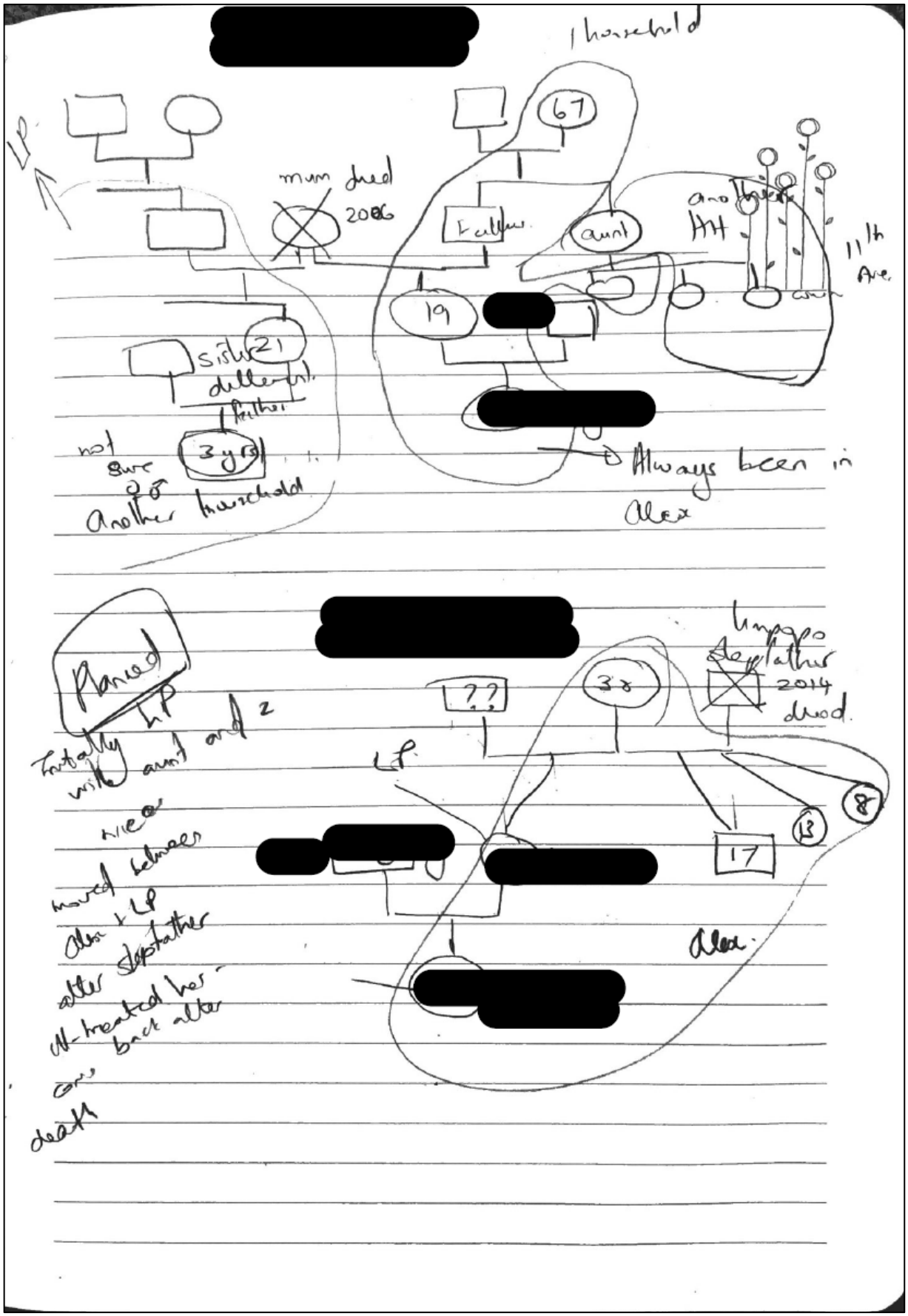

- E. Cape
- school kicked her out Grade 10
- motor. mechanic
- Her father -
Paternal
62
2005 car accident
E Cape
38
30
Alex
20
27
E Cape
Paid
R10 000
neighbour - support - stepped in as "mother"
mum
sister
2 kids
E. Cape
E. Cape
mother taught in Benoni
Zimbabwe
mother Benoni
live together as a couple
Dating
pregnancy
Boyfriend from Zim
married
Zim
Zim
section

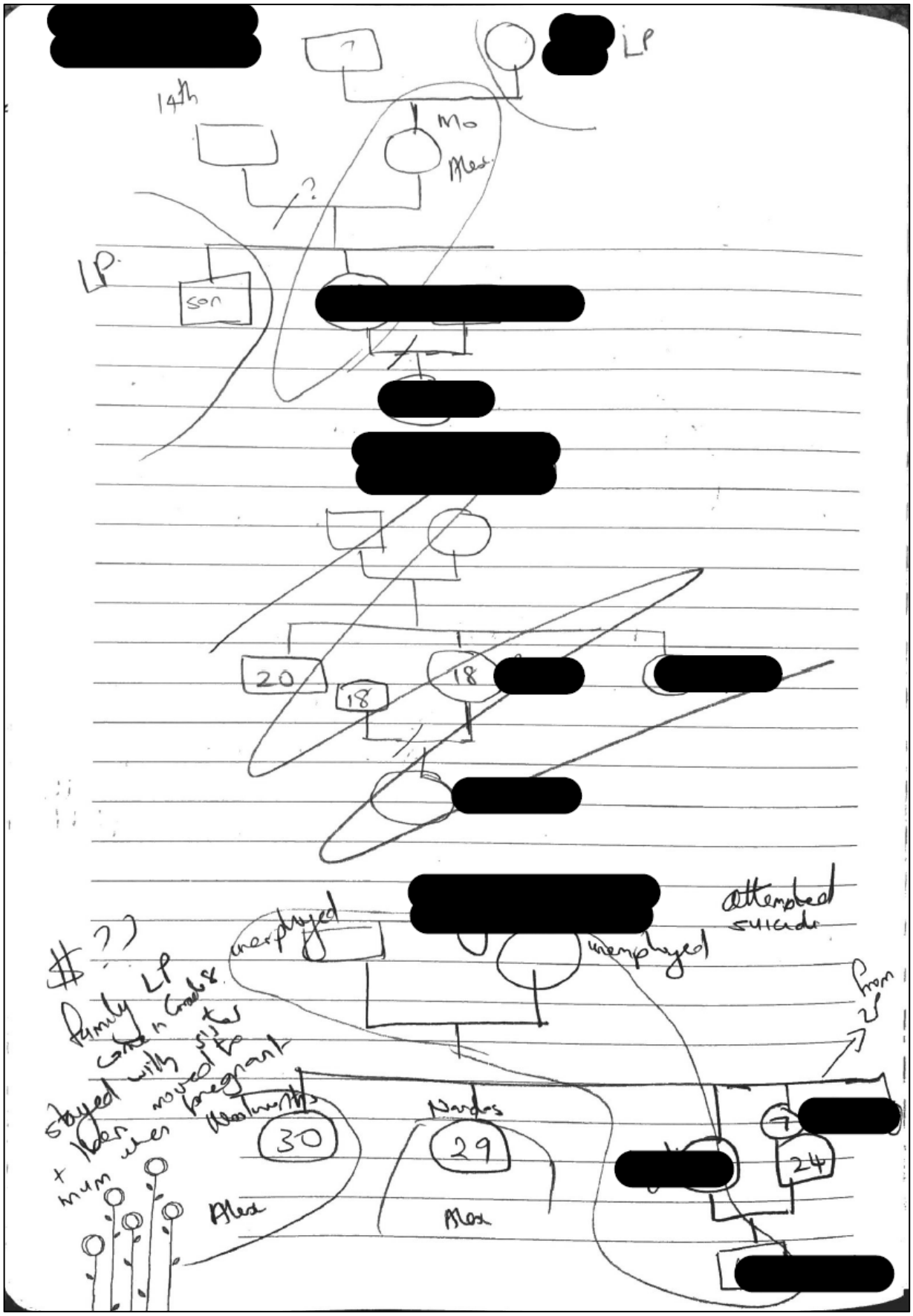

[redacted]
CGSG
Alex
Rand
working Spar
21
E. Cape
Tembisa.
hanging
[redacted]
[redacted]
24
17
Garden
centre
3 days
Alex.
Sis Alex.

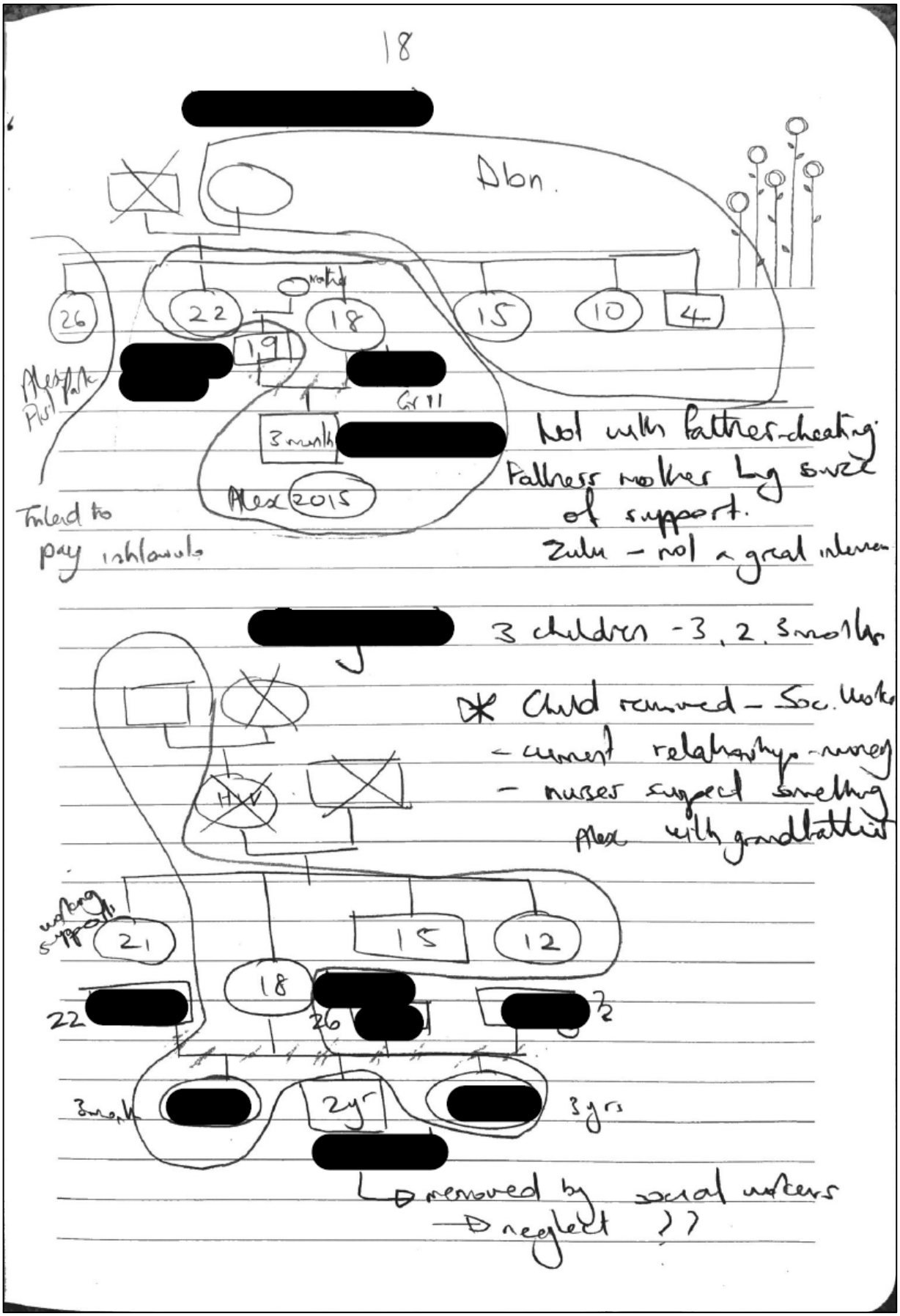

- In school
- with father
grandmother works Domestic
- disgusted by pregnant cleaners
- mutuality
father
mpu
Police
stepmother
mpumalanga
Swaziland
26
21
19
21
works
college
Claims she was thorough & patient after birth - so her @ Clin in Jan pregnant
1yr
- read informed consent thoroughly
father with
mpu
dw
grant
23
26
19
40
Father in Mp Depressed / sad
Good quotes
Sugar Daddy?
Manage?
JHB
Cape Town
mental health
depress
9 months
43
DW
stepfather
Alex
Selby
26
23
19
29
Alex high - dropped Grade 11
Father / Brother - Lf
Damages (½ paid)
R2000

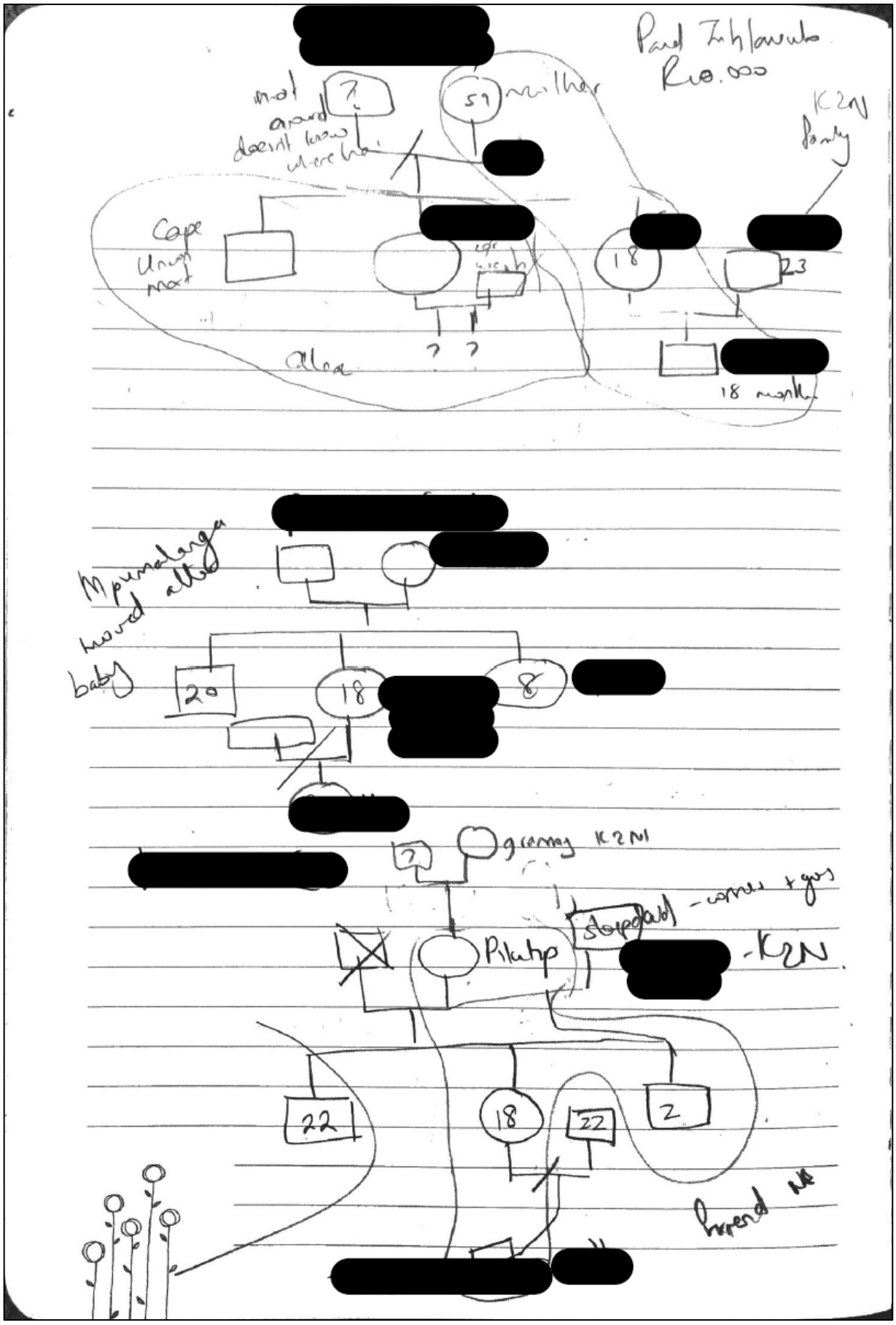

PE
Thembisa
Pinion
28
21
19
16
3
3

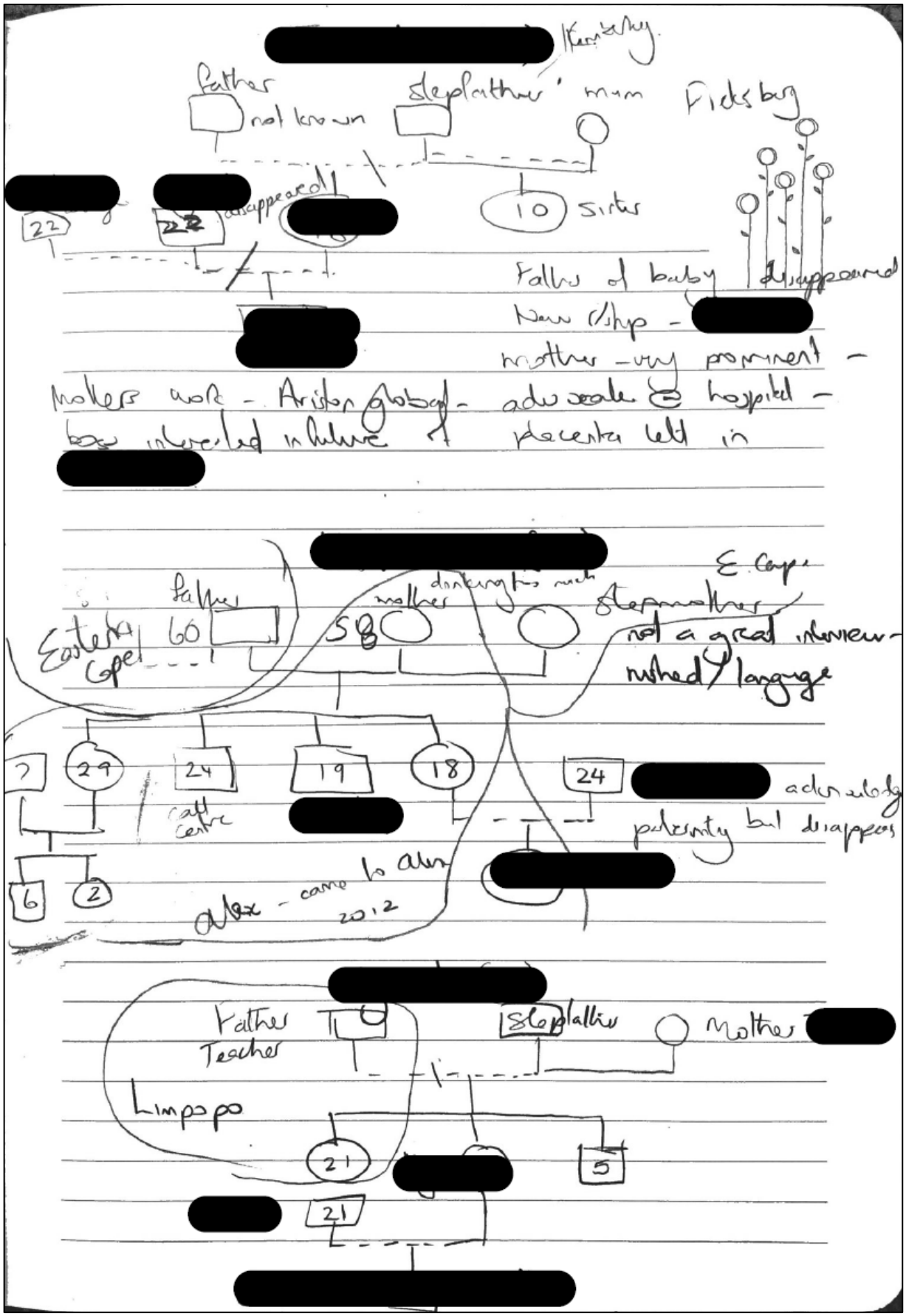

[redacted]
42
domestic worker
alb.
E Cape.
26
25
24
19
18
[redacted]
[redacted]
20
44
Ridin by
dender
48
dup father
4 in household
1 TUT
→ School language.
2 Theatres
TUT
30
27
28
[redacted]
Finished Gr 12
Lp
no maths
Thembu
[redacted]
[redacted]
School
language
Lupp
47
secretary
gave support
during prog-
Finished
Gr 12
TUT
24
19
secretarial
no CSG
Orange
Globe


[redacted]
1 household
67
mum dead
2006
Father
aunt
and them
11th Ave.
19
[redacted]
sister
21
dilleworld
father
3 yrs
not sure of another household
[redacted]
Always been in Alex
[redacted]
Planned LP
Totally with aunt and z
nice & moved between Alex + LP after stepfather ill-treated her back after ma's death
??
38
Limpopo
stepfather
2014
dead
LP
[redacted]
[redacted]
17
13
8
Alex
[redacted]


[redacted]
LP
14th
Mo
Alex
?
LP
son
[redacted]
[redacted]
[redacted]
20
18
18
[redacted]
[redacted]
[redacted]
unemployed
unemployed
attempted suicide
[redacted]
LP
family
stayed with
moved
pregnant
Nurses
30
29
Alex
Alex
from
7
24
[redacted]
[redacted]
[redacted]


18
Dbn.
26
22
18
15
10
4
19
3 month
Alex 2015
Not with father - cheating
Father mother lg supt of support.
Zulu - not a great interv
3 children - 3, 2, 3 mo/bo
* Child removed - Soc. Work
- current relationship - money
- nurses suspect something
Alex with grandfather
21
15
12
18
22
26
2
3 month
2yr
3 yrs
removed by social workers
neglect ??


Cape
Mpumalanga
baby
20
18
8
Pikitup
22
18
22
2
K2N
family
23
18 months


[redacted] Kentucky
father not known
stepfather' mum Ficksburg
10 sister
22
22
disappeared
[redacted]
Father of baby disappeared
New Bishop - [redacted]
mother - very prominent - adv addic & hospital - placenta left in
mothers work - Ariston global - [redacted]
[redacted]
E Cape
father
mother
drinking too much
stepmother
not a great interview - rushed / language
Eastern Cape
60
58
7
29
24
19
18
24
[redacted]
adv addict
paternity but disappears
call centre
[redacted]
6
2
Alex - came to clinic 2012
[redacted]
Father
Teacher
Stepfather
Mother [redacted]
Limpopo
21
[redacted]
5
[redacted]
21
[redacted]