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CHILDBEARING ADOLESCENTS' ACCESS TO SOCIAL PROTECTION IN GRABOUW, WESTERN CAPE PROVINCE

Heidi Loening-Voysey

9910317K

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ABSTRACT

Social protection is a universal right and has been institutionalised in the *Constitution of the Republic of South Africa, 1996.* Enshrined in this right are entitlements to health care, basic education and social assistance for those who cannot provide for themselves. This case study looks at the social protection needs of a particularly vulnerable group of people – adolescent mothers – who live in formal and informal settlements[1] on the outskirts of Grabouw, Western Cape Province.

Findings suggest that despite challenges in equitable service delivery in South Africa, the adolescent mothers in Grabouw are on the whole accessing their basic services. Their experiences alluded to the fact that they were not afforded the respect expected of professional health care services, but the school that some of them attended was supportive of them and encouraged them to complete their grade twelve. The over-riding element to this study was that despite their access to basic services and social assistance, they were more affected by family dysfunctionality and being trapped in chronic poverty. They had aspirations and hopes for a different life, and in some ways, it appeared that their early pregnancies were experienced as some sort of compensation for this entrapment.

DECLARATION

I declare that this report is my own, unaided work. It is submitted in partial fulfilment of the requirements of the degree of Master of Management (in the field of Social Security) in the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university.

Heidi Loening-Voysey

March 2018

DEDICATION

This study is dedicated to the adolescent mothers in Grabouw and their Child and Youth Care Workers, who are dedicated to their profession and an inspiration to all social service professionals.

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LIST OF ABBREVIATIONS

C&YCW	Child and Youth Care Workers
CRC	United Nations Convention on the Rights of the Child
CSG	Child Support Grant
DPME	Department of Planning, Monitoring and Evaluation.
DSD	Department of Social Development
DWCPD	Department of Women, Children and People with Disabilities
ECD	Early Childhood Development
HSRC	Human Science Research Council
ILO	International Labour Organisation
MDG	Millennium Development Goals
MMR	Maternal Mortality Rates
NACCW	National Association of Child and Youth Care Workers
NIDS	National Income Dynamics Study
NPC	National Planning Commission
RSA	Republic of South Africa
SAHRC	South African Human Rights Commission
SALDRU	South Africa Labour and Development Research Unit
SASSA	South African Social Security Agency
Stats SA	Statistics South Africa

UIF	Unemployment Fund
UN	United Nations
UNCRC	United Nations Committee on the Rights of the Child
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund

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Chapter One: Introduction and Background to Study

1.1 Introduction

Social assistance to vulnerable sectors of society dates to the recovery strategy after World War II. The United Nations' Declaration of Human Rights (1948), Article 22 stating that "Everyone as a member of society has the right to social security" (United Nations 2015:p.46) and Article 25 stating that "Everyone has the right to a standard of living adequate for the well-being of himself and his family" (United Nations 2015, 1948: p.52) provide the cornerstone for social protection systems worldwide. Social protection aims to build "economic recovery, inclusive development and social justice" (ILO, 2014, p. 4). Social protection for children goes beyond social security, which ensures basic household income, to also encompass nutrition and access to social services, education and health care (ILO, 2014).

South Africa institutionalised these rights in a Bill of Rights in the *Constitution of the Republic of South Africa 1996,* promulgated in 1997 (1996: Chapter 2). This confirmed South Africa's commitment to redress the divide between poor and non-poor, which had been entrenched along racial lines for over five decades.

The South African Constitution, which is supreme in terms of South African Law, enshrines equality and advances human rights. Any law inconsistent with the Constitution is considered invalid. This rights-based framework obligates the executive arm of government to respond with services and social assistance mechanisms to ensure citizens' rights to household income, universal health care and education.

Despite the large social assistance[2] programme instituted by the current government, poverty indices reveal growing disparities, with large sectors of

[2] *Constitution of the Republic of South Africa (1996, p. 11)* refers to "social security, including, if they are unable to support themselves and their dependents, appropriate social assistance," which appears to mean that social assistance, which should be made available to people who are not able to support themselves, refers to the grants and pensions, whilst social security refers to private or public contributory insurances such as unemployment insurance fund.

society trapped in poverty and not able to escape the ramifications of crowded housing, poor nutrition, inferior education and inadequate household income (SAHRC and UNICEF, 2011).

The child support grant, means tested, is designed to provide basic income to caregivers of children under the age of eighteen years. Most of the beneficiary caregivers are between the ages of twenty and fifty. A relatively small per cent (2, 3%) of the caregivers are under the age of twenty (DSD, SASSA and UNICEF, 2012). They represent a pertinent example of the people who are struggling to find their way out of poverty. The vulnerabilities of this group of young caregivers, and their next generation, are of central concern in this study.

Despite South Africa having a strong rights-based legislative framework, which expresses obligations for delivery on these rights, actualisation lags well behind the intent.

Children are, by their very nature, dependent and therefore require consideration within the national social protection floor. Child-sensitive social protection makes special provision to reach children who are particularly vulnerable, who are marginalised, living with multiple deprivations and often socially excluded. Children without mothers, living in intergenerational poverty, exposed to violence, coping with disabilities, in families affected by chronic disease and/or exposed to substance dependencies are at risk of compromised lives requiring lifelong social assistance (SAHRC and UNICEF, 2014). The social protection floor intends to assist children to move out of these circumstances. However, intergenerational poverty continues to perpetuate itself, particularly in communities living in areas that were demarcated as homelands in the previous regime, and in areas of flux such as informal settlements (SAHRC & UNICEF, 2014; Adato, Carter & May, 2006).

Within this vulnerable sector of society, a sub-group of young people particularly susceptible to the gaps in social protection are adolescent mothers, and, invariably their children. Their inability to take care of

themselves, access health care, complete education, find employment and secure child care is mostly exacerbated by the fact that they have grown up in a poor environment – added to which these adolescents are now responsible for children.

The focus of this study centres on a group of adolescent mothers living in formal townships and informal settlements[3] on the outskirts of Grabouw, which is the largest town in the Overberg district of the Western Cape. Townships are a result of forced removal in the apartheid era of South Africa. "Labour migration in South Africa historically occurred under specific institutional conditions, where a range of measures made permanent urban settlement impossible for most migrants. With the lifting of formal sanctions against African urbanisation, it might be expected that patterns of circular or temporary labour migration would be replaced by permanent migration, and particularly to urban areas" (Posel & Casale, 2003, p.1). In more recent years, this township has spread into several informal settlements as a result of the in-migration of people, mainly from the Eastern Cape, in search of employment. The growth of the urban population in this area was not only a natural consequence of the abolition of apartheid, but also correlated with the development of deciduous fruit farming and the expansion of viticulture in the district (Ewert & Du Toit, 2005). Consequently, informal housing, which sprawls across the hills on the outskirts of the formal townships (Pineview and Siteview), grows at an alarming rate along with the incumbent increased demand for power, water and social services.

1.2 Background to Study

The United Nations' Convention on the Rights of the Child (CRC), which was ratified by South Africa in 1995, recognises that children, because of their immature state, require special safeguards and that the state has the

[3] Definition of informal settlement: "An unplanned settlement on land which has not been surveyed or proclaimed as residential, consisting mainly of informal dwellings (shacks)." Definition of an informal dwelling: "A makeshift structure not approved by a local authority and not intended as a permanent dwelling" (Statistics South Africa, 2015, p 73)

responsibility to ensure that the rights to these protective measures are in place. Rights of children are categorised into areas of survival, development, protection and participation. In operationalising these rights, countries which are signatories of this Convention, are required to underpin their national policies and all forms of jurisdiction with principles of non-discrimination, respect for the child's views and his/ her right to live, and the best interests of the child (United Nations Committee on the Rights of the Child [UNCRC], 2010).

A global review of the degree to which children of member countries realise their rights was published by the UNCRC (2010). While marked, improvements were noted in areas of child survival, nutrition, girls' schooling and in views on child protection, the main challenge lies in vast disparities exist between regions and within countries, particularly in the Sub-Saharan region. Disproportionate fulfilment of rights is fuelled by gender discrimination, inadequate education of mothers, unbalanced household income and the rural–urban divide. Children with disabilities and children of minority groups are more notably affected by these disparities (UNCRC, 2010).

The Republic of South Africa (RSA) is no exception to this global trend. In its report to the UNCRC, the South African government recognised that despite areas of progress, particularly in the social assistance programme, "the structural inequities of apartheid have locked South Africa into an ongoing battle against inequality. After two decades of pro-poor development, South Africa remains one of the most unequal countries in the world, with children bearing the brunt more heavily than others" (Department of Women, Children and People with Disabilities [DWCPD], 2013, p. 5).

South African citizens are technically well protected by a Bill of Rights in the Constitution that *inter alia* places responsibility on the state to provide social security, health care, food and water for citizens who are unable to support themselves and their dependents (*Constitution of the Republic of South Africa 1996).* The Constitution further stipulates that the state must take "reasonable legislative measures, within its available resources to achieve

the progressive realization" of these rights (*Constitution of the Republic of South Africa 1996* Ch. 2, Section 27, p. 11). These entitlements are in line with international commitments to social security as a human right (ILO, 2014).

Section 28 of the South African Constitution (RSA, 1996) defines a child as a person under the age of 18 and itemises children's rights in line with those in the Convention on the Rights of the Child. These are further protected in a host of laws such as the *Social Assistance Act* 2004, *School's Act* 1996, *National Health Act* 2003, *Children's Act* 2015, *Child Justice Act* 2008, *Sexual Offences Act* 2007 and *Domestic Violence Act* 1998. However, as the SA UNCRC report states, full implementation of these laws is still hampered by structural inequality. "The rights of children to receive information and express their views are constitutionally and legislatively protected, but infrastructural inequalities, insufficient resources and resilient community and family attitudes create challenges for the effective realisation of these rights" (DWCP, 2013, p.6).

Legislative frameworks produced over the past twenty years of democracy in South Africa provide the framework for inclusive development and for accessing entitlements in each of the relevant sectors – social security, health, education, nutrition, water and sanitation and housing. The national government departments in most line functions established guidelines, norms and standards to effect legislation, and the implementation of policies emanating from this whole process is delegated by the President to the provincial substructures within the executive arm of government (*Constitution of the Republic of South Africa 1996* Ch. 5).

Legislation since 1994 led to the expansion of services for children, especially those who were excluded during the apartheid regime. New laws and progressive state spending contributed to accelerating the fulfilment of children's rights in primary health care and basic education. Social assistance, recognised as an effective strategy to tackle poverty, contributed to poor households' improved access to these basic services (Samson, 2009).

Another example of expansion of services was the scaling up (albeit late) of the provision of anti-retroviral treatment for HIV+ people. This contributed to the overall reduction of AIDS related deaths and the reduction of mother-to-child HIV transmission (AIDSMAP, 2014).

However, as noted by the National Planning Commission (NPC) in the Presidency, massive disparities between different sectors of South African society persist, despite these advances. Citizens who are not able to take care of themselves and their dependents are worst affected (SAHRC & UNICEF, 2014; SAHRC, 2011; Depts. of Health, Social Development &Performance, Monitoring and Evaluation 2014). In its Diagnostic Report, the National Planning Commission (NPC, 2011), identified the failure to implement policies as one of the main reasons for the persistent unequal access to essential services and uneven quality of public services.

A group of people who are particularly affected by this inequity is adolescent mothers and by implication their next generation. Adolescents below the age of eighteen are considered children themselves and should therefore be experiencing the protection, nurturance and self-expression that the pertinent laws inscribe. Adolescents of eighteen and nineteen years are no longer children, but are very often still of school going age and as such, are protected by the *Children's Act, 2005*. The 2016 General Household Survey, found that, 5,4% of girls between fourteen and nineteen years had been pregnant (range 0,7% 14 yr. olds to 12,1% 19 yr. olds) during the year preceding the survey (StatsSA, 2015, p.318). Prevalence of adolescent child- bearing in Western Cape metropole was 22%, whilst the national average is 25% (Karra & Lee, 2012). Information on adolescent fathers is less available.

This study focuses on adolescent mothers' perceptions of their rights to essential services, which could be influenced by their general understanding of their civic rights. Studies on children's knowledge of rights indicate that children are aware of their rights, but are not really able to advocate for the realisation of their rights (Willenberg, Tenebaum & Ruck, 2014). Two interesting results relevant to this study emanate from Willenburg, Tenebaum & Ruck's (2014) study in the Western Cape, South Africa: They worked from

the premise that children's awareness of rights tends to fall within two categories of rights - protection/ nurturance and self-determination - and that the level of awareness is affected by their socio-cultural context. Their findings indicate that although children have "appropriated some of the rights…. [but] this does not necessarily have an observable impact on the quality of everyday life" (Willenberg, Tebebaum & Ruck, 2014, p. 449). Building on this observation, this study explores the lived experiences of a particularly marginalised group of adolescents in accessing their rights to education, health care and social assistance and how this has affected the quality of their lives.

There appears to be an assumption in the rights framework that people have the agency to access their rights. Yet the Diagnostic Review of the Planning Commission (DPME, 2011) and the Report to the Committee on the Rights of the Child (DWCPD, 2013) clearly indicate that this assumption is not always realised and that this agency is often under-powered.

The motivation of this study is twofold: a) to better understand the challenges experienced by adolescent mothers, who live in low income households, in accessing these essential services, and b) to ascertain what could be done to prevent their children from growing up in what appears to be inescapable poverty. The latter is particularly important given the global recognition of the importance of investment in the first one thousand days of children's lives as a foundation for educational outcomes, social participation and economic contribution (Black & Hurley, 2016). Studies on health outcomes of children born to teen mothers in the Western Cape are consistent with international literature, indicating negative impact, particularly on birthweight and stunting (Branson, Ardington & Leibbrandt, 2011). The educational outcomes for adolescent mothers are significantly lower than their contemporaries, which inevitably have spill over effects to the next generation (Karra & Lee, 2012).

Through engaging with adolescent mothers in Pineview and enquiring about their experiences of the health, education and social assistance systems and services, this study aims to explore the assumption that the social protection entitlements are known and accessible to adolescent mothers and that these

are sufficient for them to escape chronic poverty. The intention is to gain an in depth understanding of opportunities and barriers from their experiences of their socioeconomic environment as well as their experiences of intersecting with services in the health, education and social sectors.

The adolescent mothers who are the subject of this study, are members of families who receive family support services from *Isibindi* Child and Youth Care Workers (C&YCW), a non-government organisation, operating in all provinces of South Africa. *Isibindi* offers comprehensive support services to vulnerable families, and specialised programmes such as an adolescent development programme. However, they do not have a dedicated service for adolescent mothers. This study could inform the design of specialised services that C&YCW can provide to adolescent mothers.

1.3 Problem Statement

The legislative framework in South Africa provides a solid foothold for citizens to secure social protection. However, the intent of this framework is not being realised by most citizens, least of all by survivors of multi-generations of poverty. Adolescent mothers in these circumstances find it particularly difficult to escape the poverty trap that they find themselves in, which impacts negatively on their children's potential to realise their full potential. Situational analyses and diagnostic reviews confirm these difficulties and disparities (DWCPD, 2010; SAHRC & UNICEF, 2014).

An enquiry into children's knowledge of their rights indicates that children are aware of their rights, particularly about their rights to protection and nurturance (Willenberg, Tenebaum & Ruck, 2014). However less is known about their experience of their rights, and about what the barriers and facilitators to the realisation of their rights are.

A category of children who are particularly susceptible to perpetual and multi-generational poverty are adolescent mothers and their children. Although fertility is on the decrease in South Africa, the national prevalence of

adolescent pregnancies is still alarming at 25% (Karra & Lee, 2012). The context of this study is the Western Cape where the average prevalence of adolescent births is 22% (Karra & Lee, 2012).

Secondary analysis of data in the Western Cape has shown that teen mothers have different home circumstances to that of their peers and that their educational outcomes were significantly lower than those of their peers (Ranchod, Lam, Leibbrandt & Marteleto, 2011).

The knowledge gap that this research seeks to address lies in the actual experiences of the teen mothers in a particular context – what do they understand their social protection entitlements to be? If they access their entitlements, how do they access them? And, are these entitlements sufficient to ensure that they can continue with their education, mind their child and provide for their child?

The information generated by this research will be helpful for designing more extensive research on how to tailor social protection strategies to curb the perpetuity of poverty experienced by adolescent mothers living in the informal and formal townships of Grabouw.

1.4 Purpose statement

The purpose of this study was to explore the particular social protection needs of adolescent mothers who were in receipt of services from Isibindi in a township on the outskirts of Grabouw in the Western Cape Province. The study also addresses to what extent these needs are provided for with present services, and what provisions should be made for additional social protection needs. The study focuses on three areas within social protection: health care, education and social assistance.

1.5 Research Questions and Structure of the Report

The main research question that guided this study was:

- How do adolescent mothers in Pineview and surrounding areas experience social protection?

Sub questions pertaining to the adolescent mothers included:

- What are the lived realities of adolescent mothers in Pineview and surrounding areas?
- What do adolescent mothers understand of their rights to social protection?
- What sense of agency do adolescent mothers have in accessing their rights?
- How have adolescent mothers interacted with the education, health care and social assistance service providers?

Sub questions directed at focal people within the non-government organisation that assisted with sample recruitment, and who provide social services to their families, included:

- What are the child and youth care workers' (C&YCWs) observations of adolescent mothers in this community in terms of acceptance and /or stigma?
- What do the C&YCWs know of the adolescent mothers' access to health, education and social assistance services?
- How have the services that *Isibindi* provides in the community assisted the adolescent mothers?

This chapter introduces the topic of this study with a rationale for the research that was undertaken. The next chapter reviews literature on adolescent mothers in South Africa, with some reference to studies elsewhere, particularly within Sub-Saharan Africa. The third chapter outlines the methodology used in this study, which is followed by a description of the

findings in chapter four. Chapter five discusses these findings and the final chapter six concludes the report with recommendations.

Chapter Two: Literature Review

2.1 Introduction

This chapter provides the conceptual framework for this study that looks at social protection for adolescent mothers living in intergenerational poverty. Social protection is understood to be provided by public, private and civil sectors within a rights-based legislative framework. It includes both social and economic elements, is more than a protective livelihood safety net and has a transformative function for families living in chronic poverty. Social protection acknowledges the need for strategies to address chronic poverty, which the adolescent mothers tend to find themselves in.

The introduction to this report explicates the poor realisation of children's rights, to which adolescent mothers are particularly vulnerable. This chapter expands upon the subject of adolescent childbearing by looking at the way in which South African policies and services have fulfilled their constitutional obligation to this particular group of people.

This chapter initially focuses on the South African legislation that is pertinent to the research question of social protection for adolescent mothers. Thereafter the demographic and socioeconomic situation of adolescent mothers is provided, followed by a description of the context of this study – Grabouw in the Western Cape Province. Lastly, the chapter asks why adolescent mothers need social protection.

Literature search was conducted in electronic databases of academic journals, particularly JSTOR, Google Scholar and Sage, using combinations of key words such as "social protection", "social assistance", "teenage pregnancy", "early childbearing", "adolescent pregnancy," "South Africa", "Sub-Saharan Africa", "dysfunctional families", "sexual reproductive health", "education," "adolescent parents" and "teenage parents". Articles published since 2000 were screened for relevance unless citation mining rendered useful articles published prior to 2000. Grey literature was sourced from websites of research agents such as South Africa Labour and Development Research Council (SALDRU) and Human Science Research Council (HSRC)

and websites of United Nations' agencies. Legislative documents were mostly found on government websites.

2.2 Social Protection within the South African Legislation

A working definition of social protection, provided by Devereux and Sabates-Wheeler elucidates the thinking underlying the purpose of this study:

> Social Protection is a set of all initiatives, both formal and informal, that provide social assistance to extremely poor households; social services to groups who need special care or would otherwise be denied access to basic services; social insurance to protect people against risks and consequences of livelihood shocks; and social equity to protect people against social risks such as discrimination or abuse (Devereux & Sabates-Wheeler, 2004, p. 9).

Chronic poverty, sometimes denoted to as poverty traps and inter-generational poverty is understood in this study to be multi-dimensional. It refers to people experiencing deprivations beyond material deficits and low levels of health and education to include "the inability to influence decisions that affect one's life, ill treatment by state institutions, and the impediments created by social barriers and norms and also dimensions of ill-being" (World Bank, 2001, p.29). This understanding of poverty, that goes beyond household income to include poor access to basic services and the poor sense of agency is also described by Adato, Carter and May (2006, p.239) as "structural poverty". Xaba's discussion on Sen's theory on poverty adds the notion of not being able to make "meaningful economic and political choices" to the understanding of chronic poverty that this study applies (Xaba, 2016, p.117).

The foundation for all legislation is provided by *the Constitution of the Republic of South Africa 1996,* and the principle underpinning this framework is captured in Article 10 (p.6) "Everyone has inherent dignity and the right to have their dignity respected and protected". This principle set the tone of the

original intention of the current regime, which was to redress the inequities of the apartheid era.

The *South African Bill of Rights, Article 27 1996*, articulates the right to social protection, which is particularly relevant to this study:

1. Everyone has the right to have access to a. health care services, including reproductive health care; b. sufficient food and water; and c. social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (*The Constitution of the Republic of South Africa 1996*, p.11)

The right to education is captured in Article 29: "Everyone has the right to a. basic education, including adult basic education; and b. Further education, which the state, through reasonable measures, must make progressively available and accessible" (*Constitution of the Republic of South Africa 1996*, p. 12).

Legislation produced over the past twenty years of democracy in South Africa provides the basic framework for the delivery of services for the fulfilment of these rights to health care, food security, basic education and social security. (*Constitution of the Republic of South Africa 1996*, Ch. 5).

However, what is less clear are the processes and means for the progressive realisation of these rights. Section 29 of the Bill of Rights suggests that "practicability" needed to be taken into account in fulfilling duties to deliver equitable basic services to redress the inequitable distribution of resources, services and opportunities in the apartheid era. Strategies for prioritising this practicable equity have not been clear. (National Planning Commission, [NPC], 2011; Adato, Carter & May, 2006). Despite publications on the poor rate of progressive realisation that emphasised the need for it to be prioritised

at least ten years ago (see Adato, Carter and May, 2006), there remains a void in terms of legal instruments that give life to progressive realisation of the constitutional rights. ,

Nevertheless, there are examples of how the South African government has implemented pro-poor policies, which could be emulated in creating a more comprehensive transformative agenda.

Examples of improved access to social protection include the roll out of social assistance, of antiretroviral drugs for HIV+ people and no-fee schools. Progressive state spending contributed to accelerating the redistribution of social assistance to caregivers for their children. The unconditional cash transfer – Child Support Grant (CSG) - for means tested caregivers has been recognised as an effective strategy to tackle poverty (Samson, 2009). The CSG, which was introduced to age groups incrementally, is now available to all children under eighteen years. As mentioned in the introduction to this report, an assessment by the South African Social Security Agency (SASSA) in 2012, the CSG benefits about eleven million children with positive effects on educational, nutritional and health outcomes (DSD, SASSA & UNICEF, 2012). Eyal and Woolard (2011) further found that the grant receipt is associated with higher probability of employment of caregivers between the ages of twenty and forty-five.

However, the question of expenditure in respect of this social assistance in extremely poor households needs to be asked (Adato, Carter & May, 2006). To what extent does this grant get spent on children's' basic needs, such as food and school related costs, and how much is used to ameliorate poverty in the households that have no other income? Adato, Carter and May (2006, p.239) found that people living in structured poverty come from households where

> [no adults are in] formal work or in only one formal job that is insufficient given the household size … instead the household relies on members that move in and out of informal or casual jobs. Some

> households depend on one [old age pension] as the major, or only, reliable income source.

In their Twenty-Year Review of services delivered by the African National Congress (ANC) led government, the National Planning Commission identified progress as well as areas that need attention in education (NPC, 2011). While access to schools had improved, especially through the no-fee policy, the overall quality of education had not improved. The disparity in educational outcomes across the country was indicative of inequitable gains across different sectors of South African society. Areas that needed improvement mostly related to "previously disadvantaged" communities – such as parental involvement in education, active citizenry in holding schools to account, improved management of schools, consistent supply of materials and improved infrastructures (NPC, 2012).

The challenge lies in the fact that parents in the "disadvantaged areas" where school's fees are not compulsory have invariably not completed secondary school themselves. The dependency on parental involvement in their children's learning is therefore short sighted, and the right to basic education for adults has been overlooked.

These persistent disparities in education reflect ubiquitous inequity in the South African society where the Gini coefficient is one of the highest in the world - hovers between 0,66 and 0,69 (World Bank, 2017; SAHRC and UNICEF 2014; SAHRC 2011; ; Depts. of Health, Social Development, and Planning, Monitoring and Evaluation, 2014)

Groups of people affected the most by this disparity live in circumstances that entrench poverty and who are not eligible for social assistance. Unemployed women between eighteen and sixty years, who are more likely to be black or Coloured, are particularly vulnerable (Hassim, 2005). This chapter presents a summary of what literature says about adolescent mothers - a sub group of women identified as particularly vulnerable to poverty in South Africa.

2.3 Adolescent Mothers in South Africa

Literature from the 1980s describes customary practices around teenage pregnancies as being associated with coming of age, bridal wealth, love and a sense of pride in the fertility of men. This changed when the socioeconomic landscape offered new opportunities and aspirations for African women, particularly in urban areas (Panday et al, 2009; Mkhwanazi, 2014a). “The South African history of race classification accompanied by the gross inequalities in access to economic opportunities as well as health services is reflected in the teenage fertility rates” (Panday et al., 2009, p. 37).

Teenage fertility rates in South Africa have decreased over the past three decades, but this has not been at the same rate as total fertility rates (Ranchod et al., 2011; Makiwane, 2010). “Teenage fertility has been declining, however, at a slower pace than overall fertility…. As a result of these fluctuations, the share of overall births attributable to young people has risen over time” (Panday, Makhwane, Ranchod & Marteleto, 2009, pp. 33-34). According to the longitudinal data of the National Income Dynamics Study (NIDS), the proportion of teenagers giving birth “decreased from 30% in 1984 to 23% in 2008. The proportion of young teens giving birth has also decreased, with young women aged eighteen to nineteen accounting for the majority of teen births” (Ardington et al., 2012, p. 1.). An analysis of Department of Health data indicates an overall 30% decline of teenage (15-19 years) fertility between 1998 and 2003. However, the percentage decline is not consistent across all race groups nor across all provinces (Makiwane, 2010; Willan, 2013; Kaufman, de Wet & Stadler, 2001). Black and Coloured adolescents’ fertility rates are significantly higher than that of white and Indian race groups. Rates in the Eastern Cape are slightly higher than those of the Western Cape, neither of which are the highest nor the lowest in the country (Panday et al., 2009).

Teenage pregnancy has been observed as a socially constructed problem by some researchers (Macleod, 2003). Nevertheless, data on early childbearing

in South Africa suggests adverse outcomes for some teen mothers, which can on the other hand be seen as problematic. For example, “adolescent fertility is strongly associated with a higher risk of mortality before the age of 30” (Karra and Lee, 2012 p. 3). Educational attainment of adolescent mothers appears to be generally restrained, but this depends on whether they are rural or urban based. SALDRU’s (2016) analysis suggests that in some areas, the socioeconomic factors were associated with early fertility. The educational outcomes for adolescent mothers were not significantly different to their peers in similar socioeconomic environments. Whereas adolescent childbearing in rural areas was found to be associated with significantly poorer educational outcomes than that of their peers in urban communities (SALDRU, 2016).

Literature on antecedents of adolescent pregnancies suggests that they are similar to the outcomes. . Most of the adolescent pregnancies fall within the 17 – 19 age group, and are significantly higher among black Africans and the Coloured population. “The differences can likely be accounted for by the wide variation in social conditions in which young people grow up” (Panday, et al., 2009, p. 11), including disruptions to cultural and family practices, difficulties in accessing education and health care, as well as intergenerational poverty in black African and Coloured communities. The propensity for adolescent pregnancies to occur in dysfunctional families appears in local and international literature. Woodward, Fergusson, & Horwood, (2001, p.1172) in their profile description of teenage pregnancies in New Zealand describe “conduct problems related to family characteristics… multiple parental transitions”. Kheswa (2017) describes “divorce, substance abuse by parents, poor socioeconomic status and permissive parenting styles” (p. 162) as dysfunctional. Yakubu and Salisu (2018), in their systematic review on factors influencing adolescent pregnancy in Sub-Saharan Africa, also identify “severe family dysfunction” (p. 9) as a risk factor for early childbearing.

The dynamics of early childbearing in townships has been well documented by Mkhwanazi (2014 a, 2014b) from historical, policy, social and ideological perspectives. The ethnographical approach to her studies provides an interestingly nuanced picture of how these changes have improved

communication between mothers and daughters on sexuality and reproductive health. On the other hand, norms and values pertaining to gender roles perpetuate gender inequality and there is increasing evidence that gender-based violence is normalised, putting young mothers at increased risk of vulnerability as a parent and as a woman (Mkhwanazi 2014 b). Whilst the introduction and scale up of adolescent friendly reproductive health services has been welcomed, and decline in adolescent fertility has in part been attribute to this (Branson et al, 2011; Branson & Byker, 2016), the inequitable access to such services particularly affects young mothers who would need to incur cost to reach clinics (Mkhwanazi, 2014 b).

Studies on causes and consequences of early childbearing for young mothers and their children in South Africa are generally in keeping with those of other regions (Gupta & Mahy, 2004; Kaufman, et al., 2001; Majozi, Ige & Tshabalala, 2016; Ribar, 1999).

Consistent in the literature on teenage mothers are assertions that socioeconomic factors have precipitative and consequential influence on the trajectory of the lives of the adolescent mothers as well as their children – with implications for social protection policies (Willan, 2013; Ardington et al., 2012; Mkhwanazi, 2014b; Cluver, Orkin, Meinck, Boyes & Sherr, 2015). Analyses of longitudinal data also indicates adverse consequences for children of adolescent mothers, especially in terms of educational and health outcomes (Branson, Ardington & Leibbrandt, 2011; Ardington, Branson & Leibbrandt, 2012).

This study focused on adolescent mothers' access to three areas of entitlement within the social protective framework: health care, education and social assistance. The critical question is whether the social protection provisions for adolescent mothers are sufficient to break the intergenerational cycle of poverty, which is typical of families living in multidimensional poverty in South African townships (Finn, Leibbrandt and Woolard, 2013) and which are exacerbated amongst seasonal workers on fruit farms in the Western Cape (Du Toit, 2014; Ewert & Du Toit, 2005).

Researchers have identified that despite pro-poor strategies within a rights-based legislative framework, outcomes for adolescent mothers are persistently poor. Strategies include no fee schools, school meals, grade R in all areas, life-skills to avoid early sexual debut and unwanted pregnancies within curriculum (Davids & Waghid, 2013; Majosi et al., 2016). Within the reproductive health services strategies have included expansion to adolescent friendly clinics with peer counsellors (Branson & Byker, 2016) and an expansion of the child support grant to include zero to eighteen year olds.

This study looks at adolescent mothers in a particular context, which the next section of this chapter describes.

2.4 Grabouw Context

Grabouw is a small town in the Theewaterskloof municipality in the Overberg district of the Western Cape, with a population of approximately 33, 337 of which 55% are Coloured and 38,5 % are black African. The income of 65% of households is less than R38 200 per annum and 17 % of the households have no income (Stats SA, 2011) The communities living in the Pineview township and informal settlements on the outskirts of Grabouw, as with all townships in South Africa, carry the legacy of apartheid, which by design restricted black and Coloured people from accessing educational and economic opportunities. However, because of the nature of the industry in the area, two critical phenomena have impacted on the livelihoods of the people in Grabouw in a particular way (Ewert & du Toit, 2005).

Grabouw's economy is based on servicing the surrounding agricultural industry, which produces most of the country's deciduous fruit, particularly apples. It produces most of South Africa's export apples and is home to the well-known Appletiser factory. In addition, the wine-making industry is growing in this district. The implications of this industry growth are two-fold. Firstly, it has attracted an influx of people looking for work, who have built their own make-shift houses at the back of houses that are supplied by

government, or have spread onto the slopes alongside Pineview. Not only has this created competition in the labour market, but the infrastructure and the provision of basic services like clean water, electricity and effluent removal are scarce. Nevertheless, these informal dwellings become more permanent dwellings, as the community develops their own pattern of living with accompanying social norms and cultures. Secondly, the globalisation and de-regularisation of agricultural industry, which became increasingly buyer-driven, accompanied by labour regulations that led to the increase of casual and seasonal workers. Analyses of the political-economy of this situation is beyond the scope of this study, suffice to say that the economic growth from agro-industry in the Grabouw area is heavily dependent on manual labour, but the people supplying this labour are doing so under adverse conditions, which invariably keeps them in chronic poverty (Du Toit, 2004).

2.5 Why is Social Protection for Childbearing Adolescents a Necessity?

This section of the literature reviews presents a rationale for upholding social protection for adolescent mothers, particularly those living in marginalised circumstances such as in the Grabouw settlements. Within the social protection framework, the constitutional rights to health care, including reproductive health care, education and social assistance are the focus of this study.

2.5.1 Health Care Services

For the past couple of decades, maternal health has been an international priority to unite efforts against multiple deprivations and to eradicate extreme poverty. Improved maternal health has been one of the main areas receiving focused global efforts, as the catalytic effects of this strategy are recognized as being particularly significant - “Good quality care during pregnancy is

fundamental to the health, well-being and survival of mothers and their babies" (UN, 2013, p. 30). Moreover, the well-being of babies, starting from conception, has long term implications for society as a whole – socially and economically (Heckman, 2008).

Acknowledging that the Millennium Development Goals (MDG) have been replaced by the Sustainable Development Goals, this literature review takes a retrospective view in terms of South Africa's performance in health care over the past twenty years. One of the goals focused exclusively on improving maternal health, which is a global indicator for the quality and accessibility of health care services and is used as one of several indicators of multi-dimensional poverty (World Bank, 2001). The aim was to "reduce by three quarters the maternal mortality ratio between 1990 and 2015" (UN, 2013, p 28). However, the results of the MDG efforts in Sub-Saharan Africa fall far short of this goal, which was partly due to the high HIV rates in this region (UN, 2013). But the HIV pandemic alone could not be blamed for the persistently high maternal mortality rates in South Africa. A correlation of maternal mortality rates (MMR) with gross domestic product (GDP) per capita indicated that South Africa had a particularly high MMR for the level of GDP per capita. For example, compared to Swaziland, South Africa had the same level of MMR (over 400 per 100 000 in 2008) but with more than double the GDP per capita (close on $4000 at prices in 2000), and a similar MMR rate to Uganda, but four times the GDP per capita (Van den Heever, 2014).

South Africa's National Treasury reported a twofold magnification of the social wage between 2002/3 and 2012/13 – which was partly due to the doubling of the health budget (South African Treasury, 2013). Primary health care, of which ante-natal care is part, is free of charge and pregnant women are exempt from fees for hospital services (*Constitution of the Republic of South Africa, 1996*; South Africa National Treasury, 2013). However, the disparities in services for mothers between private and public sector are enormous, with admissions for delivery being limited to less than twenty-four hours for normal delivery in public sector and a couple of days with a lot of special care in the

private sector (Dept. of Health, 2007). The quality of health care accessed is therefore strongly associated with income level (National Treasury, 2013).

The nutritional status of mothers, naturally a part of health status, and central to the well-being of mother and child, warrants distinct attention during pregnancy as well as during lactating months within the first six months of a child's life. The findings of the *Diagnostic/Implementation Evaluation of Nutrition Interventions for Children* show that malnutrition is still the main cause of death amongst children under five years, 21% of children are stunted (which will also affect their next generation) and insufficient attention is given to food security, dietary diversity, nutrient requirements and obesity (Depts. of Health, Social Development and Performance Monitoring and Evaluation, 2014).

An evaluation of programmes undertaken by the Dept. of Health in South Africa, found that nutrition services have better results when mainstreamed in health services (Dept. of Health, DSD & DPME, 2014). The re-engineering of health services, with the intention of focusing more on primary health care could have been an opportunity to integrate key nutrition messages and associated metrics with the general scope of community health workers, but this opportunity was missed and nutrition services are still centre-based. The respondents of the evaluation also lamented the perennial problem of poor implementation of policies and the need for policy leadership and adequate resources.

Nutrition-specific programmes, especially food fortification (e.g. folic acid, Vitamins A and B, iron) and supplements distributed at routine antenatal examinations, reap positive results. More fundamentally, for women in poverty, basic food security, cost of accessing health services (specifically early antenatal health care) and affordability of nutrient rich foodstuffs such as protein and mineral rich vegetables is a real concern. Essentially this means feeding and carrying their unborn child during pregnancy and nurturing, nourishing and protecting the child post-partum is challenging. Without income to pay for access to health care, personal items and essential nutrients, the well- being of the child is compromised. The nutritional health

and emotional status of the mother has significant impact on the short and long term well-being of the child (Black & Hurley, 2008; Chersich, Scorgie, Kern, Blaauw and van den Heever, 2011; Victora et al, 2008).

Articles on how maternal well- being can be improved all refer to an integrated approach, using the pregnancy services as the key platform for these coordinated programmes (UCT, 2011; Black & Hurley, 2008; Chersich et al, 2011). The underlying principle of the South African Constitution (1996) is for all women to have universal access to quality health care and social security. Studies on nutrition support, mental health services and mothering preparation for mothers indicate that these are best located in antenatal care. The advantage of this approach is that poor women would not need additional resources to attend multiple service points and they could receive consistent and comprehensible messaging and positive reinforcement of healthy patterns (Dept. of Health, DSD & DPME, 2014).

2.5.2. Education

Article 29 of the *Constitution of the Republic of South Africa 1996* (p. 12) states that “everyone has the right to basic education, including adult basic education.” The *Convention on the Elimination of Discrimination Against Women* 2007 (CEDAW) states that member states, including South Africa, must: ‘take all appropriate measures to eliminate discrimination against women ... to ensure to them equal rights with men in the field of education and in particular to ensure . . . the reduction of female student drop-out rates’ (Part III.10 (f). The African Charter on the Rights of the Welfare of the Child (cited in Draga, Stuurman & Petherbridge, 2017, p. 164) agenda states that

> State parties [including South Africa] to the present Charter shall have all appropriate measures to ensure that children who become pregnant before completing their education shall have an

opportunity to continue with their education on the basis of their individual ability (Article 11 (6)).

Furthermore, pregnant learners are protected by national law. *The South Africa Schools Act* 1996 (No.84, section 5.1 cited in Draga et al, 2017, p. 163) states that a "public school must admit learners and serve their educational requirements without unfairly discriminating in any way", which means childbearing learners, especially those who are of compulsory school-going age, must be enrolled and permitted to attend school. "A school cannot refuse to admit a learner because of their pregnancy, as this would go against sections 3 and 5 of the Schools Act. It would also violate a learner's rights to equality, dignity and a basic education" (Draga et al, 2017, p.162).

The *South African Schools Act* (No. 84 of 1996) defines compulsory school attendance "until the last school day of the year in which the learner turns fifteen years, or the ninth grade, whichever occurs first" (*South African Schools Act, 1996*: p. B-5). In addition, the Government Gazetted Guidelines for the Consideration of Governing bodies in adopting a Code of Learning for their Learners state, "A learner who falls pregnant may not be prevented from attending school. A pregnant girl may be referred to a hospital school for pregnant girls" (*South African Schools Act, 1996*, p. B-36).

Despite these rights, there are cases of expectant mothers being discriminated against in South African schools. There are cases of young mothers being excluded from school. Mkhwanazi (2014b) provides the example of two learners who were excluded and after several court hearings the rulings were upheld on the grounds that the school governing bodies, who had the authority to make these rules, would otherwise be rendered superfluous. The schools were nevertheless ordered to review their policies to be in line with the Constitution. In addition, there are reports of more insidious exclusionary practices, such as no catch up plans being facilitated by teachers (Draga et al., 2017; Ngabaza & Shefer, 2013; Mkhwanazi, 2014b)

Panday et al. (2009) state that there is an inverse relationship between education and teenage pregnancies. There is a concentration of pregnancies

among teenagers in primary education and declines in secondary education, which supports the theory that there is higher probability of teenagers falling pregnant when there is a “tenuous relationship” with the school or there is “poor achievement” (Panday et al., 2009, p. 38).

Draga et al. (2017) point out that there were 99, 000 expectant learners in South Africa in 2013, which places a lot of responsibility on schools to uphold laws and to accommodate the requirements of young mothers as learners. Mkhwanazi (2014b)) emphasises the critical roles that schools play in a) offering women a step out of poverty as poor education is associated with poverty, pregnancy and gender-based violence; b) in providing quality education on sexual reproductive health so that young women are better informed to be able to make decisions and choices in their lives, and c) to shift the stereotypical gender imbalances in demonstrating “alternative performances of gendered identities” (p. 331).

2.5.3 Social Assistance

Social security for mothers themselves, particularly mothers who are not in formal employment and therefore not able to support themselves and their dependents, has not yet been realized in South Africa. The Unemployment Insurance Fund (UIF) is a contributory scheme (employee and employer each contribute 1% of salary) that benefits individuals who contribute during employment. Depending on her salary, a woman can claim up to 58% of her salary for up to four months (DOL, 2014). Although some employers pay salaries to an employee during maternity leave, there is no legal obligation to do so. The unemployment rate in South Africa is high, which makes formal employment opportunities for women with low levels of education and limited skills hard to secure. This group of unemployed women, as well as those who earn small wages from casual, seasonal or informal work, would not benefit from the UIF.

There is no specific non-contributory social assistance scheme for mothers in South Africa (*Social Assistance Act 2004*). In terms of the Constitution this

is potentially an infringement of their rights. Social assistance for adults in South Africa is provided in the form of Old Age Pensions, Disability Grants, War Veterans Grant and Grant in Aid, most of which are relevant to mothers only if they are over 60 years of age, disabled, a war veteran or in need of full time attendance due to a physical or mental condition (*Social Assistance Act 2004*). Social relief of distress is another form of assistance-in-kind provided to families who are not able to meet basic needs – usually in the form of a food parcel or food voucher – to people in crisis or in the case of mothers while waiting for children's grant application to be processed (*Social Assistance Act 2004*).

In the 1930s a State Maintenance Grant (SMG) was introduced for widows. It was means tested and was later available to divorcees, abandoned and unmarried mothers. From 1992 it was paid to either parent who had to prove that they had failed to obtain financial support from the absent parent (Wright, Noble, Ntshongwana, Neves & Barnes, 2014). The SMG, which was equivalent in monetary value to a pension, was limited to white people in the apartheid era, and when parity was gradually sought in the transition period of the late 1990s, with varied levels of administrative fluidity, the SMG became too expensive to uphold. "Therefore, most lone mothers ceased to be eligible for any form of social assistance for their own material needs" (Wright et al, 2014, p.11).

With no formal social assistance for mothers who are not able to support themselves, informal social security is relied upon – social networks, extended family and reciprocal support (Du Toit & Neves, 2009). However, rapid urbanization in South Africa contributes to a breakdown of family support structures, which impacts on traditional childcare arrangements (Kasen et al, 2009; Panday et al, 2009).

It is argued that the social wage, which has doubled in monetary value over the past ten years (National Treasury, 2013), include social assistance to mothers – through housing, health care and subsidies to early childhood centres (Wright et al, 2014). However, this has not been quantified and would not provide income for mothers' personal care.

In their study on how poverty affects mothers, Wright et al (2014) ran focus groups with mothers in the Western and Eastern Cape. Mothers described their experience of poverty in very real terms and spoke of how poverty destroys their sense of dignity as mothers. Some even related how they had engaged in “demeaning casual work”, “begging” and “transactional sex” as a “means of survival for themselves and their children,” and how their self-esteem was negatively affected by their lack of financial autonomy, because they were made to feel a burden by their families (Wright et al, 2014, pp. 50-51).

Wright et al (2014) introduced the idea of social assistance to mothers in this focus group discussion. The idea was positively received by the mothers, they explained how it would help them to eat properly so that they could take their anti-retroviral drugs, afford toiletries, clothing and housing and help them to basically survive - “it would end up protecting us in many ways, right now we are susceptible to diseases because of the lives we lead, just to survive” (Wright et al, 2014, pp. 51–53). However, the positive response was not without caution – some mothers felt that the state would never provide such a grant as it would prevent women from looking for work, and others suggested that some women may spend the money on themselves and forget about their children (Wright et al, 2014). However, overall, women were positive about the prospect of not being dependent on men who tend to be abusive and about the potential of regaining dignity and not having to deny themselves a humane existence (Wright et al, 2014).

These personal statements are supported by international evidence of how cash transfers can alleviate structural poverty (Slater, 2011). For example, social assistance programmes (conditional and unconditional) in countries such as Chile, Colombia, Mexico, Jamaica and Peru have all shown positive results (SAHRC & UNICEF, 2014).

Social assistance to children, in the form of child support grants and dependency grants, provides some financial reprieve to poor households, although they are meant to be used to meet children’s needs. Research on the experience of mothers in receipt of grants on behalf of their children

reveals conflicting outcomes – on the one hand mothers can purchase items essential for children, and on the other hand they face undignified treatment on the part of officials when applying for the grants. Furthermore, members from the household and absent fathers often demand financial assistance from mothers when they are aware of the income (although meagre) obtained from child support grants (Wright et al, 2014). The failure of social assistance to reduce gender inequality in South Africa has been well documented (Hassim, 2005; Goldblatt, 2005; Patel &Hochfeld, 2011; Patel, 2012).

Child-care is particularly challenging for mothers in the first three years of their child's life – beyond that, children can be part of a more formal education system (Patel, 2012). Within the first three years quality child care is expensive and not regularly available (Wright et al, 2014). Between three and five years of age, children are placed in some form of early learning centre or day care, all of which are poorly regulated and monitored. Registered early learning centres with qualified teachers are inconsistently subsidised, making them unaffordable for most mothers in South Africa. This limits a mother's ability to pursue a career, to seek employment and to fit into flexible and after hours forms of working arrangements.

The Early Childhood Development (ECD) Policy and related programmes (Richter et al, 2014; Marten et al, 2014) are an attempt to regularise this gap in child care. However, implementation will take a mind shift from centre based ECD to continuous and home based ECD, which will include positive and stimulating parenting. There are therefore two issues around child care for mothers living in poorly resourced circumstances – a) if they want to work and have the opportunity to work they need to be able to pay for child care while they are at work, and this is expensive, and b) if they are unemployed, and want to seek employment, they need to pay for child care while job hunting, but without resources they are stuck in a typical "poverty trap" (SAHRC & UNICEF, 2014).

Parental support has gained international attention to prevent child maltreatment, maternal depression and childhood aggression (WHO, 2009; UCT, 2011). According to the perinatal mental health programme at the

University of Cape Town (2011), one in three mother's experiences mental illness, and this is three times higher than in developed countries. Women in under-resourced areas are particularly prone to depression because of poor access to health services. Mental illness has immediate impacts on the bonding between mother and child, and long term adverse effects on child outcomes, which leads to a high probability of poor mental health in the adult-child (UCT, 2011; Barbarian et al, 2001).

2.6 Conclusion

This literature review positioned the conceptual framework for this study within international and national imperatives to provide accessible pro-poor basic services and social assistance in an equitable manner. Situational analyses, diagnostic reviews and research reports concur on the increasing disparities in South Africa. Households dependent on social assistance alone are worst off. A transformative approach to social protection suggests that basic services and social assistance are insufficient to shift people out of poverty traps to a position where they are able to make meaningful economic and political choices for themselves.

Literature on adolescent mothers, which includes situational reviews, statistical analyses of longitudinal and census data and ethnographic studies confirm that teenage fertility is on the decline but not at the same rate as total fertility rate, with black and Coloured adolescents in poor socioeconomic environments carrying the highest proportion. South African and international literature show that outcomes of early pregnancies, such as poor educational performance, are often also antecedents. Other common intrapersonal characteristics, such as substance abuse were observed, and familial characteristics such as dysfunctionality associated with absent or abusive parents.

With this background information from the literature review, this study intends to ascertain whether the adolescent mothers in Grabouw are accessing their entitled services as outlined in the international conventions and South

African legal instruments and to what extent these were hampered by the poor policy implementation that is reported in South African diagnostic reviews. Furthermore, the question this study addressed was whether these services were sufficient for the particular needs of adolescent mothers in Grabouw, and if not, what else would be required.

Chapter Three: Methodology

The literature review on adolescent mothers in South Africa was informed by multiple sources, which provided a broad overview of the rationale, contents and shortfalls of the relevant social protection elements. This research project collected primary data in one setting in the Western Cape and compared these findings with what was found in the literature. This chapter presents the methods used in collecting this primary data.

3.1 Research Strategy

Research strategies are designed to answer research questions. There are basically three approaches to research strategies – quantitative, qualitative and pluralist or mixed methods (Bryman, 2012; Fives, Canavan & Dolan, 2014). This research used a qualitative approach to gain an empathetic, contextual understanding (Neuman, 2006) of the lived experiences of adolescent mothers in the formal and informal settlements around Grabouw. Qualitative, inductive methods were used to collect primary data from adolescent mothers themselves. This qualitative approach allowed the researcher to find an "in depth and interpreted understanding of research participants, by learning about their social and material circumstances" (Ritchie, Lewis, MacNaughton Nicholls & Ormston, 2014 p. 4). The ontological foundation of qualitative approach lies in phenomenological and constructive enquiry, with a belief that we cannot be objective about human experience. Qualitative epistemology is imbued in descriptive, inductive processes, versus the deductive processes that generally lead to causal explanations and theories on human behaviour, and which are more characteristic of quantitative approaches (Bryman, 2012; Neuman, 2006).

In an effort to "lessen[ing] the distance and become an 'insider'" (Creswell, 1998, p. 17), the researcher consciously minimized the generation gap and potential power distortion between herself as a white older researcher and the young black and Coloured respondents by working interactively with a

young black research assistant who spoke isiXhosa. Secondly, the researcher used her social work non-judgmental, accepting and active listening skills during the interviews and focus group discussions while purposefully including the research assistant in the questioning and reflective process.

The axiological assumption of the qualitative approach was that the researchers would bring their own set of values and perspectives to the interviews and focus group discussions. Creswell (1998) suggests that there would be an "open discussion on the different perspectives" (p. 17), which did not really take place in the three days of exchange with the respondents. In fact, researchers were careful not to respond with their views or interpretation, but with prompts to encourage respondents to continue with their story or relating a phenomenon in the community. This was particularly apparent when abortion was discussed with the C&YCWs. However, researchers did show empathy, such as when a respondent spoke about her abuse, and advice such as when a mother's child was continuously coughing.

This study was envisioned to be an interpretative and constructive study, describing the phenomenon of adolescent mothers' experiences of social protection, with the intention of recommending specific interventions for *Isibindi* and informing more extensive research that could guide social protection reform for adolescent mothers.

The research strategy included the logistics of the study. Contact was established with the director and research manager of the National Association of Child and Youth Care Workers, and the founder of *Isibindi*, which is a non-government organization (NGO) offering support to children and their families in the Western Cape. Their services do not yet include specified outreach to adolescent mothers. The research findings could assist them to design a programme specifically for adolescent mothers. The director and research manager ensured that a) appropriate, suitable adolescents were identified for the study and b) written consent to record interviews and focus group discussions was attained from all respondents and c) arrangements for the interviews and focus group discussions to take place.

Identification of the adolescent mothers took place in November 2017, and the primary data collection took place on 11, 12 and 13 January 2018. The role of the research assistant was to interpret language, especially colloquial expressions, to co-facilitate the focus group discussions and to be a "touchstone" for the researcher to cross-check interpretations and meanings.

The semi-structured interview schedule was piloted by the research assistant in Khayelitsha, a township in Western Cape. The recommendation was to change a few words to be more in tune with local expressions, especially relating to sexual reproductive health terminology. The recommended revisions were made.

3.2 Research Design

A case study design was applied, the boundary being around adolescent mothers living in the Western Cape and receiving services from *Isibindi*. Case study lends itself to contextual, detailed and intensive investigation of a people's reality. Ritchie et al (2014) recommend case study design when one wants to gather multiple and detailed perspectives on a pre-defined issue/system/geographic area/ phenomenon in a context. "The integration of different perspectives on the context or interaction means that case study designs can build up very detailed in-depth understanding" (Ritchie et al, 2014, p. 67).

An interpretive orientation to the case study was employed in looking for implications and mutuality in the experiences and perceptions of the respondents. Schwandt and Gates (2018) propose that there are several "pathways" to case studies and one of these uses an interpretive orientation to gain an "understanding of social life and lived experience" (p. 343) in a single site, or in multi-sites. This study used one site, but could be replicated in other comparable sites to expand the case and further understand the

phenomenon of adolescent mothers' experience of social protection in settlements located elsewhere.

3.3 Sampling

A purposive and convenience method was applied to sample selection. Qualitative research tends to use non-probable sampling, deliberately selecting respondents to reflect the experiences, issues or phenomena under study (Ritchie et al, 2014). The respondents were selected because of their age, childbearing status, living context and because they are known to *Isibindi*. The respondents were therefore not selected randomly and are not statistically representative of all adolescent mothers in the Western Cape.

The sampling method was as follows: Young mothers within Pineview were identified by *Isibindi*, a local non-government organisation. Isibindi child and youth care workers are well known to the community and to the families whom they support. They were selected to assist with the identification of young mothers in this community because they are trusted members of the community. The researcher knows *Isibindi* to provide ethical and professional services and they are reliable in liaising meetings. The feasibility and purpose of the study was discussed with the *Isibindi* mentor, who in turn had preparatory and agreeable discussions with the child and youth care workers and adolescent mothers.

The researcher aimed to select at least ten adolescent mothers from the purposeful sample suggested by *Isibindi*, mindful of race and age representation. However, only eight mothers were available and all eight participated in the focus group discussion. Seven of the eight mothers were available for individual interviews. Adolescent pregnancies are relatively well documented in health and demographic reports. Adolescent fathers are less well documented and although organizations working with adolescent boys report that they are aware of biological fathers and believe that their experiences would also be documented, the scope of this study is limited and therefore did not include adolescent fathers.

3.4 Data Collection

Data collection methods included semi-structured interviews and focus group discussions with childbearing adolescents and their child and youth care workers. The views of the child and youth care workers provided some form of observational triangulation, adding their perspectives to the narratives of the adolescents, and these were included in the exploration of recurring themes in the data (Neuman, 2006; Ritchie et al, 2014). Added to this were the researchers' observations of the respondents' living conditions/environment, tone of expression, and their body language.

The key features of semi-structured interviews, as outlined by Ritchie et al (2014, pp.184-185) included a) maintaining a balance of "structure and flexibility" in the interviews which encouraged interaction between the researcher and the interviewee and which provided unique primary data; b) a set of standard questions; c) a skill in reflection and use of prompts to "get below the surface"; and d) recordings as well as brief note taking that captured actual language used. The recordings not only provided the actual language, but the tone of voice, which helped to elucidate meaning. Interviewing skills were used to establish rapport within a confidential interaction, and thereby gained personalised, but anonymous, insights of adolescent mothers lived experiences of social protection.

Focus group discussions were held with nine child and youth care workers within *Isibindi*. The purpose of focus group discussions was to explore the ways in which the child and youth care workers, in conjunction with each other, make sense of the adolescent pregnancies and adolescents' access to their entitled social protection. To a certain extent, the researcher had less control over the respondents' discussion in the group setting. It was the interaction amongst the community workers on the issue of adolescent mothers and their access to social protection that elucidated collective and varied views and feelings on the topic (Bryman, 2012).

The self-reported experiences of the social protection system were triangulated with accounts provided by social support services offered to the adolescents through a non-government service. Demographic profiles of the population of adolescent mothers in the Western Cape were extracted from reports on general household survey data.

Three added participative activities were included.

a) The first one was a neighbourhood map done in sub-groups of neighbours. This was done to encourage participation amongst the young women as at least half of the group were initially silent in the group; secondly, overcome the language barrier between the researcher and respondents and thirdly for the researchers to gain insight into what respondents saw as resources and threats in their neighbourhoods.

b) The second one was a *tree of life* for individuals to do as a springboard into the interviews. The idea behind this was to shift the power dynamic to the respondents, so that they would have ownership of their life-story in the interview.

c) The third activity was designed spontaneously on the second day when interviews were to be held. The research team tried to establish a schedule for the respondents, but they chose to come as a group to the *Isibindi* safe park[4] where the primary data was collected. The researcher did not want to feel pressurised by waiting respondents and thought the time could be used gainfully. Respondents then each drew their own house and were asked to indicate who lives in the house, who brings money to the house, who they have affinity with and who they have conflict with. In addition, they wrote down the top three expenses to the household. These diagrams together with the

[4] Safe Parks are demarcated areas where children can participate in organized activities or play freely under supervision of trained child and youth care workers. Most Isibindi Safe Parks are equipped with a shelter, lock up space and recreational facilities. However, Safe Parks can be set up informally by child and youth care workers in any space where they create a boundary within which they supervise and engage with children. (http://www.naccw.org.za/isibindi/safe-parks)

trees of life provided the researcher with tangible illustrations to use in the more structured part of the interviews.

3.5 Data analysis

Recorded interviews and focus group discussion were stored on an external drive and collated per time, venue and respondents' demographic details. The drawings and maps were photographed and stored on the same drive. Notes of key words, expressions and sentences were noted for recall purposes.

Recordings were transcribed and coded for all research questions using an inductive approach, looking for themes within and across the questions. Quotes were not mutually excluded. Responses to questions were coded per emerging themes regardless of the question posed by the researcher.

A deductive analysis of data in relation to the literature study was used once the themes had been inductively established. Analysis was comprehensive, in that the full verbatim reports were analysed manually using colour coding for emerging themes.

3.6 Data validation

Qualitative data is thought to be valid if it is transferable (generalizable). Three forms of transferability are considered relevant, the first one being most pertinent to this study (Ritchie et al., 2014).

Inferential generalisability, which relies on dense descriptions and full methodological accounts, was relevant to this study. Chapter Five of this report presents the comprehensive and systematic analysis of the data, which is referenced with specific quotes from the primary data as well as quotes from the literature with which the data corroborates or confers.

3.7 Ethical Considerations

Ethics of the study took confidentiality of participants into account. Participants were assured of anonymity in the reporting. Written consent for participation in the study and for recording the interviews was obtained from each respondent and the parent of the one under age respondent. Respondents were also given the option of withdrawing from the research process if they so wished. The findings of the study will be shared with *Isibindi*, who will in turn share with the respondents.

The researchers could refer respondents requiring psychosocial or health interventions to the child and youth care workers, but there were no critical or acute cases requiring professional attention. However, the chronic situation will be discussed with the management of *Isibindi* with recommendations for tailor made interventions for adolescents, particularly adolescent mothers.

Application for ethical clearance was duly submitted to the School of Governance, University of Witwatersrand.

Chapter Four: Research Findings

This section presents the findings from the qualitative study. Firstly, a demographic description of the respondents is provided together with an overview of their living conditions. Secondly, a brief overview of the data generation tools is provided as an anchor for the analysis on the findings that these elicited. Thirdly the themes that arose from the analysis of the data that were captured in the interviews and focus group discussions are presented. There are three themes: Theme one describes the respondents' experience of social protection, focusing on education, health care and social assistance. Theme two captures respondents' references to their social support network, and theme three summarises what respondents suggested could be done to improve their situation. The presentation of themes includes both general findings pertaining to the community, neighbourhoods and housing conditions as well as more individualistic data pertaining to specific respondents.

4.1 Demographic profile and living circumstances

Three days were spent collecting data at the *Isibindi* Safe Park where the child and youth care workers offer support and recreational activities to children in the neighbourhood. They had recruited young mothers, from the families that they support, to participate in the study. The relevant demographic and household data of the respondents is represented below in Table 1.

Two days were spent with the adolescent mothers and one day with the child and youth care workers. There were eight young mothers on day one, and seven of these could return on day two for the individual interviews. The nature of the group of young mothers was reflective of the demographics of the community – three of them were born in Grabouw and their home language is Afrikaans, five of them originate from the Eastern Cape and their home language is Isi-Xhosa.

Table 1: Demographic and Household Data

Respondent	Age of Respondent (years)	Age of child/ children	Current grade or when left school	Type of Household	Household income	No of people in household and number of generations	Household expenditure
1	24	6 yrs., 3 yrs., 8 m	9 (left school)	Shack at back of government housing, shared toilet; water and electricity prepaid	Boyfriend working; CSG older 2 children, not yet applied for youngest	5 people; 2 generations	Food, water and power
2	22	3 yrs.	11 (left school)	Lives with mother and step father, two brothers and her own son in council flat with prepaid electricity and outside toilet water supply	Stepfather working; CSG for her son, but had difficulty in applying for disability grants	6 people and 3 generations	Clothes, food and school stationery
3	19	11 m	7 (left school)	Lives with parents and 3 siblings, one of which is younger than her child in council flat with electricity and outside toilet & water supply	Father working; CSG; No disability for TB; Father of child pays intermittently	6 people, 3 generations	Food, nappies and milk formula
4	18	0 m	9 (current)	Lives in a one room "shack" informal settlement with parents, 2 siblings, 1 cousin and her own child	CSG, seasonal income from mother, father not working	6 people, 3 generations	Food, paraffin, baby food
5	23	3 yrs.	12 (current)	Lives in 2 roomed government apartments, toilet outside with mother, 3 brothers, a sister and her child	CSG and mother's disability grant (High blood pressure)	7 people; 3 generations	Food, electricity and water
6	18	3 yrs.	7 (left)	Lives in shack behind government supplied flats with grandmother, mother, 2 uncles, one aunt, 3 siblings and her own child	CSG and mother's disability grant (blind)	10 people; 4 generations (grandmother still too young to qualify for pension)	Food, debts and children's school clothes
7	19	4 m	10 (current)	One roomed shack in an informal settlement with parents, 3 siblings and her son	Father working; Applied for CSG; No CSG for siblings yet either	7 people; 3 generations	Electricity, water and food

Only three of the young mothers live in a government provided brick and mortar building with pre-paid electricity. The others all live in structures that are commonly referred to as “shacks”, where they either run electricity from the formal structure of the property on which the shack is built, or, if they are in an informal settlement, run from a main line electricity supply to Grabouw. The latter are commonly referred to as “*Izinyoga-nyoga*[5]”, illustrated in Figure 1. None of the homes has indoor running water and toilets. Water is collected on a prepaid basis from communal taps or from outside taps on the property of council flats.

Figure 1: Izinyoga-Nyoga - illegal electricity connections

Nine child and youth workers (C&YCWs), who live and work in the same community as the young mothers, participated in the focus group discussion (FGD) on day three. Two of the nine have worked as C&YCWs in Grabouw for over eight years, and the others for four years; seven of the nine are female and only one of the nine was born in Grabouw. Eight of the C&YCWs spoke Isi-Xhosa and originate from the Eastern Cape.

[5] Snakes – referring to the danger of these wires, which, according to local inhabitants, have killed people who touch them.

Table 2: Details of Isibindi C&YC Workers

C&YCW	Sex	Number of years of C&YCW experience	Home language	Where born
1	Female	8 (Project mentor)	Afrikaans	Grabouw
2	Female	8	Isi-Xhosa	Eastern Cape
3	Female	4	Isi-Xhosa	Eastern Cape
4	Female	4	Isi-Xhosa	Eastern Cape
5	Female	4	Isi-Xhosa	Eastern Cape
6	Female	4	Isi-Xhosa	Eastern Cape
7	Female	4	Isi-Xhosa	Eastern Cape
8	Male	4	Isi-Xhosa	Eastern Cape
9	Male	4	Isi-Xhosa	Eastern Cape

4.2 Description of data generation process

The first day with young mothers involved participative group work in which they drew and then verbally described maps of their neighbourhood, illustrating resources that they accessed as well as places that they found threatening. They also worked individually, but within the group space, on their personal tree of life. These were then used as a springboard into the interviews on day two.

On day two, the young mothers preferred to be at *Isibindi* Safe Park all together for the duration of all the individual conversations, even though they knew this would incur waiting time. An exercise was then spontaneously devised for them to occupy themselves while waiting, which was then used

to triangulate interview data. They were very willing to engage in this activity, illustrating their homes, number of people in their homes indicating who provides income with a “R”, who they get on well with/ who they find supportive with a heart, and who they have conflict with, with an “X”. They also listed the top three cost items in their homes.

The maps created by the respondents clarified that the respondents live in different settlements surrounding the township. This study was intended to take place in Pineview, a township outside Grabouw. However, in their maps of their living spaces, respondents indicated that they lived in four different neighbourhoods (including Pineview) on the outskirts of Grabouw. Each of these neighbourhoods had access to the clinic, a secondary and/ or a primary school, Isibindi and the Department of Home Affairs which is positioned adjacent to the South African Social Assistance Agency (SASSA). See figures 2- 5 below for details.

This exercise served three purposes – a) an illustration of what respondents perceived as resources versus risky areas in their communities, b) an indirect way for researchers and respondents to relax into the process and to familiarize themselves with the topic c) encouragement of peer support and d) to triangulate data generated from interviews.

4.3 General Findings

There were four notable aspects to these illustrations:

1) Although there is real mix of cultures in the area, particularly of black African and Coloured, the neighbourhoods appear to still carry the legacy of apartheid’s policy of separate living areas - three Coloured women (respondents 1,2, and 3) live in a formal settlement although one of them is living with her boyfriend and three children in a shack at the back of the house (figure 2) ; two of the black women live in an informal settlement called *Xola-Naledi* (figure 3), one black woman lives in a one roomed house in Siteview which is a Reconstruction and Development Programme (RDP) area (figure 4) and one black woman lives in a shack at the back of a house in a formal settlement called Pineview (figure 5).

2) All four maps illustrated access to the Isibindi NGO - Figures 2 and 4 even included the homes of their Isibindi C&YCWs - police station, schools, clinics, Department of Home Affairs and SASSA as resources that they access; three maps illustrated churches, which was spoken about in the interviews as was the Agape NGO, which is illustrated in figure 1.

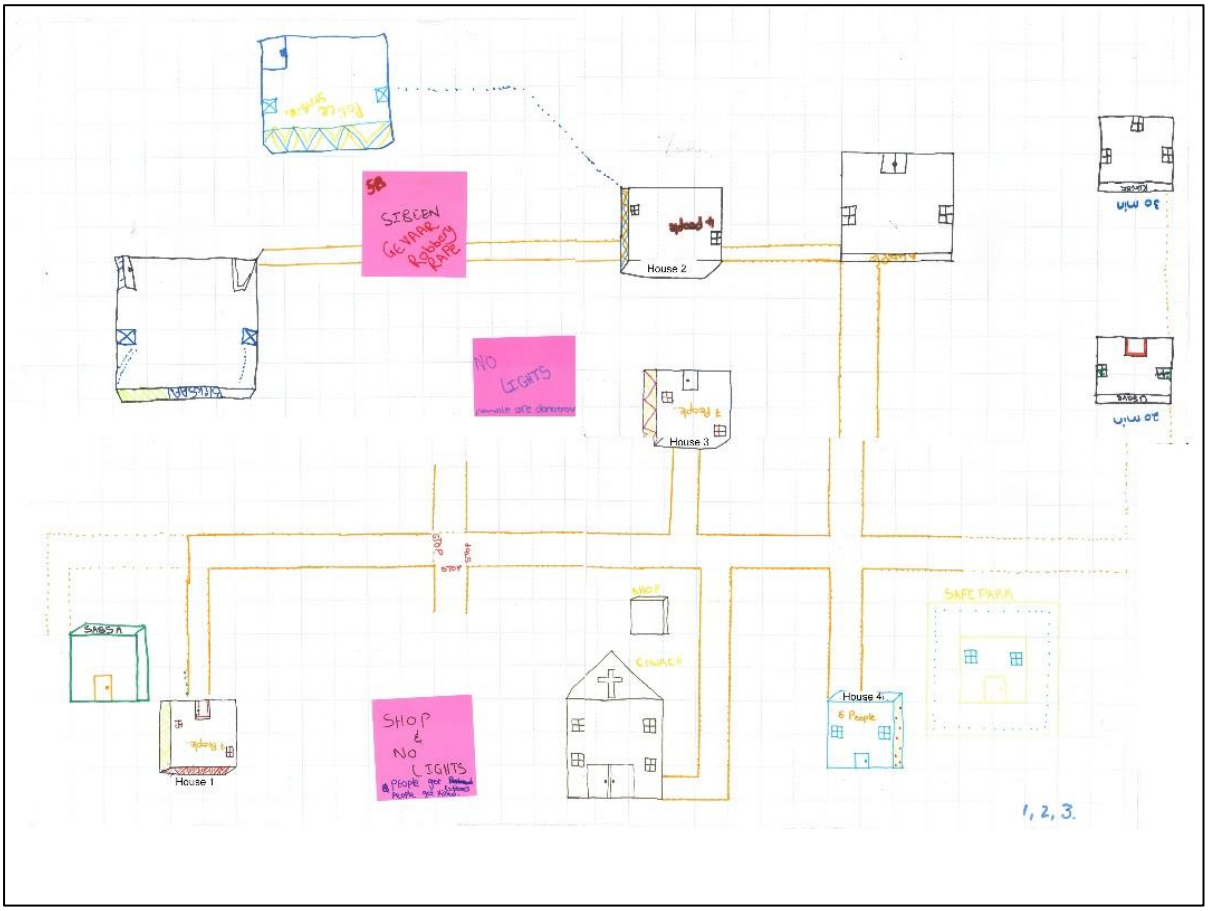
3) Figure 1 further includes three "*gevaar*" (dangerous) areas where there are "no lights, people get killed, people get robbed" and "people are dangerous, robbery, rape".

Figure 2includes the dump ("*dumstar*") near the trees, and indicated that this is a risky area for them to walk in. Two of the maps (Figures 1 and 4) included the "*shebeen* (tavern) which were seen as both a threat and a resource by respondents. Lastly, cultural mix in this area is illustrated by the language used - for example, figure 1 refers to the communal hall in their area as a "*bliksaal*" while an isiXhosa speaking respondent referred to it as "*eholweni*".

4) The multiple neighbourhoods are indicative of the mushrooming of informal settlements around formal townships in the area.

The demographic profile of the respondents was not homogenous. It included families who have lived in Grabouw for more than one generation and others who have migrated from the Eastern Cape within their lifetime. Of the seven young mothers, three were Coloured (mixed race), Afrikaans speaking, and were born in Grabouw. Four of the young mothers were black and isiXhosa speaking, one was born in Grabouw, although her mother and grandmother came from the Eastern Cape, and the other three all came from the Eastern Cape. Of the nine C&YCWs only one was born in Grabouw, although her father came from the Eastern Cape. A large sector of the community was originally from the Eastern Cape and migrated to this area for economic reasons. People who have lived there for generations are mostly Coloured and have generally worked in the fruit industry settlements is beyond the scope of this study. What is relevant to this study, is the common experiences of the young mothers within this heterogeneous community.

Figure 2: Neighbourhood map of respondents one, two and three



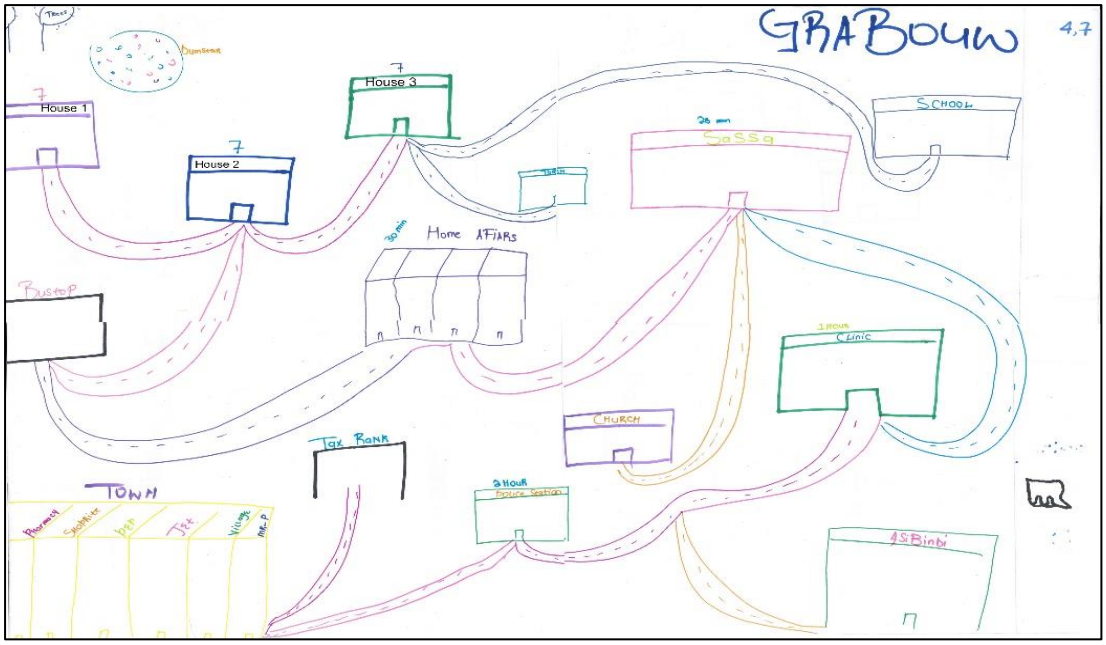


Figure 3: Neighbourhood map of respondents four and seven

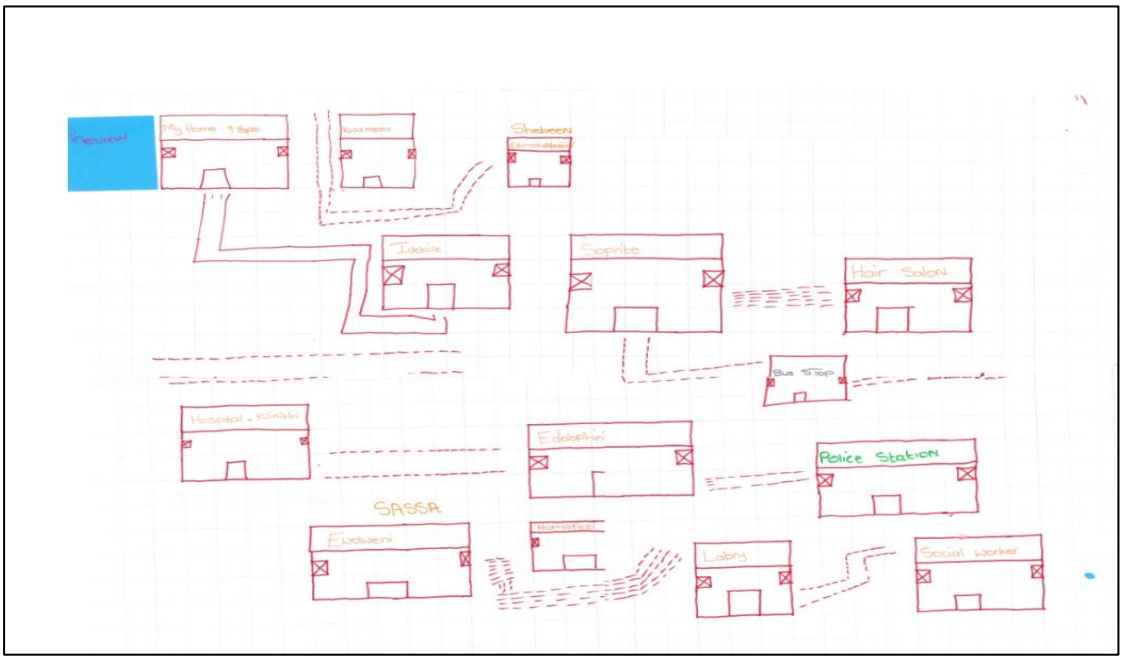


Figure 4: Neighbourhood map of respondent six

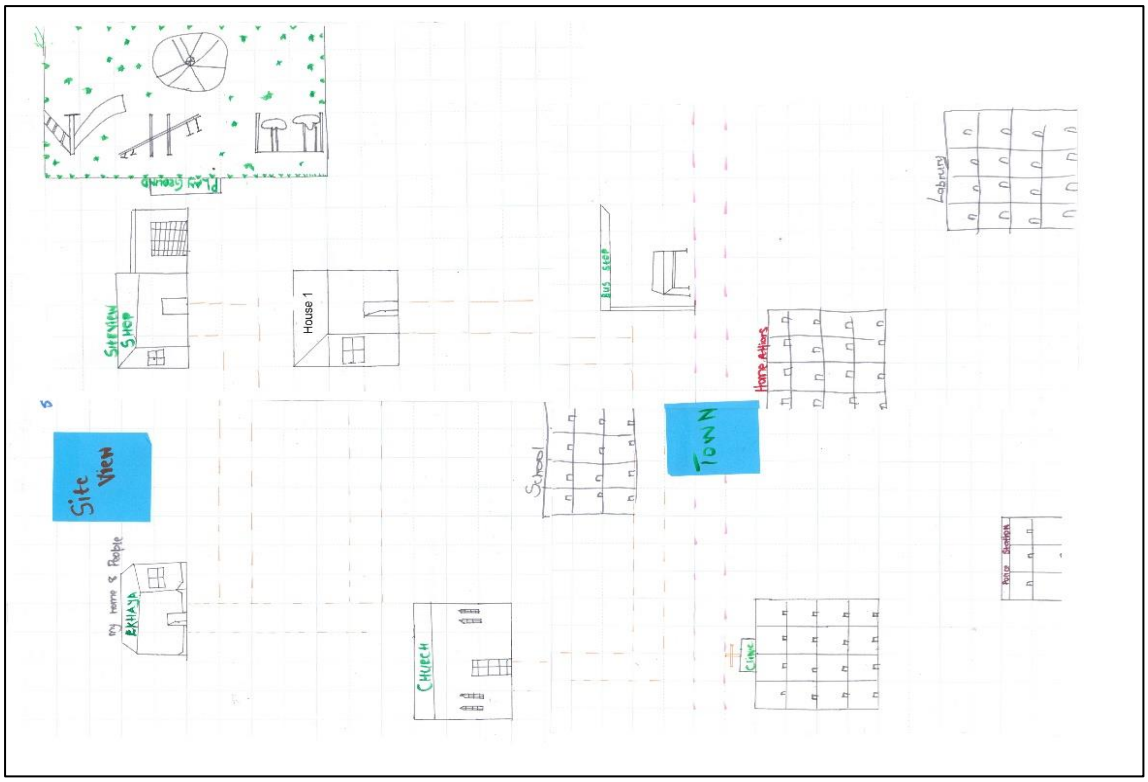


Figure 5: Neighbourhood map of respondent five

4.4: Theme one: Adolescent mothers' access to education, health care and social assistance.

The first theme describes the adolescent mothers lived experiences of education, health care and social assistance. Woven into this theme are the findings related to respondents' awareness of their rights as well as their sense of agency in accessing these rights.

The maps of their neighbourhoods copied above (Figures 2, 3, 4 and 5), illustrate the awareness of where to go for these services.

The first group exercise asked of respondents to map their communities, illustrating their homes in relation to resources available to them as well as places of danger or threat to them. The eight respondents divided themselves into four (two groups of three each and two individuals) according to their own neighbourhoods. Each of the Figures below included clinic, police station and Department of Home Affairs (also referred to as SASSA). It is interesting to

note that the four respondents who were not attending school did not include a school in their map, but did include the faith-based organisation that has supported two of them in overcoming their substance abuse. The homes of the child and youth care workers, as well as the *Isibindi* Safe Park were identified as resources in two of the maps.

4.4.1 Education

All seven respondents acknowledged the importance of education. In fact, when asked about their dreams for themselves and their children, they all spoke of a desire to learn and for their children to be educated.

However, four of the respondents were not in school at the time of the study. Only one of the seven respondents left school because of her pregnancy. She was fourteen in grade seven, and despite having had a positive relationship with a teacher who gave her clothes and books, she did not return to school. Her child was three years old at the time of the interview, but she did not want to return to school. She preferred to work to "bring money home" (Respondent 6, 11 Jan. 2018). The dependency level in her home was high with ten people across four generations living off a disability grant and one child support grant. Respondent 6 was the only isiXhosa speaking respondent who was born and raised in Grabouw, but whose mother migrated from Eastern Cape. She was also the only respondent who spoke about being part of a "trend" in her peer group - "all of them in that group had babies" (Respondent 6, 11 Jan., 2018).

Two of the respondents stopped going to school because of home circumstances. One said that her mother, who had a substance abuse problem, had left home and not returned, so she had to stay home to look after her younger brother and grandmother, who was old and sick. The second respondent described how she and her brother used to stand at the gate at night begging for money to buy food and there was too much noise in the house for her to sleep.

> Even now anyone can walk into our house, I was scared, anything could happen to us, I had little brother and my mother didn't care about him …. The day he was born it was the same day his father was buried … it was difficult for me (Respondent 1, 11 Jan., 2018).

She stopped going to school six years ago, when she was sixteen and in grade eleven, because she was too hungry and tried to concentrate. She recalls speaking about her situation to a teacher, who helped her but her home situation was too difficult to continue. "I complained in grade eight, grade nine and grade ten and when I was in grade eleven I felt too bad to go complain every-time…. I kept it to myself" (Respondent 2, 11, Jan., 2018). She was already sixteen years, over the legal school leaving age, so she went to work on the apple farms. There were no queries from the school regarding her absenteeism, but she recalls receiving mail from the school. The fourth respondent who was not in school, also stopped at the age of sixteen years. She was not pregnant at the time, she merely stopped going. She was in grade seven when she left. The average age in grade seven is twelve to thirteen years.

Three of the respondents were still attending school. They were all attending the same school, so their experience may not necessarily be typical of all secondary schools in that area. Each of the respondents expressed commitment to complete their schooling and described the support they received from the school to do so. One spoke of the school feeding scheme – "school is better for me, I can eat, then focus on my studies, because I am in grade twelve" (Respondent 5, 11 Jan., 2018); another mentioned that the school expects pregnant learners to stay in school as long as possible and the third said that her teacher had even brought the exam papers to her home so that she could still attempt a promotion despite being absent for the delivery of her baby. Two of these respondents rely on their mothers for child care whilst they attend school. The third respondent, who is repeating grade nine, said she is finding school difficult because of her child and her mother

has to take the opportunity to do seasonal work when it is available as they need the money. The home circumstances of the latter are exacerbated by the fact that the respondent's father is allegedly an alcoholic and the respondent's sister has two children whom the respondent's mother is also taking care of.

The C&YCWs agreed that the schools enable and encourage pregnant learners to complete schooling and believe this is partly as a result of their campaigns – "we fought for long for school for teenage moms" (FGD, 12 Jan., 2018). However, there were two comments that communicated an uncertainty regarding the schools' management of early childbearing in Grabouw – the one referred to the way in which teenagers enjoy the attention they get by displaying "look at me" type behaviours (FGD, 12 Jan., 2018). For example, talking publicly about their cravings, which they felt was part of peer trend-setting in schools. This view was not the experience of one of the young mothers in Grabouw, who said she only had one friend at school, and when she was pregnant she "used to like sleeping", she felt "bored" at school, "no-one else was pregnant" and the other children used to "stare" at her (Respondent 5, 11 Jan., 2018).

One of the male C&YCWs referred to a practice in Eastern Cape schools, which he thought highly of, where the responsible fathers were not allowed to attend school for the time that the young mothers were out of school – "what I like about my area in Eastern Cape – they don't just chase away the females – both of them are chased away" (FGD, 12 Jan., 2018). The C&YCWs generally supported the notion that the young fathers be made to think about their parental responsibilities. They felt that the attitude in Grabouw is very different to what they experienced in Eastern Cape – "here they are too proud" (FGD, 12 Jan., 2018).

4.4.2 Health Care Services

As a group the young mothers responded positively to questions about the local health care services. They all included the clinic in their neighbourhood

maps. They used phrases such as "*Ku-right*" and "they are nice" (Jan., 2018). But during individual interviews I learnt that their experiences were not so positive, particularly in relation to child birth. The interview questions concentrated on three areas – child birth, contraceptives and paediatric primary health care.

Four of the respondents gave birth in the local clinic, and although these young mothers had little to say about this experience, it was only on probing that it was found that the nursing care was not ideal. For example, one respondent described how the nursing staff were all asleep while she was in labour, and it was only when her mother "shouted" at the staff that they came to assist her (Respondent 4, Jan., 2018). They had no equipment to assist the birth (although she could not describe what assistance was required) and the baby was born soon after the nurses woke up. The baby was born at 01h00 and they were discharged at 08h00 after they were "wiped with toilet paper" and with no further advice (Respondent 4, 11 Jan., 2018).

Three of the respondents gave birth in a local hospital. They had been transported there by ambulance and referred by the clinic because of complications such as high blood pressure and Tuberculosis. Two of these three respondents described how they had been left in the labour ward until the baby's head was out, and that the staff had an aggressive attitude and had mistreated them – "*Hulle was hard gewees*" (Respondent 3, Jan., 2018) and "*Hulle het my gevloek en geslaan*[6]" (Respondent 1, Jan., 2018). The third respondent had no complaints about the hospital – "*kukuhle… ku-right*" (Respondent 5, Jan., 2018) where she had been referred to a week before her baby was born. The clinic had sent her by ambulance because she had severe headaches and swollen feet and for two weeks she was kept in hospital for post-natal observation.

All seven respondents confirmed that they are preventing further pregnancies and received contraceptives from the clinic. All of them had been advised on contraceptives at the time of their child's birth. None of them felt they were

[6] They swore at me and hit me

able to talk to their mothers about contraceptives when they were first sexually active. This was the case even if the mother knew that her daughter was in a relationship with a boy/ man:

> It was not a subject. I was still young and getting my periods. My mother didn't think I was sexually active, although she knew I had a boyfriend. Only after my baby did I get the injection (Respondent 3. 11 Jan., 2018).

> I was too scared to speak to her…and when I met my boyfriend I was too scared to go to the clinic… I never discussed it with my boyfriend either…I fell pregnant the first time…. I didn't know anything…. I never spoke about it…my mother noticed it when I was six months pregnant…she noticed my mood swings…. she was angry because of what was going on in her life…I told my boyfriend and we went to the clinic together… (Respondent 5, 11 Jan., 2018).

Respondent 5 (11 Jan., 2018) also confirmed that they were taught about reproductive health in school, but she said "I thought it was far away from me - I would not be doing it".

Except for one young woman, none of the respondents spoke about contraceptives with their boyfriends. The young woman who spoke with her boyfriend, described how they always used condoms, but he confessed to having perforated the condom package with a pin prior to intercourse with the intention of making her fall pregnant. The reason he gave her was that he

was scared to lose her, he purposefully wanted to “trap” her, which hurt her a lot - “*Yoh- ndibuhlunghu kakhulu*![7]” (Respondent 7, 11 Jan., 2018).

The other respondents spoke with their friends or a neighbour. Respondent 6 (11 Jan., 2018) said she was sexually active when she was 14 years, and she spoke to her “tjommies” (friends) about sex, who said it was “nice to have boyfriends and its ok to have a child”. Respondent 1 added that she learnt about sex from television programmes.

Two of the respondents believed that they would not fall pregnant. Respondent 1 (11 Jan., 2018) said “the injection is not working for me” because she believed that she fell pregnant twice on the injection. Respondent 2 (11 Jan., 2018) had been told by her doctor that she would never have children – “I sweared a lot when he told me [that I was pregnant] – the same doctor who treated me after the rape – they took three tests and a scan at the hospital”.

All seven respondents confirmed that their children are fully immunized and their road to health cards for infants were up to date. The C&YCWs confirmed that the clinic helps the mothers to attend regularly, by giving them return dates in their take-home clinic cards.

One young mother was carrying her six-month-old baby, who was coughing continuously and when asked about the clinic’s advice and treatment regarding the cough she replied “they gave me antibiotics and Panado, it didn’t help. They told my mother to give her lemon juice in hot water with some sugar, it also didn’t help” (Respondent 4, 11 Jan., 2018). This young mother and her baby live with her family in an informal settlement, where cooking, cleaning and living happen in one room. Respondent 4 confirmed that they cook with paraffin, and agreed with the researchers’ suggestion that the fumes may be the cause of the cough.

The C&YCWs had a different view of the clinic to that of the young mothers (FGD, Jan., 2018). When asked to rate the clinic on a scale of one to ten (ten

[7] “Yoh - It hurt me a lot”

being excellent), eight of the nine rated the clinic services at a maximum of four. Their reasons for this were mainly to do with the "disrespectful" attitude of clinic staff – "They don't treat with dignity", "they don't have the relationship" and "they don't need to speak to us as if we don't understand". They were of the impression that they "need to know someone there" to be treated well. Apart from the attitude, their view was that the clinic is too small for the size of the community and their hours are too limited – "sometimes we sit there all day from seven to four and then get told to come back the next day" (FGD., 12 Jan., 2018).

One of the nine C&YCWs rated the clinic at five out of ten. He clarified that he had not had personal experience of the clinic, but had heard the clinic manager speak at a "Grabouw stakeholder meeting" about her concern for teenage pregnancies and their intention to build a "youth-friendly" clinic. She had apparently reported that teenagers are reluctant to attend the clinic, which all the C&YCWs confirmed – emphasizing that "they must look at *why* they do not want to attend" (FGD, 12 Jan., 2018).

The C&YCWs acknowledged that the health care services do extend beyond the clinic to the SASSA premises one day per week and they take public health campaigns to schools, which they hoped would improve access to health care for young mothers. However, they did not have details of these services.

The health-related information available to the young mothers was of concern to young mothers. They believed that this was partly because information is insufficient, as well as the way in which this is distributed is not always easy to comprehend, even if printed in local languages. They maintained that teenagers tend not to read and rely more on what their friends say. Although young mothers in this study were all aware of contraceptives, and confirmed that they have an implant or regular injections, they were not aware of the implications of each method. For example, one respondent had had an implant since 2014 and did not realise that it was due for replacement. Another respondent spoke about falling pregnant on the injection, but did not

want an implant, because she had heard that it tends to “move around in my body” Respondent 1, 11 Jan., 2018).

Another example of inadequate information is the misunderstanding amongst young people that contraceptives also prevent sexually transmitted diseases. For example, one of the young mothers, who was preventing further pregnancies, was HIV infected a year after giving birth, whilst she was still breastfeeding her child. They are both HIV positive now. This was a big concern for one of the male C&YCWs - “even the teenagers who using contraceptives, not using condoms, they’re forgetting about the diseases” (FGD, 13 Jan 2018). This discussion was ended with an expression of frustration by a C&YCW, which they all agreed to – “some just don’t listen…. after teaching them everything…. Maybe its peer pressure….and also parents are not supportive” (FGD, 13 Jan 2018).

Two health care concerns, which were not raised by the C&YCWs, were put to them by the researchers for their considered response. The first was to do with the mental health of young people. They had all observed depression and knew of suicide cases, but felt that this was not something that the health care services dealt with. Two of the C&YCWs had younger sisters, who had given birth to babies in their early teens, whom they were supporting and whom they thought were depressed, but did not know what to do beyond suggesting counselling:

> I advised her to go for counselling and then she said there’s nothing wrong. But there is something wrong. It’s not like she’s got stress because currently I am supporting her and her child…. The father accepted responsibility but he won’t support them (FGD, 12 Jan, 2018).

> Now, shame, my sister is too big. After birth, she gained weight. I am worried about her – what if she can die. She can eat…. She is now too

> big…. he still loves her but he is scared of that body… stress can make you gain weight (FGD, 12 Jan., 2018).
>
> She's changed. No longer outgoing. She had her baby in grade 10. My mother left her job to look after the baby. She passed her matric but she's not doing anything. It's like she's depressed. Before she was an outgoing person. Bubbly. Now it's like she doesn't have hopes and dreams anymore. I'm supporting her and her child. The father is staying opposite but he's not supporting them (FGD, 12 Jan., 2018).

The second concern was about abortion. This ignited an animated vocal response amongst the C&YCWs because their experience is that abortion is heavily stigmatized in the community. In fact, one of the young mothers explained how her mother had responded when she had been informed by their neighbour of her pregnancy – "she was not angry – she just said I must keep the child and not have abortion." The C&YCWs recognised that everyone has their own reason to terminate pregnancies, and although it is generally done in secret, someone gets to know about it –

> If you tell your mother or a neighbour…. And she gets drunk…then everyone will know… and you will hear about it for the rest of your life…. they will rather throw babies in the drain… in one year they found five babies in the drain - (C&YCW FGD, 12 Jan., 2018).

Not only are they labelled "butcher, killer, murderer, municipality/[waste]", but they are also annually reminded on the anniversary of the termination, which they suggested may be an expression of their Christian beliefs. As child and youth care workers, they believed it was their responsibility to support young people in their decisions regarding terminating pregnancies, but, for as long

as this is a taboo in the community, the young people will not talk about it and will not seek counsel on the subject.

4.4.3 Social Assistance

This section captures the respondents' narratives on state social assistance as well as any financial support they may have/ have not received from the fathers of their children or any other family member.

All the respondents identified SASSA and Home Affairs as resources in their neighbourhood maps and their illustrations of their homes indicate sources of income and what their main expenditures were. Table 1 above summarises details of sources of household income.

Two of the respondents' households are totally dependent on social assistance (CSG and disability grant) and the remaining five have intermittent income from seasonal employment. Seven of the respondents' nine children were beneficiaries of the Child Support Grant (CSG). Respondent one had not yet applied for a CSG for her third child, an eight-month-old baby. She also had not yet registered the child, and although her older two children were registered, their birth certificates had been eaten by a rat. Respondent seven had applied for the CSG and was anticipating receiving it in February 2018.

> At first I struggled a lot. SASSA told me they were closing for holidays – in December- then I had to wait until January to apply. Now everything is ok. I will collect it in February. (Respondent 7, 11 Jan., 2018).

This delay meant that her child would be five months by the time she would receive her first CSG payment. The latter also had siblings for whom her mother had applied for CSG, but "SASSA told her she must go back to

Eastern Cape, where she started" to collect grants as this is where they were born.

A further example of the challenge associated with uncertainty of eligibility and the application process was associated with the disability grant. It was not clear from what the respondent said where the challenge lay, apart from the fact that the respondent was confused herself about their eligibility, as well as the application process between medical certification and SASSA's approval. Respondent 2 had failed to apply for a disability grant (she is HIV+) and while her application was being processed, SASSA stopped the CSG:

> Child support grant was easy for me but … they told me I could apply for a disability grant – doctor told me I must apply for both of us - but I didn't know I mustn't do it one time- so I went there with my papers and my son's papers and they refused – because they told me I must come one time for me and one time for my son, so they declined…. At that time, they had stopped the child support grant while they were seeing if I qualify… (Respondent 2, 11 Jan., 2018)

The question of whether the fathers of the children supported their mothers in any way was asked of all the young mothers. Only one mother (Respondent 1) lived with the father of her three children in a "shack" at the back of someone's house. Respondent 1 was twenty-four years old, had her first child when she was eighteen years old, and the father of her children, whom she refers to as her "boyfriend", was thirty-two years old. She reported that he worked. She was also noticeably more unkempt than the other young mothers who participated in this study – poor personal hygiene, torn clothes, no shoes and a serious bruise on one of her eye sockets. Her life story suggested that she may be part of an intergenerational pattern. She spoke of having to leave school to look after her younger brother when her mother,

who “smoked dagga and drank left home and never came back” and her brother is now in jail for “*verskillende goete*[8]*… hy is ‘n skollie*[9]” (Respondent 1, 11 Jan., 2018).

Only one respondent spoke about her experience of applying for maintenance from the father of her child. Respondent 2, said the father of her child “sometimes” provided money for the child, but only when he is working at the apple company:

> I did go to maintenance court but the money was too little to go to shops where they give you slips… the supermarket gives slips… but it’s cheaper there where they don’t give slips…so he goes to court and ask them if I can come and show him the slips …and I didn’t have any slips…and he won’t give money with no slips….he was thinking I was using he money for drinking, for myself (Respondent 2, 11 Jan., 2018).

Of the five remaining respondents, only two had contact with the fathers of their children, and of the two only one received intermittent financial support from the father (Respondent 3). The father of Respondent 7’s child was still a scholar and therefore not able to help financially. Two respondents mentioned that their families had met with the families of the fathers, and they were still expecting the latter to pay for “damages” (Respondents 4 and 7, 11 Jan., 2018).

In their illustrations of their homes, respondents included a list of the three top household expenses. The most commonly cited expenses were food, water and power (including paraffin). Electricity and water are obtained on a pre-paid basis in their settlements.

[8] Brother in jail for all sorts of things

[9] “Skollie” is a common South African term which generally refers to someone who has no respect for the law and is a trouble-maker/ delinquent / gangster/

Respondent 6 wrote “debts” as one of her top three expenses. In a conversation with the senior child and youth care worker (referred to as the *Isibindi* mentor) about the financial situation of the families whom they support, she confirmed that debt management is a major problem in her community. She spoke of the battle they have with loan sharks and “*shebeens*[10]” who confiscate their clients’ SASSA cards and demand their personal identification numbers, so that they can draw the grant.

4.5 Theme Two: Social Support System

The focus of this study was on adolescent mothers’ access to education, health care and social assistance, and to determine what provisions should be made for additional social protection needs. The findings thus far suggest that these government provisions are insufficient to meet the basic needs of the young mothers. This theme describes the sources of support identified by the young mothers.

4.5.1 Identified Sources of Social Support

Despite the economic hardships and the associated challenges with meeting basic needs such as food, water and shelter, six of the seven respondents could identify someone who supported them in their lives. These relationships were illustrated in the respondents’ *tree of life* and further elaborated on in the interviews. The following quotes and paraphrases provide insight into the role that the child, family and friends played in the lives of the young mothers:

<u>*Respondent 1:*</u> “*My oom XXX gee Om vir my*[11] “and “*Tannie XXX het my Groot gemaak*[12].” She also described how she has given her life to Jesus and

[10] Taverns
[11] My uncle XXX cares for me
[12] Aunty XXX raised me

finds support from a faith based organisation called “Changing Lives” (Interview, 11 Jan., 2018).

Respondent 2: For information she may need regarding welfare and employment matters she named three people who have helped her at the “welfare and courts”; She also described her son as a “gift” because he motivated her to stop smoking and drinking - “I don’t want my son to see me drinking, I don’t want him to grow up like I did, he can have a different life” - “*Tannie* xxx is my mentor, I see her every day, she can’t read and write, so I help her, she doesn’t smoke and drink, she’s my role model”; “In the [rehabilitation] group I dealt with it (rape)”; “I invited God into my life”; (Interview, 11 Jan., 2018).

Respondent 3: “My grandmother went the extra mile for me when I was in hospital, she helped me whenever I needed something” (Interview, 11 Jan., 2018).

Respondent 4: Named her grandmother and her child and youth care worker as the two most significant sources of support – the latter particularly as “*uyandinceda kakhulu,*[13]” “she is always there for me and my mum”. She particularly appreciated her support at the time when she told her mother about her pregnancy – “my mother trusted her…. if she was not around my mother would have shouted or done something else” (Interview, 11 Jan., 2018)

She went on to say that if she has any problems, such as when she found out she was pregnant, the person she spoke to was her child and youth care worker.

Respondent 5: “My mother is my hero in life” and her child and youth care worker who always helps her.

Respondent 6: Spoke about her “*tjommies*” (friends) as her source of support; she lives in a household with nine other people, none of whom were cited as

[13] Helped me a lot

sources of support or mentors; her one brother was removed by a social worker when her mother could no longer see (2006) and her father died (1999); her *tree of life* asks for help to find employment so that she can support her family. She described her three-year-old son as "clever" as he responds to his blind grandmother's discipline and can even guide her to the outside toilet (Interview, 11 Jan., 2018).

Respondent 7: Illustrated her whole nuclear family in her *tree of life*, including her older brother who has moved out of their one roomed "shack" and is also working on the fruit farms. However, she said her brother and father "do support – but not that much - they give up early on me", whilst she can "every-time rely" on her mother and boyfriend. She also spoke about the support her child and youth care worker gave her family (Interview, 11 Jan., 2018).

Child and youth care workers: The two C&YCWs who had experiences of adolescent childbearing in their families and who were mentioned above in relation to depression and health care services, were supporting their sisters financially and emotionally. C&YCW 2 said, "we did sit with her – me and my sisters – and told her she mustn't stress because I am working and her children are getting grants – and even if I complain, I do help her, buy clothes to help her" (FGD, 12 Jan., 2018).

Part of the focus group discussion with the C&YCWs focused on family care of children. One C&YCW felt that this contributes to poverty:

> It is also cultural… for a mother to look after her daughter's children … we are five and raised by my grandmother…so if I have children I expect my mother to take care of them… and that's where the poverty starts (FGD, 12 Jan., 2018).

Another C&YCW felt that it was not this cultural practice itself, but the abuse of this practice combined with state social assistance that causes poverty, “It was different to our mothers… they left us with our grandmothers to go to work… but our generation have children and just say ‘bye-bye’ …. And live off the child support grant” (FGD, 12 Jan., 2018).

The C&YCWs gave the example of a young woman in Grabouw who sent her first child to the Eastern Cape for her mother to look after him/her and then she (the mother) continued to collect the CSG and had two more children, who were also sent to the Eastern Cape (FGD, 12 Jan., 2018).

4.6 Theme Three: What additional provisions are required?

The young mothers and the C&YCWs were asked to think about what would be the most helpful intervention for young mothers in Grabouw. Their responses fell into seven categories, each being suggested by at least two respondents.

a) All the young mothers expressed a need for basic necessities in their introductions on day one. But two respondents very specifically believed that they were “suffering” and that basic necessities such as milk and nappies would alleviate their distress (Respondents 3 and 4, 11 Jan., 2018).

b) Most respondents and C&YCWs believed that some sort of child care would enable the mothers to stay in school and to further educate themselves.

> I want to go back to school, I don’t have anyone to look after my child, I have no money to pay for crèche; since I had the baby I have not been back to school; my mother works sometimes, so she’s not able to look after my child all the time…I am trying to make a plan now, (Respondent 4, 11 Jan., 2018).

c) The C&YCWs and one respondent suggested that contraceptives need to be more readily available in an adolescent- friendly way. Respondent 6 said “at fourteen I was too young to know what to do” (Interview, 11 Jan., 2018). The C&YCWs believed that public health messages on sexual reproductive health are insufficient and inadequate for the Grabouw population.

d) Two of the respondents and all the C&YCWs suggested recreational activities that would be positive alternatives to the tavern and jukebox. Respondent 5 suggested “projects that can occupy their minds so that they won’t focus on something else … they are tempted by drugs… they can learn how to carry themselves… ways to achieve” (11 Jan., 2018). Respondent 2 suggested that “young people can’t see for themselves…. they have abusive boyfriends… lots of young mothers are drinking and smoking…. Lots are also on drugs, they sleep with anyone to get a fix” (11 Jan., 2018).

e) The C&YCWs suggested skills development and parenting groups. Although they identified that the young mothers “really love their children…they really give them their love”, they also “spoil them” and therefore felt that some supportive educational groups for young parents would have a positive effect (FGD, 12 Jan., 2018).

f) Groups for the young men were suggested by the C&YCWs. They felt very strongly about this intervention – both as a preventative measure as well as a way to teach them how to take responsibility. “They grew up without their fathers and they also want their children to grow up without their fathers… They need to learn about responsibility…. It’s not only about money… it’s about love and spending time” (FGD, 12 Jan., 2018). There was a suggestion that some men in the community encourage their sons to reproduce – one C&YCW quoted a father saying publicly “all my boys are like me…when I was young I was always making babies” (FGD, 12 Jan., 2018).

g) Finally, a strong suggestion from C&YCWs was that parents (mothers and fathers) need to talk about sex with their children. One C&YCW described her personal change in attitude in this regard – “Isibindi taught me that its ok to talk about sex…I used to walk out when the topic came up… but now I don’t

have a problem… and I have been able to support many young girls to complete their studies and not to have babies" (FGD, 12 Jan., 2018).

4.7 Summary of the research findings

This chapter presents the findings of the study which set out to ascertain the extent to which adolescent mothers in Grabouw were accessing social protection, and what other provisions need to be provided. Findings suggest that education, health care services and social assistance were available and were being accessed by the young mothers. There were concerning issues relating to the quality of services, especially health care and about whether the young mothers knew what they could access in terms of disability grants. Findings in relation to their social support network suggest that everyone had someone they could talk to. These confidants ranged from friends to grandmothers and their child and youth care workers. Fathers of the children were noticeable by their absence both emotionally and practically. Recommendations for other provisions within the social protection framework included material goods, child care, help to find work, recreational activities, skills development, rehabilitation programmes, parenting groups for parents of the young mothers and for the young mothers themselves and bringing parents' attention to the necessity to talk about sex and reproductive health with their children.

The next chapter interrogates and discusses these findings with reference to insights gleaned from literature on social protection for adolescent mothers.

Chapter Five: Analysis of Research

5.1 The analysis process

"*Research is about listening, not expertise. Research is about being curious, sceptical, surprised, and sometimes helpless*" (Ackerly & True, 2010, p. 20).

This chapter interrogates the findings and discusses the meaning and significance of the data in relation to the purpose of the study – which was to identify to what extent adolescent mothers' needs are provided for in presently available services and what provision should be made for their additional social protection needs.

The process of analysing data started on day one of data collection, with a shared reflection (by the researcher and assistant researcher) on the narratives and illustrations of the respondents in the group work. This process continued on day two after the semi-structured interviews and on day three after the C&YCW focus group discussion. As Ackerly and True (2010) say, "analysis involves an iterative process of reading data, constructing an interpretation or an argument, rereading data and reconstructing an interpretation or an argument" (p.178). This dynamic process, which started with our daily reflections and which included critical self-reflections, served as constructive "peer debriefings" (Guba & Lincoln, 1985, p. 328), and opportunities to clarify meanings of terms used.

Guba and Lincoln (1985) provide helpful categories for qualitative researchers to ensure trustworthiness and believability in their findings. These include safeguarding credibility through mechanisms such as member checking, peer debriefing, adequate referencing, persistent observation and prolonged engagement; triangulation of data from multiple sources; transferability through peer debriefing and assessing the concurrence of data in other settings; and dependability and confirmability of data through audit tails (Morse, 2018). In the following discussion on research methods used in this study, these recommended good practices in qualitative research are reflected...

5.2 Credibility of data

This study did not engage persistently and over a long period of time with respondents in Grabouw. The number of participants in this study is also not representative of all adolescent mothers in Grabouw. Nevertheless, their answers to the structured parts of the interviews were similar, suggesting saturation on the basic questions of whether they were accessing their entitled basic education, health care and social assistance services.

In triangulating the mothers' responses with those of the C&YCWs, which also served as "member checks" (Guba & Lincoln, 1985, p. 328), it was clear that these basic services are indeed provided, but they are not always accessible nor of good quality. The C&YCWs not only validated what the mothers had said, but they played a valuable role in amplifying and providing the story behind the narratives given in the interviews. Finally, our observations of the respondents' sense of agency and their living conditions in the formal and informal settlements provided an added source of data for triangulation purposes.

This exploratory study collected data from interviews and participatory group work with seven young mothers in Grabouw and a focus group discussion (FGD) with nine C&YCWs who were providing psycho-social support to the families of the young mothers. Since some of the respondents were no longer adolescents at the time of the interviews, this analysis refers to the respondents as young mothers as opposed to adolescent mothers.

The mothers who participated in this study were selected by the C&YCWs who were all employed by *Isibindi*, a local NGO in Grabouw. They were purposefully and conveniently selected as young mothers who had given birth (and whose children were still alive) when they were adolescents, who lived in one of the settlements outside Grabouw where *Isibindi* provided services, and who were willing and available to participate in the study on the days of data collection. The C&YCWs working at the *Isibindi* safe park were all invited to participate in the focus group discussion. They self-selected who would remain on duty with the children in the safe park, while nine participants

volunteered to participate in the focus group discussion. Two of the nine C&YCW participants were male and the number of years they had worked for *Isibindi* ranged between four and eight years.

Being mindful of the perception the respondents could have had of the researcher, the only white woman amongst them and of an older generation, it was important to be continually aware of the discomfort the power distortion this may have brought. Hence the value of the co-researcher, who was black and lived in a similar neighbourhood and could translate into isiXhosa. As Ackerly and True (2010) point out, researchers need to commit to self-reflexivity and be attentive to power relations in the way we conduct research and in how we share our findings. Feminist research is particularly attentive to relationships and the effect that the research questions themselves, which can carry messages that are harmful to the respondents (Ackerly & True, 2010). The co-researcher was particularly helpful in piloting the semi-structured interview schedule and translating colloquial expressions into English and vice versa. Furthermore, the researcher, being a trained social worker, was able to balance research skills with empathy and a non-judgmental attitude, by clarifying the purpose of the interview and, while being sensitive to the respondent, still following a sequence of questions.

5.3 Theoretical references

Findings of this study are referenced against data reported in relevant South African studies as well as in publications from the Sub Saharan region. In addition, articles on early childbearing in England, New Zealand, Australia, and the United States of America are included. The analysis is informed by a rights-based approach with a “critical sociological perspective” (Denzin & Lincoln, 2018, p. 20) on multi-dimensional and intergenerational poverty.

During the process of analysing the data, it became increasingly clear that there are multiple factors affecting the chances of well-being for the adolescent mothers and their children and that these factors are more readily seen in socio-ecological layers around the respondents. These layers are

informed by Bronfenbrenner's socio-ecological theory (Bronfenbrenner, 1986), which has been simplified in Figure 7 below.

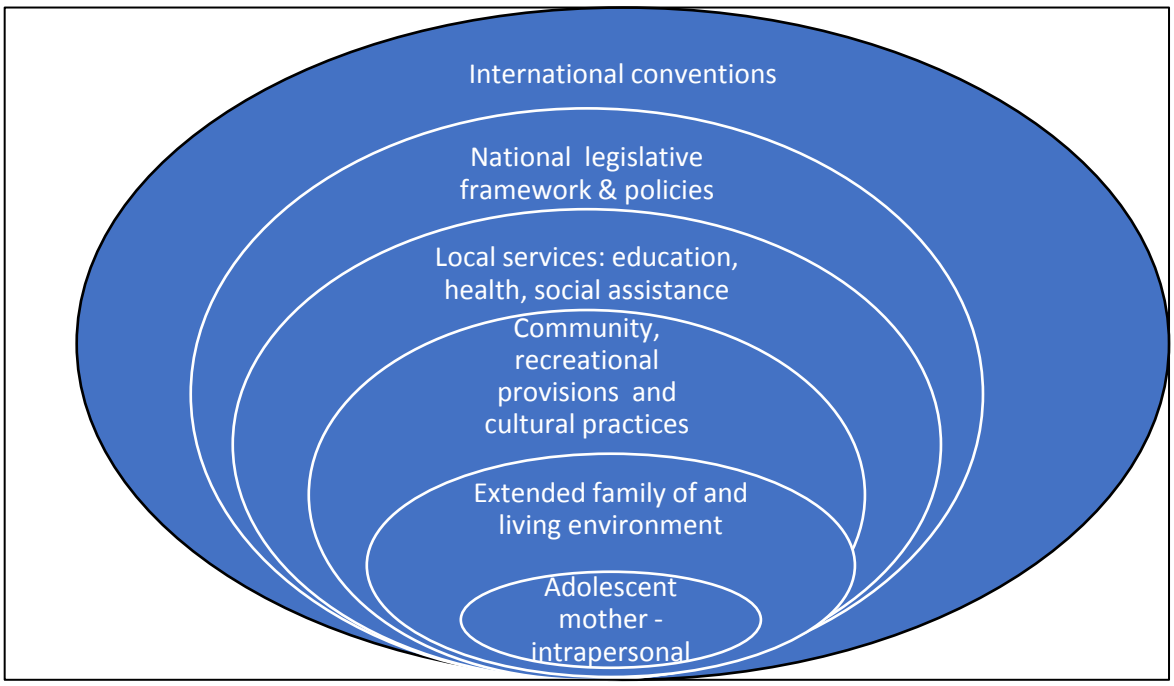


Figure 6: Layers of influencers on adolescent mothers' needs for social protection

The discussion of findings in this chapter is presented in the following three sub-sections: Intrapersonal profile of the respondents; Interpersonal including families, living environment and community; and local service provision within the complexity of national legislative frameworks and international conventions.

5.3.1 Intrapersonal Profile of Respondents

The findings from the group work and individual interviews reflect what appears to be typical of the profile, ages and living circumstances of early childbearing mothers in South African townships (Mkhwanazi, 2014a; Mkhwanazi 2014b; Ranchod, et al., 2011) and consistent with national trends (Willan , 2013). Writings on teenage mothers in Sub-Saharan countries

indicate that the antecedents and consequences of early childbearing are similar to what was identified in this study (Were, 2007; Gupta &Mahy, 2002; Gupta & Mahy, 2003). While writings from New Zealand (Woolard, Fergusson and Horwood, 2001), Australia (Shea, Bryant & Wendt, 2015) and the United States of America (Camarena, Minor, Melmer & Ferrie, 1998) indicate that some of the profiles of teen parents' families and their peer groups may be similar to those of this study, the outcomes are not as challenging as in South Africa. This may be due to the fact that teenage pregnancies were viewed by those societies as "epidemics" and "catastrophes" and as "children having children" in the 1980s (MacLeod, 2003, p. 419). As such, the issue of adolescent fertility rates was addressed as a social problem requiring policy driven interventions a few decades before South Africa faced the same issue, which was not seen as an epidemic itself, but was associated with the HIV epidemic.

The profile of the young mothers fits the data on teenage fertility in South Africa. Most of the teenage pregnancies occur in the eighteen to nineteen year olds range and the rates are highest amongst black and Coloured populations (Panday et al., 2009; Arlington et al., 2012).

Other studies on teenage pregnancies refer to individual factors (Woodward, et al., 2001, p. 1172) or intrapersonal (Panday et al, 2009, p. 54) which seem to be associated with early pregnancies. Woodward et al. (2001), describe these as "delinquent" tendencies which include substance abuse and deviant peer involvement in New Zealand (p. 1172). Panday et al. (2009) include factors associated with knowledge, perception, beliefs, attitudes and capabilities within the intrapersonal realm – three of these factors resonate with the intrapersonal characteristics of respondents in Grabouw:

a) Ambivalence towards pregnancies increases the risk of pregnancies, and ambivalence is more common amongst teenagers from impoverished backgrounds. "For them the benefits of childbearing – maturity, love, responsibility, and the perception that it will lead to a better relationship with the baby's father, outweigh any possible risks" (Panday et al., 2009, p. 58). for such adolescents, the desire to not avoid pregnancy outweighs any

contraceptive action. The C&YCWs were asked if they perceived any benefits to the adolescent women having babies – to which they exclaimed loudly "Yoh: they love their children! Even if those boyfriends are not there, they give them their love and sometimes they spoil them; they don't neglect them."

b) Panday et al. (2009) also report on literature that suggests adolescents intentionally become pregnant in search of something hopeful to correct their childhood experiences "characterised by dysfunctional family relationships, poor scholastic experiences, and growing up in homes and neighbourhoods where teenage pregnancy was normative" (p. 58). This would concur with what C&YCWs described as "they're looking for love in the wrong place …and after one child they find it difficult to find someone… after one child they lose hope …although they love that child - she doesn't go to look for work … she just lives off the grant - so they need that encouragement [from us]" (FGD, 13 Jan. 2018).

c) Immature cognitive functioning (Panday et al, 2009; Woodward et al, 2001) which suggests a limited understanding of the risks associated with sexual relationships and the costs of having a baby. At least one of the Grabouw respondents, who was several years older than the average age in grade seven when she stopped going to school, is a good example of this limitation.

d) The association of early sexual debut and substance abuse, which three of the seven Grabouw respondents acknowledged were their personal behavioural patterns (Woodward et al, 2001; Panday et al, 2009).

e) Strong association between sexual abuse and risky sexual behaviour, which although was acknowledged by only one Grabouw respondent, was described by the C&YCWs as common practice amongst the teenagers in their communities (Panday el al, 2009; Kheswa, 2017; Jewkes, Vundule, Maforah & Jordaan,2001).

f) Lastly, the Grabouw respondents were asked about their hopes for themselves and for their children – to which they all willingly shared their aspirations, some of which required many years of studying (e.g. medical doctor) and others were very practical such as becoming a child and youth

care worker. What all respondents hoped for was “to be a good mother for my child” and to help their children have a better life than they had. Camerana, Minor, Melmer & Ferrie (1998) discuss the significance of supporting young mothers in their aspirations and to build resilience in dispelling the negative stereotypes associated with early childbearing. This view was supported by the C&YCWs who spoke about the need to support the young mothers to harness their resilience and maintain a sense of hope.

5.3.2 Interpersonal Profile of Respondents including Families, Communities and Living Environments

This section looks at data on family functionality and living circumstances. Two of the Grabouw respondents depicted dysfunctional families. Respondent one described her mother as a “dagga [marijuana] addict” who had disappeared when she was young, leaving her to raise her brother, who was in prison at the time of this research. Her sister (Respondent two) had been placed in foster care with family members and although she had been raped by the foster father and therefore had to be returned to the mother, she had managed to stay in school until grade eleven and was more conversant in English and able to negotiate state institutions – such as maintenance court and applying for piece work. Respondent one was twenty-four years old and had three children under the age of six. She lived in a one room shack at the back of a house, and came to the interview unwashed, with a bruised face - she left school in grade nine. Neither respondent one nor two had a relationship with their father. Respondent four spoke of an “alcoholic father” who was therefore unable to work. Respondent six lived in a household with nine other people, all dependent on the disability grant of her mother and the child support grant for her son. She herself frequented the tavern and said part of her grant money goes to repay debts. The underlying factor in all seven families was their poor socioeconomic status.

This observation in Grabouw confirms what was reflected in the literature section of this report. Woodward et al (2001) in their profile description of teenage pregnancies include “conduct problems related to family characteristics… multiple parental transitions” (p. 1172). Kheswa (2017)

includes “divorce, substance abuse by parents, poor socioeconomic status and permissive parenting styles” as some of the “deleterious factors that contribute to sexually-risky behaviour of female adolescents, especially in households having step parents” (p. 162). Yakubu and Salisu (2018, p.9) identified “severe family dysfunction” as a risk factor for early childbearing.

This study was intended to take place in Pineview, a township outside Grabouw. However, in their maps of their living spaces, respondents indicated that they lived in four different neighbourhoods (including Pineview) on the outskirts of Grabouw. The multiple neighbourhoods are indicative of the mushrooming of informal settlements around formal townships in the area. Each of these neighbourhoods had access to the clinic, a secondary and/ or a primary school, Isibindi and the Department of Home Affairs which is positioned adjacent to the South African Social Assistance Agency (SASSA). See Figures 2 – 5 in Chapter three for details. Figure 2 provides an indication of how long it took a respondent to get from her home to the various facilities – all within +/- 30-minute walk.

This exercise served three purposes: – a) an illustration of what respondents perceived as resources versus risky areas in their communities, b) an indirect way for researchers and respondents to relax into the process and to familiarize themselves with the topic, c) encouragement of peer support and d) to triangulate data generated from interviews. There were four notable aspects to these illustrations: 1) Although there is real mix of cultures in the area, particularly of black African and Coloured, the neighbourhoods appear to still carry the legacy of apartheid’s policy of separate living areas - three Coloured women (respondents 1,2, and 3) live in a formal settlement although one of them is living with her boyfriend and three children in a shack at the back of the house (figure 2) ; two of the black women live in an informal settlement called Xola-Naledi (figure 3), one black woman lives in a one roomed house in Siteview which is a reconstruction and development programme (RDP) area (figure 4) and one black woman lives in a shack at the back of a house in a formal settlement called Pineview (figure 5).

The Bill of Rights within the *Constitution of the Republic of South Africa* (Chapter Two) which "affirms the democratic values of human dignity, equality and freedom" and "enshrines the rights of all people", includes the right to "adequate housing" and "the state must take reasonable legislative and other measures within its available resources to achieve the progressive realization of this right" (*Constitution of the Republic of South Africa 1996,* Article 26, p.10). Furthermore, everyone has the right to "an environment that is not harmful to their health or well-being" (*Constitution of the Republic of South Africa 1996,* Article 24, p.10).

Since the African National Congress (ANC) came into power in 1994, a variety of legislation has been promulgated to address the housing shortage, and strategies shifted from an emphasis on housing to human settlements – an estimated three million fully subsidized housing units have been built over the past 20 years (Jarbandhan, Viljoen, De Beer & Blaauw, 2016). In their Twenty-Year Review, the National Planning Commission y recognised the shortage of housing and recommended improved participative empowerment within the planning of human settlements, assessing capacity of local government to deliver on housing plans, to tap into private sector and to improve on rates collection and redistribution "in a manner that supports the poor" (NPC, 2014). Jarbandhan et al (2016) support the notion of involving the private sector and argue that partnerships between two interdependent sectors, private finance institutions and local and provincial governments' housing developments, need to be developed to address the backlog of affordable housing units. The dire shortage of housing giving rise to 14, 2 % of South African households living in informal dwellings has led to numerous disruptive protests, including in the Western Cape, where sanitation is an ongoing problem. Oldfield and Greyling refer to the paradoxical situation that waiting citizens find themselves in - on the one hand they are entitled wards of the state (as stated above to, "adequate housing," and while they wait for the government to have the means to fulfil this right, they are also entitled to live in "an environment that is not harmful to their health or well-being") and on the other hand their wait requires subversion – "an agency that is sometimes visible in its mobilization and protest, and at other times out of

sight, simultaneously contentious and legitimate (Oldfield and Greyling, 2015, p. 1112)"

The relevance of this contextual picture is that South African reports on teenage pregnancies claim that one of the drivers of this "serious problem" (Panday et al*,* 2009, p. 3) of unintended pregnancies is the pervasive poverty that they live in (Willan, 2013). Panday (2009,p. 72) report that one fifth of South Africa's population live in severe poverty and that this is concentrated in the black and Coloured populations, particularly the young people aged eighteen – thirty-five years, who inevitably live in rural or informal settlements. In the settlements surrounding Grabouw, not only are the informal dwellings unsafe and lack space for privacy, but all the dwellings in that area have no running water into the houses. (See figure 7 for illustration of home with a water tank on the outside.)

The Grootboom case is of relevance to this failure of the state to provide adequate housing in Grabouw, and its obligation to redress this failure, and relief to those in waiting for housing.

> To this the Court stated that under Section 26(2) of the Constitution, the government is required to devise and implement, within its available resources, a comprehensive and coordinated program progressively to realize the right of access to adequate housing. This right extends to all individuals including those without children. The state housing program in the area of the Cape Metropolitan Council fell short of compliance in that it failed to provide relief for those desperately in need of housing. In summary, the Constitutional Court declared that the government had not met its Constitutional obligations and ordered the government, within its available resources, to devise, fund, implement and supervise measures to provide relief for all, including those without children, who are in desperate need (Global Health and Human Rights Database, 2000, p. 1-2).

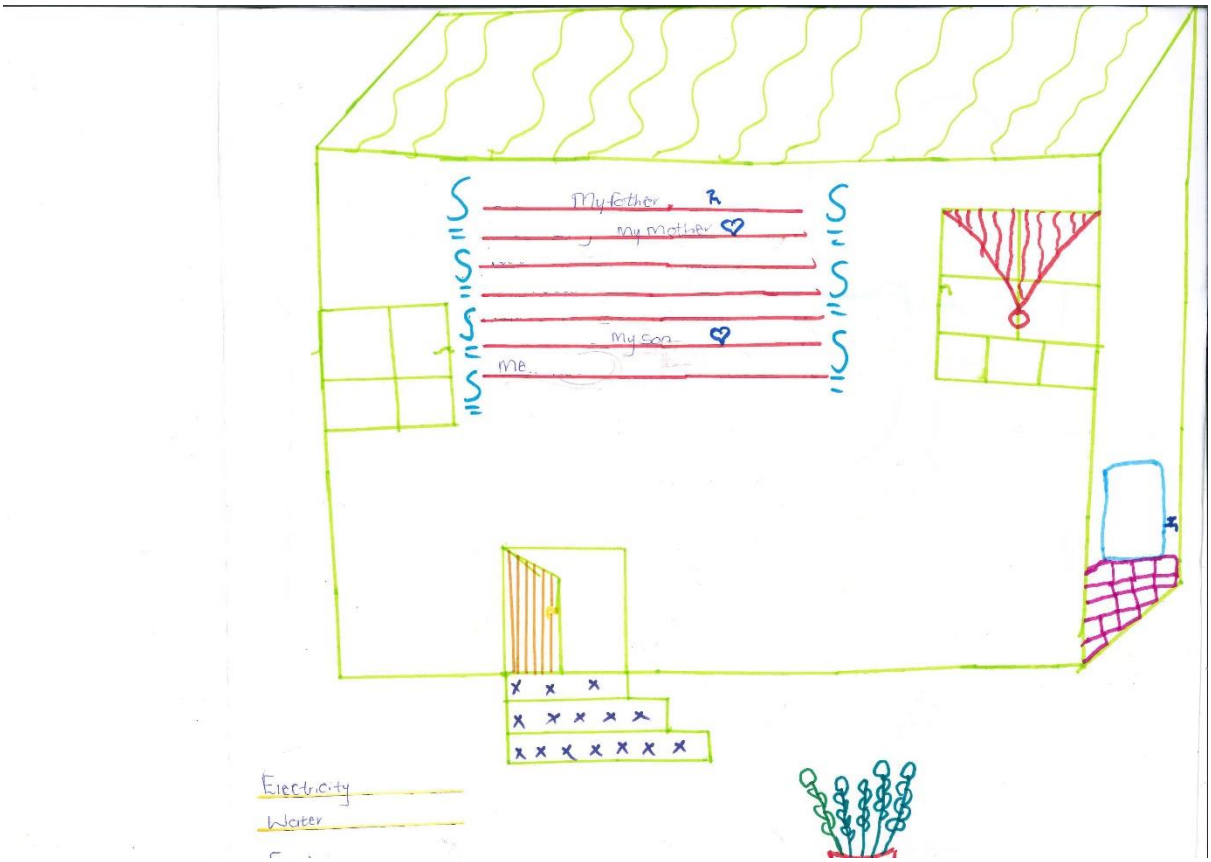


Figure 7: Respondent seven's home with water tank on outside

The living circumstances associated with adolescent pregnancies in Grabouw are not dissimilar to what is described by were (2007) in relation to the Busia district in Kenya. In looking at determinants of teenage pregnancies, "key factors as outlined by the adolescents themselves include peer pressure and social environment related factors like inappropriate forms of recreation, which act as rendezvous for pre-marital sex, as well as lack of parental guidance and counselling" (p. 322).

5.3.3 Respondents' access to local services within national legislation and international conventions

This section looks at the respondents' access to their entitled services within their immediate environment and in the context of the relevant national legislation and international conventions.

5.3.3.1 Education services

Three of the seven respondents said they were in school, although one (Respondent 4) of them was uncertain if she would make it as she had not secured care for her baby. All three of these respondents attend the same school, and their reports on the school's expectation to complete schooling were consistently positive. The reports of the women who had stopped going to school ranged from what seemed like poor achievement (being sixteen years of age in grade seven), to having to look after a younger sibling to being too tired, hungry and shamed at her poor dress, when she was in grade eleven, to continue going to school (Respondent 2). Only one respondent left because she was pregnant and although the school, especially one teacher, assisted her, she did not want to return to school for economic reasons. The latter came from a household with a high dependency ratio – ten people living on disability and child support grants.

These findings corroborate what is reported in national studies on poor educational outcomes for childbearing teenagers and their education (Panday et al., 2009).

Although there are cases of expectant mothers being discriminated against in South African schools, sometimes through policies instilled by school governing bodies or unhelpful practices of teachers (Draga et al., 2017; Ngabaza & Shefer, 2013; Mkhwanazi, 2014b.), this was not the experience of the young mothers in Grabouw. In fact, the experience was more like that which was recognised, in Bhana, Clowes, Morrell & Shefer's study (2008), as contrary to the stereotypical view that schools are resistant to expectant learners, and rather that despite the occasional moralistic attitude they do on the whole "care and help" (p. 78). Respondent four said that the headmaster expected their learners to attend until the day they went into labour, but this was seen as encouraging as opposed to a barrier. As Panday et al (2009) reported, South African learners tend to stay in school during the compulsory years of schooling, but "dropout increases dramatically from grade 9

onwards, particularly for Coloured and black learners" (p. 39). This was the case with respondents one and three in Grabouw. Reasons for non-attendance of the other two "drop-out" respondents in Grabouw were more in line with what Ranchod et al. (2011) referred to as "pre-existing adverse characteristics" (p. 18), which invariably precluded any child care facilities or services from friends or kin (Willan, 2013).

> Teen mothers in South Africa do exhibit significantly lower levels of education than their peers, whether measured in years of schooling, the probability of high school graduation or the probability of dropping out of school. However, they also tend to have low socioeconomic status growing up. Accounting for this reduces the estimated effect by approximately 90% when considering the probability of high school graduation or years completed by age 22 (Ranchod et al., 2011, p. 17).

According to Gupta and Mahy (2003) this is also true for sub-Saharan Africa where improving opportunities for girls to be educated is key to delaying first pregnancies, increasing schooling at primary level has little effect on fertility decline among adolescents. Reflecting on international literature there are examples of effective interventions to delay sexual debut. For example, Tortolero, et al. (2010) found that a curriculum based intervention in secondary schools in Texas was effective in delaying sexual debut for up to twenty-four months.

Within the context of education, it is noteworthy that none of the young mothers reported learning anything about sexual reproductive health in schools. The C&YCWs felt strongly that the schools could play a valuable role in addressing this knowledge gap. Mkhwanazi (2014b) writes about this observation from her ethnographic study with young mothers in the Western Cape – "the topics that can be covered under the life orientation syllabus…. [but] … my research …points to a discomfort that teachers and others entrusted with the task of providing sexuality education experience in talking to young people about sex" (p. 335)

5.3.3.2 Health care services

The respondents' perceptions and experiences of health care services varied – as a group the young mothers acknowledged that they receive contraceptives and immunisation for their children regularly – but individually their narratives told a different story. Either they were indignant at the disrespectful (for example, the swearing and smacking reported by Respondent one) treatment they received or the lack of treatment, or they were unaware of what they were entitled to receive from effective reproductive health clinics. For example, Respondent seven, who was eighteen at the time of giving birth, had no idea what to expect during child birth, and if not assisted by her mother in the clinic, may have ended up unassisted. She was discharged a few hours after delivery without any guidance on what to do for herself or for her child as she returned to her family's one room shack in an informal settlement. The literature study in Chapter Two highlighted the critical importance of guidance on nutrition and breast feeding during pregnancy and post- partum.

Other examples of not knowing what to expect and not being informed came from Respondent three who had tuberculosis and was not able to see her child for a few months – she intimated that she assumed that there was no way she could see her child, she never asked if, for example, she could wear a mask and see her child. There also appeared to be a general acceptance of what they were told by health care professionals, without enquiry – one respondent spoke about her mother going blind, but could give no explanation except that it may have been a curse. Respondent five spoke of her transfer to a hospital because she had headaches, but she was not informed of any other symptoms characteristic of ante natal risks such as pre-eclampsia.

A systematic review of studies (one quarter of which emanated from South Africa) in Sub Saharan Africa, which looked at determinants of unintended pregnancies amongst adolescents found the following results within the health sector:

a) Cost of contraceptives; b) inadequate and unskilled health workers; c). long waiting time and lack of privacy at clinics; d) lack of comprehensive sexuality education; e) misconceptions about contraceptives; f) non-friendly adolescent reproductive services, and g) negative attitude of health workers towards providing reproductive health services for adolescents (Yakubu & Salisu, 2018, p. 6).

Apart from the inadequate and unskilled health workers, the aforementioned determinants were mentioned by the adolescent mothers and their C&YCWs in Grabouw. For example, the C&YCWs described the way in which they are treated disrespectfully by clinic staff and having to wait all day to be attended to (FGD, 13 Jan., 2018). Furthermore, they felt that the public health information provided was not helpful to the general community and definitely not comprehensible by the youth. Regarding contraceptives, all seven of the respondents in Grabouw had not used birth control measures prior to their first pregnancy and all were on some form of contraceptives after child birth. This trend of contraceptives being more accessible post first child birth and this active encouragement to delay a second pregnancy is in keeping with what is reported in national reports (Panday et al., 2010; Willan, 2013). Were (2007) found a similar pattern in the Busia district of Kenya, where almost 50% of the 350 respondents (with an average age of seventeen years) were mothers and only 18% were using modern contraceptives?

Lastly, the taboo of sexual talk in homes, together with the misconceptions that respondents had about contraceptives, confirm the incomprehensive sexuality education in the communities where this study took place. Mkhwanazi (2014a), who undertook long term ethnographic studies in the Western Cape found that between 2001 and 2013 there had been a significant change in young women's access to information on sexuality and contraceptives, familial conversations on the same topic and respectful health care services. Although the qualitative data collected in Grabouw was not longitudinal, some of it was retrospective, especially the voices of the C&YCWs who had worked in the community for the past nine years, and these did not infer progress over the past ten years. This may be because the

Mkhwanazi study (2014a) took place in townships closer to Cape Town metropolitan, where familial public services and cultural practices may be influenced by the growing consciousness of civil and social rights and where the likelihood of services from adolescent friendly clinics is higher than in the outskirts of Grabouw.

These examples of poor access to information about health matters that concerned the respondents support the notion that people living in poverty tend to have no voice and no sense of agency. In a study on how poor people themselves define the multi-dimensional phenomenon of poverty, one of the aspects described is this "lack of voice, power and independence that subjects them to exploitation… and rudeness, humiliation and inhumane treatment." (Narayan with Patel, Schaft, Rademacher & Koch-Schutte, 2000, p. 31), which the researcher observed in Grabouw. The people interviewed in the afore-mentioned study were aware of their voicelessness, but the young mothers in Grabouw, as a group, referred to the health services as "'*kuright*" (all right), which may mean that they did not expect anything better. The question remains: Did they not know of anything better than what they had experienced, or had they resigned themselves to this lifestyle, or did they believe this was what they deserved, or are they less exposed to modernisation than the young women in the Cape Town metropolitan area? The C&YCWs, on the other hand, are schooled in principled service provision and the rights of the adolescents whom they support, and expressed indignation at the disrespect of the health professionals.

Gupta and Mahy (2002) looked at the association of socio-demographic modernisation with onset of sexual behaviour and knowledge of reproductive health. They found that the only significant socio-demographic factors were the innovations in their education and the retention in secondary schools, which were associated with lower probability of early sex among girls. However, the association was not the same for boys.

Teenage pregnancy is a clear marker of unprotected sex, which is not only an indication of use or absence of contraceptives, but also an indication of HIV risks. In 2010, according to a study by the South African Department of

Health (as cited in Willan, 2013, p. 19) South Africa had one of the highest prevalence rates of HIV globally with 30,2 % of women between fifteen and forty-nine years old living with HIV.

Programmes with the objective of delaying sexual debut were therefore offered through adolescent friendly reproductive health services in South Africa. The intention to provide such services was mentioned by the C&YCWs who rated the clinic higher than all his colleagues. He spoke about the multi-stakeholder meeting called by the clinic in Grabouw to discuss this prospect. The other eight C&YCWs were doubtful as to whether this would happen – which could have been a reflection of what Narayan et al, (2000) refer to as "experience of long term poverty [which] is often accompanied by its almost fatalistic acceptance, even if people have not given up the struggle" (p. 42).

The child and health care workers confirmed that they had observed severe depression that their family members who had given birth in their teen years, and were subsequently trapped by child care responsibilities, experienced severe depression. The literature associates this with changing social status, difficulty in finding child care and the isolation experienced from discrimination and stigma associated with early childbearing (Willan, 2013).

Abortion for women fewer than thirteen weeks pregnant is a sexual reproductive health right in South Africa, no reasons need to be provided (RSA, 1996; Willan, 2013). Statistics from public hospitals indicate an annual increase in the numbers of women taking up this right (Makiwane, 2017) and yet it is associated with severe stigma and discrimination in Grabouw. Literature indicates that this is not uncommon, particularly in black and Coloured communities (Majozi et al., 2016; Brand, 2013). When abortion does take place, it seems for the pregnant girls to be "much less about a moral and religious decision – or pressure – than about their desperation to end an unwanted pregnancy" (Kaufman, 2001, p. 151). This is an example of how the civil rights of the young mothers are overshadowed by socio-cultural practices entrenched in densely populated communities and which feed into the voiceless nature of long term poverty. Brand (2013) analyses the effect of discourse around the criminality of young women's sexuality through

legislation (i.e. *Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007*) and suggests that this "protectionist" perspective undermines the autonomy of young women. Brand (2013) recommends a shift to encourage a more autonomous view within the "transformative values of the constitutional era. For teenage girls, law has the ability to expand sexual autonomy as well as access to information about sex and reproductive health support through the Children's Act [2005] and the Choice of Termination of Pregnancy Act [2007]" (p. 217). This transformative approach within a context of multi-generational poverty, where cultural practices are often maintained as a form of shared solidarity, may paradoxically take longer than in situations of greater flux (Narayan et al, 2000).

An adolescent-friendly clinic intervention was tested in South Africa for its potential short term effect on clinic attendance and long term effect on early childbearing and secondary effect on wage earning potential. Using geo-references to the clinics and data from the National Income Dynamics Study, Branson and Tyler (2016) correlated adolescents' proximity to adolescent friendly clinics with age of childbearing and found that the probability of delayed childbearing increased "by 1.2 years on average with greatest impact on women who otherwise would have given birth by age 17…. and also, provides the longer-term benefits of improved later-life outcomes" (p. 24). The protocol of these interventions was developed by a NGO called LoveLife, and the rollout of these clinics was dependent on their partnership with government. By all documented accounts, this model was effective, but dependent on funding for NGOs (Branson & Tyler, 2016). Until all state operated clinics are standardised, with recognised and proven adolescent-friendly good practices, there will be no certainty that marginalised communities, such as those in Grabouw, will access their entitled health care, particularly reproductive health care services. The need for such good practices to be accompanied by tested implementation strategies is essential in ensuring that they get taken to scale in regular services beyond the ownership and responsibility of the purveyor (Fixsen, Naoom, Friedman, & Wallace, 2005; Campbell & Graham, 2006).

5.3.3.3 Social assistance

Child support grants were introduced in 1998 as a poverty alleviation strategy by the South African government in partial fulfilment of the Constitutional commitment to "social security, including, if they are unable to support themselves and their dependants, appropriate social assistance" (RSA, 1996: Section 27.1.c.) It replaced the old maintenance grant which favoured white people during the apartheid regime. It was one of the few social assistance programmes in the Global South that cost more than one per cent of the GDP, but because of its political and economic gains, was increased in its eligibility and uptake from 0,03 million beneficiaries in 1999 to eleven million beneficiaries in 2014 (Seekings, 2016).

A common accusation made against the CSG was that it acted as an incentive for teenagers to have babies. This view has been dispelled several times with data that confirms that teenage fertility has declined since the introduction of the CSG and that the uptake of CSG is disproportionately lower than the fertility rate within the fifteen – nineteen-year-old bracket (Makiwane, 2012; Panday et al., 2009).

Table one, in the previous chapter, provides details of respondents' access to social assistance. Six of the respondents were in receipt of child support grants, the seventh had applied but been told to wait for the offices to resume services after the December holidays before she could receive the grant. One of the respondents, who had three children, had not yet applied for her youngest child.

Four observations were made from the analysis of the respondents' experiences with accessing CSG and disability grants. These observations are more reflective of their socioeconomic status than of the services they interface with:

a) All the respondents knew where to go and how to apply for a CSG. Apart from one applicant whose payments were delayed due to office closure in December (which seems unreasonable as they had expenses in December as in any other month of the year) none of the applicants spoke of

challenges in relation to the application. Nor did they express concerns about the attitudes or incompetence of the staff at SASSA. This is an interesting finding given that research on SASSA staff's attitude to teenage mothers found that 36% of the respondents had a stigmatized view of teenage mothers, with the Western Cape having the highest proportion of these responses in South Africa (Van Vrede, 2015). However, Respondent two experienced difficulties with accessing the correct information required for an application for a disability grant for herself and her son, which appeared to be due to different messages she had received from SASSA and the Department of Health medical officer. Respondent seven reported that her mothers' application for her siblings' CSG was held up as they had to return to the Eastern Cape for this application. Van Vrede (2015) refers to numerous incidents of "applicants being misled with confusing information and being kept anxious through the application process" (p. 88) unnecessarily by SASSA administrators. Respondent seven's experience illustrates one such incident.

b) Respondent one, who had not yet applied for a CSG for her eight-month-old child and who had lost the birth certificates of her older two children to a rat, appeared to have had more of a dysfunctional family life than the other respondents – suggesting that the inaccessibility was not due to poor grant administration, but more to the young mother's ability to manage her life.

c) The high dependency of the respondents' households on CSGs is indicative of the fact that this social assistance, which is meant for the child, is not only used by the whole family for basic utilities such as power and water, but is insufficient for mothers to access the child care they require to enable them to pursue further education or employment. Within the context of heavy migration to an area where people seek employment in fruit and wine farms in the Western Cape; and where the casualization of labour within a competitive global market has attenuated the labour market (Ewart & Du Toit, 2005; Du Toit, 2004) this finding is not surprising - but speaks to the poverty cycle that is almost inescapable for teenage mothers.

d) The findings of this study also confirm the widely-documented feminization of poverty. Of the seven young mothers who were interviewed and the two who were sisters of C&YCWs, only two had maintained personal relationships with the fathers of their children and only two were financially supported by the fathers of the children. Two of the respondents mentioned that **"**damages**"** had not been paid by the fathers of the children, despite the respective families acknowledging paternity. This customary practice is generally upheld in *amaXhosa* communities. "In general, damages are meant to provide compensation to the girls' family for the decreased amount they would receive for her "brideprice" because she had had a child by another man" (Kaufman et al, 2001, p.152). The fact that these respondents had not received any financial support might be indicative of the level of poverty that the men are living in, or the abdication of their responsibility, or both. Jewkes, Vundule, Maforah and Jordaan (2001) write about relationship dynamics and teenage pregnancies and suggests that young women are disempowered by sex being reciprocated with gifts, and that they are particularly at risk of pregnancy in "forced sexual initiation" and where they are "unwillingness to confront unfaithful partners" (p. 742). Jewkes, Morrell and Christofides (2009) therefore suggest a "critical reflection and engagement with men and boys on issues of masculinity, including their role in child rearing, as well as examination within families of their engagement with supporting pregnancy prevention and responses to pregnancies" (p.675).

In recognition of the absorption of child support grants by households of recipients, the responsibility of women to care for children and the need for mothers to have some form of social security for themselves Wright et al., (2014) ran focus group discussions with "lone mothers" to hear their views on this perceived need. The idea of additional social assistance for "lone mothers" was well received, it was thought that it would protect them from taking risks, such as transactional sex, and would enable them to "buy basic requirements for their own dignity and a sense of belonging to humanity" (Wright et al, 2014, pp. 51–53). However, they were also concerned about mothers forgetting their responsibilities to their children, which was also the

cautionary note provided by the C&YCWs in Grabouw – they had observed young women taking advantage of grandmothers' care of their children while living off the CSG. They suggested a strategy to "meet government halfway – not to be totally dependent on grants" (FGD, 13 Jan, 2018).

Shireen Hassim (2005) in her analysis of gender patterned poverty, argued that the South African government's progressive realization of social assistance has failed to "erode gender inequalities in addition to race inequalities" (p. 621). Young African women are worst affected (Glodblatt, 2005). Patel (2012) confirms this view with a concern that the CSG risks the perpetuation of the view that women are "merely conduits for the delivery of services to children" (p. 118) Although women, who are the main custodians of the CSG, are assisted by this extra cash, women living in extreme poverty often have difficulty accessing the grant and the grant alone will not transform gendered poverty (Patel & Hochfeld, 2011; Goldblatt, 2005). Patel (2012) continues to suggest "complementary social development interventions, such as support for their livelihood strategies with seamless access to effective public services [and] that take account of the gendered nature of care and poverty itself" (p. 118).

It is clear from the data provided by the respondents in this study that social assistance provided in the form of grants, even if they are meant for children (CSG) and people with disabilities, are going to basic household expenditure. And, "these grants do not fully end poverty both in the sense of fully meeting basic physical and social needs, and in Sen's sense (1999) of allowing the full exercise of human capabilities through 'choices'" (Xaba, 2016, p. 103).

5.4 Summary

The purpose of this chapter was to interrogate the findings with reference to relevant local and international studies. The overall finding of this study was that the young mothers were accessing their entitled education, health care and social assistance services. There were some issues regarding attitudes

and poor quality of services, which were expressed by some mothers in their interviews. The disrespectful attitude and poor service in the clinic was not mentioned by the mothers themselves, which may be a reflection of their sense of disempowerment as a group and their obliviousness of the right to dignity and progressive realization of equity. This phenomenon of "voicelessness" is well documented in writings on multi-dimensional and entrenched poverty (World Bank, 2001; Adato, Carter & May, 2006). The C&YCWs provided data on the disrespectful behaviour of health workers in the FGD, which was useful for triangulation purposes.

What is presented above is an interpretation of what we saw and heard with reference to findings from other studies within South Africa and in other countries. We are aware that this small window into the lives of the young mothers did not give us a full picture of their lives. The questions related to education, health care and social assistance were all answered, and very similar answers were provided by the young mothers and C&YCWs, but we had the sense that more time was required to fully saturate these issues. The contextual issues need further enquiry, particularly of the service providers themselves and of the housing situation, to better understand the realities of extreme poverty experienced by young mothers. Nevertheless, the findings of this study corroborate relevant situational analyses in South Africa, which confirm that adolescent pregnancies not only lead to poor educational outcomes for the mothers, but are often preceded by poor socioeconomic environments. These are characterised by poor information about sexual reproductive health, relatively high school drop-out due to the care burden at home or cost of attending school as opposed to piece work, and high dependency on social assistance, particularly on the child support grant.

Chapter Six: Conclusions and recommendations

The purpose of this study was to explore the particular social protection needs of adolescent mothers in the settlements on the outskirts of Grabouw. The study applied a transformative approach to social protection and was informed by a human rights perspective, which was defined in terms of the relevant global declarations and the corresponding national translations of these global imperatives. This study focused specifically on health care, education and social assistance as these are critical to the well-being of adolescent mothers and the rights to these social services are clearly stated in the *Constitution for the Republic of South Africa 1996* as well as in the relevant sectors' legislation.

The literature study that was undertaken in preparation for the field work suggested that there are large disparities in the quality and accessibility of basic services across South African society, with people living in rural areas and informal settlements being the most deprived. Situational analyses on teenage pregnancies provided demographic data and assessments of contributing factors as well as outcomes of early childbearing. These analyses were undertaken for two main reasons: To better understand why teenage fertility was not declining at the same rate as the total fertility rate was declining, particularly amongst black and Coloured communities in poor socioeconomic environments, and why the HIV prevalence amongst adolescents was similarly not declining at the same rate as the national prevalence rate. A close examination of data on the uptake of the CSG and teenage pregnancies dispelled the myth that the CSG was perversely incentivising adolescents to have babies. Ethnographic studies on socioeconomic and cultural dynamics relating to teenage sexuality over a period of time in the Western Cape provided an interesting lens into the adolescent mothers in Grabouw. There are mixed reports in the literature on school policies and practices in relation to pregnant learners. Some that report inclusionary practices and some that report insidious exclusionary practices.

A common theme in the literature was the association of early sexual debut with low school retention and poor education performance, and the antecedents and consequences for pregnant adolescent learners were similar. In other words, education outcomes and work opportunities for adolescent mothers are poor, but they were also living in poor circumstances prior to the pregnancy. Lastly, a common finding was the poor access to information on contraceptives and to adolescent friendly health services.

A case study design was used to collect primary data from a purposefully selected group of early childbearers to ascertain what the adolescent mothers' experiences and perceptions were regarding education, health care and social assistance. The boundaries of the case were the group of adolescent mothers known to the *Isibindi* C&YCWs in Grabouw. Qualitative data collection methods were applied in this interpretive and constructivist orientation to the case study.

Data was collected in semi-structured interviews and participative focus group discussions with the adolescent mothers by the researcher and a research assistant. Creative activities were used to facilitate discussion and to provide data on household demographics and structure and sources of income. A focus group discussion was also held with nine C&YCWs who were providing supportive services to the adolescent mothers and their families. This approach to data collection lent itself to an inductive enquiry, allowing the researcher to ask specific questions while simultaneously following the narrative of the respondents. The group activities with the adolescent mothers were particularly useful. They served the dual purpose of facilitating full participation and providing the researchers with a visual reference for the conversations. The focus group discussion with the C&YCWs was animated and reflective of the collaborative nature of their team work. This discussion proved to be very useful in terms of triangulation of data as well as in learning more about socio-cultural factors affecting the adolescent mothers.

Contrary to what the researchers expected from preliminary literature review, the adolescent mothers in Grabouw were, on the whole, accessing their entitled social services. The school, which was attended by three

respondents, was reported to be helpful and encouraging of the adolescent mothers to stay in school during pregnancy and to return to school after giving birth. Challenges in attending school were more to do with no free child care and the child support grant being required for basic household expenses such as water and power, so not available for child care. Additionally, two young mothers left school because they had to look after siblings and one left because she was pregnant and chose to not return. One respondent left school when she reached school leaving age and was still in grade 7, suggesting poor cognitive ability. These findings suggest that, contrary to what was expected, access to education is less of a challenge than the multidimensional poverty that these adolescent mothers and their parents live in.

There were some concerns raised about the attitude of health care workers, especially around the disrespectful treatment that the adolescent mothers received. Sentiments regarding the inadequacy of public health messages and information on sexual reproductive health were also expressed.

The child support grant was available to all mothers, and although there was generally a delay in disbursements in December, all the respondents were satisfied with the social assistance services. Information on the eligibility and application process for a disability grant was confusing for one respondent. There were no suggestions of undignified or disrespectful attitudes at SASSA. One respondent spoke of health clinic services being offered one day a week at SASSA, which may have to do with applications for disability grants. Multi-sectoral services at one stop would be advantageous for beneficiaries, but this information was not verified by the C&YCWs

Although the basic health, education and social assistance services, which this study focused on, were on the whole being accessed by the adolescent mothers in Grabouw. The socioeconomic profiles of the respondents reflected patterns of poverty traps. These resonate with findings reported in literature on socioeconomic circumstances having predictive and consequential influence on the lives of adolescent mothers and their children.

Socio-cultural factors affecting adolescent mothers were discussed by the C&YCWs. The following three salient points were raised and form the rationale for recommendations below. The first one relates to the way in which the *shebeens* and the loan sharks hold beneficiaries' grant access cards in lieu of debt accrued with them. The second is the shame ascribed to anyone who chooses to terminate pregnancies. The third is the taboos associated with conversations about sex, particularly between parents and their children. The sense that the researchers were left with what was described by C&YCWs in the FGD (13 Jan 2017) as "they are looking for love…in the wrong place."

Recommendations

This study is indicative of the need to improve the progressive realisation of rights and to address poverty traps that are typical of adolescent mothers in Grabouw informal and formal townships. The social protection measures in Grabouw will need to shift from the basic coping and surviving environment in which adolescents continue to live within the social assistance safety net and are likely to continue their compensating behaviour of "looking for love…in the wrong place" (C&YCWs, FGD, 13 Jan 2017). The shift will need to seek ways to prevent this compensating behaviour and build in strategies for accessing further education and training, employment opportunities and avenues for empowered self-actualisation

In recognition of the partnership model that the Department of Social Development relies on, the following recommendations are more specifically for *Isibindi*, the non-government organisation that has immediate and regular contact with the current and potential adolescent mothers in Grabouw. It is suggested that *Isibindi* and any other relevant local non-government organisation form working alliances with public and civil organisations to design a targeted adolescent-friendly programme to address following preventative and restorative strategies:

a) improve adolescents' knowledge of sexual reproductive health matters

b) create advice centre on matters such as applications to vocational and educational training, establishing small businesses

c) information and support (potentially from private sector) for livelihood options

d) offer gainful and appealing recreational services as alternatives to frequenting the *shebeen*

e) support the adolescents in their attempts to stop drinking

f) identify options for child care that include stimulation for young children

g) parenting skills for adolescent and other young mothers

h) fatherhood programmes

i) parenting programmes for parents of adolescent in which conversations about sexuality and sexual reproductive health can take place

j) liaise with the health care colleagues to plan adolescent-friendly services with appropriate information on contraceptives

k) establish a mothering of mother's programme for those who come from dysfunctional families

l) Assistance with budgeting and education on exasperating effects of accruing debts (acknowledging that the income is infrequent and minimal).

The above recommendations are for services to complement state provided basic services. Underlying this approach is the assumption that the NGO sector can accompany the adolescent mothers in their aspirations to be good mothers for their children, to find work to support themselves and their extended families and, for some of them, to complete their schooling and pursue a career. But, this should not detract from what national and provincial government departments need to do to address the trap that people in extreme poverty live in. The monetary value of the social assistance programme assist households with basic costs, but is insufficient for them to overcome poverty. A comprehensive and multi-dimensional programme

within the social protection package is required to assist adolescent mothers in Grabouw to escape the poverty cycle for themselves and their children.

The limitation of this study is that it was not representative of all adolescent mothers in Grabouw. It was limited to the relatively small number of adolescent mothers who were known to *Isibindi* and were available and willing to participate in this study. Furthermore, three of the seven mothers were in their early twenties, having given birth within their adolescent years. Nevertheless, the findings of this study provide insight to the lived experiences of the adolescent mothers in Grabouw, which could inform more extensive research in the area and beyond.

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Grabouw: Semi structured interview with adolescent mothers

January 2018

Introduction

Thank you for meeting with us. We understand from your child and youth care worker that you have agreed to be interviewed. Is this correct?

(If no, clarification will need to be sought)

We appreciate your time in giving us insight into your experience as a young mother. The reason we want to talk to you today is because we are wanting to learn more about how you are managing as a mother, what you are enjoying about being a mother and what you are having difficulties with. We are particularly interested in the services you have been able to receive, and if there are ways in which these services can be improved.

This interview won't take more than an hour. Your participation is voluntary and you are free to withdraw if you wish. This will not affect your relationship with Isibindi. We are interviewing several young mothers and your general/ collective views will have written up in a report which will be shared with you and Isibindi. We will ensure that anything you say will not be reported with your name.

Because it is important for us to make sure we record and reproduce correctly the things you say here, we will record the interview. Is this okay?

Do we have your consent to proceed?

Yes?

No?

Do you have any questions? Signed: Date:

Interview guide:

1. Personal and household data?

- Please tell us a little bit about yourself and your child. Your age? Your child's age and name? (depending on age of child, conversation on what child is doing and how mother interacts with child will be pursued)

- Who else lives in your household? (age and sex for all family members of this household would be helpful.)

- Do you have family members living outside of the home? Where? How often do they come home? Do they depend/ support your family financially?

- Who in your opinion…. Provides financial support? Maintains the home? Cooks? Provides support/ advice to you as a young mother? Provides emotional support? Provides information/ guidance on sexual reproductive health?

- How did your family respond to your pregnancy? And to the child?

- What support/ child care do you get from family members?

- Do you have contact with the father of the child? If yes – any emotional/ childcare/ financial support?

2. Education

- Are you still attending school? If yes, what grade? If no, highest grade attained?

- How do/ did you get to school? How much does it cost to get to school?

- What was the reaction of the school to your pregnancy?

- Who, if anyone, provides emotional support to you at school?

- Who, if anyone, at home or in your community helps you with your studies?

- Is there anything else you would like to tell us about your school? Friends? Attitudes? Inclusive/ exclusionary behaviour?

3. Health care
- Where is your closest clinic?

- Did you receive ante-natal care? Please tell us a little more about this – how often?

- What did you receive and what was the attitude of staff towards you as a young mother?

- Have you taken your baby/ child to the clinic? What does it cost to get there? How much time does it take? How often have you been? Road to health card updated?

- Have you ever received any advice on contraceptives and other reproductive health issues – like sexually transmitted infections? Who gives you this advice/ guidance/ information? What about your friends? Anyone in your family? Is this something you discuss with them? And with your boyfriends?

4. Social assistance
- Do you know if anyone at home receives a child support grant for you? And for your child?

- If yes – how are these received?

- If no – do, they know how to apply for child support grant? Who could help you with this?

- Any other form of social assistance – such as pension, disability grant, foster child grant?

- What would you consider to be the top three expenses in your household?

- How are these expenses budgeted/ managed in your household?

- Is the child registered? If yes, how and when was this done? How far / transport cost to get to Dept. of Home Affairs?

5. Aspirations
- What is your dream for yourself? Where would you like to work? Live?

- And with whom? What will help you to reach this dream?

- What is your hope for your child? Top three wishes?

6. Closing questions
- Anything you want to ask us?

- Any recommendations you would like us to include in our report?

OUTINE FOR FOCUS GROUP DISCUSSION: Isibindi Child and Youth Care Workers

Pine View, Grabouw

January 2018

A) Introductions to each other and create circle of confidentiality.
B) Explanation of purpose of study.
C) Verbal recording of consent to record focus group discussion.

D) Question one:

As an introduction to the topic:

Could you each please tell me a little bit about yourself and your family? How long have you lived in Pineview and how did you become involved with Isibindi?

E) Question two:

Please describe the family/ household of 'your' teenage mother. Who lives in the house, where do they live, how did her family members respond to her pregnancy? How would you describe the relationship between the teenage mother and her family members?

F) Question three:

Please tell us what you know about her access to

a) health care – for herself and her baby
b) schooling or any other training
c) grants
d) social assistance

G) Question four:

Could you please share with us something about your relationship with the teenage mother?

a) How long have you known her?
b) How would you describe the relationship between the teenage mother and her child?
c) In what way have you helped her?
d) What would you say are her challenges?
e) What would you say are her strengths?