“I have to provide for another life emotionally, physically and financially”: Understanding pregnancy, motherhood and the future aspirations of adolescent mothers in KwaZulu-Natal, South Africa

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Abstract

Background Adolescent pregnancy and adolescent parenting have been controversial and much disputed subjects in the field of public health. There are increasing concerns that the psychosocial challenges that adolescent mothers face may remain in the background because research in this field has mainly focused on the medical complications of early childbearing. Aim The aim of this qualitative study was to explore adolescent pregnancy and motherhood in order to understand this phenomenon from the perspective of adolescent mothers and to gain insight into their future aspirations. Methods This descriptive qualitative study utilised data that were generated from focus group discussions with adolescent mothers who utilised healthcare services at a hospital in the Ugu district in KwaZulu-Natal, South Africa. The data were analysed using thematic analysis. Results Adolescent mothers reported a range of positive and negative experiences. Some adolescent mothers' partners were in denial and rejected them and the child, while others' partners were happy and supported them during their pregnancy. Families' reactions to the pregnancies ranged between anger and disappointment to abandonment, the "silent treatment", and acceptance and forgiveness. The psychological issues experienced by some of the adolescent mothers included suicidal ideation, guilt, loneliness, anxiety, and stress. They also experienced financial constraints, difficulty in returning to school, and stigmatisation by society. The participants envisioned completing their education, focusing on their dream careers, and contributing positively to society. Conclusion Experiences of adolescent pregnancy and parenting are multifaceted and the healthcare needs of pregnant and parenting adolescents extend beyond information and knowledge. A multidisciplinary approach is required in the care of adolescent mothers. A key policy priority should encompass the collaboration of different professionals from various healthcare sectors to assist adolescent mothers in achieving better health and psychosocial and socio-economic outcomes as steps to securing a better future for themselves and their children.

Background

To date, adolescent pregnancy and parenting has been a controversial and much disputed subject in the public health field.[1] The literature suggests that moral judgement and the scientific scrutiny of adolescent childbearing continue to receive attention, whereas the psychosocial experiences of adolescent mothers are often marginalised.[2] The issue of early childbearing has been avidly discussed within the complexities of the socio-ecological system.[3,4] In addition, adolescent motherhood is constructed within a social class domain that is subjected to the labels of being a 'good' or a 'bad' mother.[1] A primary concern is that the stigma attached to adolescent motherhood may have a disempowering effect on these young women.[5] Moreover, pregnant adolescents are more likely to experience poor medical and psychosocial outcomes.[6]

Research on adolescent health has had the tendency to focus mainly on biological and reproductive health aspects rather than the psychosocial dimensions of this phenomenon. The transition into

motherhood can be a turbulent time for adolescent girls as they struggle with the conflicting identities of being an adolescent, a mother and an adult.[7] The adolescent mother has numerous parental responsibilities, while she also has to take care of her own educational and developmental needs.[8] Adolescent parenthood has been associated with school dropout, unemployment, poverty, and poor parenting outcomes.[6]

In 2017, approximately, 97 143 adolescent girls gave birth in South Africa, which accounted for 13.9% of all registered births.[9] South Africa remains a largely patriarchal society in which gender and stereotyping dominate the landscape of adolescent childbearing.[5,10,11] Earlier research in South Africa focused on the physical health outcomes of adolescent pregnancy while the focus on the experiences of adolescent pregnancy and motherhood was limited. There is an increasing concern that the challenges facing adolescent mothers remains in the background as research in this field has mainly focused on the medical complications of early childbearing.[12] It was against this backdrop that the purpose of this qualitative study was to explore and understand the phenomenon of adolescent pregnancy and motherhood and to gain insight into the future aspirations of adolescent mothers. The main integrated research questions that needed to be addressed were the following:

(1) What are the experiences of adolescents during pregnancy and motherhood?; (2) What are the problems and needs of adolescent mothers?; and (3) What are the future aspirations of adolescent mothers?

Methods

Study design

This was a descriptive qualitative study that formed part of a larger mixed-methods action research (MMAR) PhD project. The larger study aimed to develop a community of practice model for a multidisciplinary and comprehensive approach towards caring for parenting adolescent mothers. The quantitative component of the MMAR study involved a questionnaire survey about adolescent pregnancy and sexual and reproductive health among 326 adolescents using maternal health services at a hospital in the Ugu district in KwaZulu-Natal, South Africa. The survey also included questions related to current pregnancy health practices by and social support for adolescent girls. The qualitative research design allowed the participants to identify with their own meanings of their social world and it provided them an opportunity to let their voices be heard about their experiences and needs.[13] The qualitative component of the study also established a portal for a better understanding of adolescent pregnancy and motherhood as well as the future aspirations of these mothers.

Research setting

The research was conducted in a district hospital in the Ugu, southern KwaZulu-Natal. Ugu district has been classified as 84% rural while the remaining 16% is urban. The population size of Ugu district was about 722 484 at the time of the study. This district experiences the triple burdens of unemployment, poverty and inequality. The district hospital offers both antenatal and postnatal care as well as labour and delivery services. Prior to the study, the adolescent delivery rate at this district hospital was approximately 23%,[14] while the prevalence of adolescent repeat pregnancy was 19.9%.[15]

Study population

The population of interest was parenting adolescent mothers (i.e., first time and repeat mothers) in the age group 13 to 19 years. The definition of a first-time adolescent mother that applied to this study was a female between 13 and 19 years of age who had given birth for the first time to a live infant, while the definition of adolescent repeat mothers was female individuals between 13 and 19 years of age who had given birth twice or more to live infants within 24 months.

Sampling Method

The quantitative strand of the larger PhD study was also employed as a model for the selection of the participants of this qualitative strand. This model can be explained as a process whereby categories of first-time adolescent mothers and adolescent repeat mothers identified by the quantitative data were purposefully selected for the qualitative strand.[16] The quantitative study identified participants who had experienced adolescent pregnancy and motherhood and who were willing to share their experiences. The participants were given information pamphlets about the qualitative study. Consent to participate in the focus group discussions (FGDs) was obtained for all participants over the age of 18 years and parents'/guardians' as well as the participants' consent was obtained for those under the age of 18 years.

Sample Size

Four focus group discussions were held. These discussions involved 18 participants in total. The minimum and maximum number of participants for the focus group discussions were 4 and 5. Data saturation was reached by the fourth focus group discussion.

Data Collection

The data for this strand of the study were collected using focus group discussions. A focus group discussion guide was designed in collaboration with a clinical psychologist, a social worker and a clinical

midwife. The guide was also perused and approved by the research supervisors and the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu-Natal (UKZN). The discussions were conducted between March and April of 2018. The participants unanimously agreed that the focus group discussions should be conducted over weekends. Each of the focus group discussions was held in a comfortable, non-threatening and private learning resource centre at the hospital.

Group confidentiality was discussed with the participants. Consent to audio record the discussions was sought from and granted by the participants. The home language of the participants was IsiZulu and the discussions were thus conducted in this language and facilitated by a qualified social worker and a trained research assistant. The duration of the discussions ranged from 120 to 180 minutes. A note book was also used to record field notes. Data were collected on the experiences of adolescent pregnancy and parenting, healthcare services, perceptions of sexual risk behaviour, and the future aspirations of the participants. The findings that are presented in this paper relate exclusively to the participants' experiences of pregnancy and parenting and their future aspirations. A later paper will present and discuss the findings regarding the participants' understanding of sexual risk behavior.

Data analysis

The recordings from the focus group discussions were transcribed in verbatim format. The transcriptions were translated into English by a research assistant who was proficient in both IsiZulu and English. The anonymity of the participants was maintained by assigning a pseudonym to each. The data were analysed using the thematic analysis process as proposed by Braun and Clark[17]. The transcripts were repeatedly read to become familiar with the data, and the data were coded and then categorised into themes.

The credibility of the findings was confirmed by sharing the data and the findings with the research supervisors who ensured that the data had been analysed appropriately. The transcripts were taken back to the participants for review and reflection. The research participants were familiar to the research team which means that trust and confidence had been established prior to data collection. Clear, thick descriptions of the research process may assist future researchers with the transferability of the findings.

Ethical approval

This study was approved by the Bioethics Research Committee of the University of KwaZulu-Natal (ref no: BFC553/16), the KwaZulu-Natal Department of Health (ref no: KZ_2016RP26_545), and the Chief

Executive Officer of the district hospital. Written consent was sought and provided by all the participants aged 18 years and above, and consent was obtained from the parents and the participants who were under the age of 18 years.

Results

Profile of the participants

In total, 18 adolescent mothers participated in the study (Table 1). Nine of the participants had experienced repeat pregnancies while nine were first time mothers. The majority of the participants had dropped out of school due to their pregnancy and parenting responsibilities. Thirteen themes emerged from the data. These themes are summarised in Table 2.

Discussion

The aim of this study was to explore adolescent pregnancy through the eyes of affected young women and to develop an understanding of this phenomenon and the aspirations of these mothers. The themes that emerged most predominantly were: the complexities of adolescent pregnancy; participants' relationship with the father of the child; the prevalence of father-child interaction; the reality of life since the pregnancy and its ensuing motherhood; parenting responsibilities; sources of financial and emotional support; parenting concerns; difficulties in accessing healthcare services; experiences with healthcare providers; the impact of an adolescent repeat pregnancy; the need for health information; and the dreams and aspirations of adolescent mothers for a better future.

The most prevalent concerns of these adolescent mothers were that they experienced financial constraints, had difficulties to return to school, and were judged by the community. The needs that they prioritised were: financial support and independence, educational attainment, family support, and support groups for adolescent mothers.

The participants explained that the complexities of an adolescent pregnancy included dealing with an unplanned pregnancy, being compelled to fall pregnant, their partners' negative reaction to their pregnancy, the family's reaction to the pregnancy, and psychological issues. It was found that unplanned pregnancies impacted their lives quite drastically. Prior studies also noted that many adolescent pregnancies were unintended.[7,10,18-20] An important finding was that some young women were victims of imposed pregnancies, which is a phenomenon that is prevalent in South Africa due to societal pressure,[21]

particularly as some men need to 'prove' their fertility.[22] In sub-Saharan Africa, childbearing and motherhood are regarded as integral parts of a woman's life that it is her duty.[23]

Some participants in the current study reported that their partners had desired and insisted on the pregnancy. Such pregnancies were also reported by Mohammadi et al.,[24] who found this practice prevalent among married adolescent Iranian women. Mashala et al.[19] and Ntinda et al.[25] suggest that adolescents may justify their pregnancies by assigning complete responsibility to their partners. Another possible explanation for these young women's willingness to submit to an imposed pregnancy may be attributed to the patriarchal nature of the South African society where male partners still influence the sexual and reproductive decisions of women.[7,10]

Some partners of the participants welcomed the pregnancy while others were in denial of their complicity in the pregnancy. Gyesaw and Ankomah[6] also found that partners' reactions to a pregnancy could be diverse. Previous studies also found that the disclosure of an adolescent pregnancy could upset family members and result in strained relationships.[19,25] The participants in our study reported that their fathers were not supportive ,while their mothers were more supportive once they had grown used to the idea. Strained father-daughter relationships following the disclosure of an adolescent pregnancy were found in South Africa and Swaziland.[19,25] The revelation of suicidal ideation, anger, guilt and shame confirms that pregnant adolescents experience psychological distress. One study suggests that the risk of suicide is three times greater in pregnant adolescents than in adult pregnant women.[26] Moreover, suicidal behaviour is associated with depression, anxiety disorder, physical abuse, and low education levels.[26]

The participants' relationship with the father of the child and father-child interactions were also explored in the current study. The relationships were varied as the fathers of the children were either caring and supportive, abusive, or in denial. Some participants described their relationship with the father of the child as complicated while others stated that the relationship was non-existing. Studies have suggested that when adolescent mothers are no longer involved in a relationship with the father of the child, the risk of the father not being involved in the child's life is great.[27,28] The inability of the father to contribute financially towards the care of the child also leads to the failure of the relationship and the prevalence of the 'absent father' phenomenon.[27] Furthermore, the denial of paternity leads to the non-involvement of the father in the child's life.[7] Our study showed that the actively involved father was financially supportive.

The findings under the subtheme 'it's complicated' suggest that an adolescent woman may have to tolerate the fact that her partner is in a relationship with another woman. Gender power imbalances and

cheating in relationships have been reported by several authors.[29-33] However, the tolerance of adolescent women of their promiscuous partners renders them vulnerable to HIV/AIDS and STDs.[33,34] Some participants' comments about the abusive attitude of their partners also resonate with the literature. Wood and Barter[35] state that adolescent pregnancy and motherhood increases the risk of physical, sexual and emotional violence in relationships and it has been reported that South African women experience high levels of partner abuse or intimate partner violence.[36-39] Adolescent women who are young and submissive are thus at great risk of intimate partner violence.[35]

The theme that emerged regarding the reality of life after pregnancy and during motherhood revealed that the participants felt that their children's needs were their first priority. They struggled with a non-existent social life, loneliness, disruption of schooling, anxiety and stress,[8,40] but their children's needs came first. Leese[2] also found that adolescent mothers realised that their children's needs had to be put before their own. Loneliness, disruption of schooling, the lack of a social life, anxiety and stress are common in the lives of adolescent mothers,[8,19,41,42] while an unsupportive family and a judgmental society also fuel loneliness and depression in adolescent mothers.[43,44]

Clearly, the transition to motherhood can be stressful for adolescents,[8,40] but this study found that they associated their parental responsibilities with nurturing their children. Similarly, adolescent mothers in Swaziland felt that becoming a parent gave them a sense of maturity and the responsibility to provide and care for a child.[25] Ngum Chi Watts et al.[23] argue that, while motherhood brings a lot of responsibilities, African Australian adolescent mothers associated motherhood with a sense of purpose. For many of these mothers, the health and well-being of their children was a primary concern. Melvin and Uzoma[45] found that adolescent mothers in Nigeria regarded child illness as a dreadful condition. According to the current study, additional parenting concerns included obtaining baby consumables such as food and nappies, and securing the future of their children. Being concerned about the future of their children mirrored the fear that adolescent mothers in Swaziland and Nigeria expressed.[25,45]

The problems listed by the adolescent mothers also reflected their needs. Financial hardship was a primary concern, and this was consistent with similar findings by Mashala et al.[19] and Bhana and Nkani[7]. Most participants in the current study indicated that financial constraints, parenting responsibilities and a lack of their families' support resulted in their inability to return to school. This is underscored in South African literature that states that only one third of adolescent mothers return to school.[46] In the current study, it was the participants with repeat pregnancies in particular who associated this phenomenon with dire financial hardship, an increased feeling of isolation, guilt, and physical and emotional draining. This suggests that adolescent repeat pregnancies limit educational attainment and compound the socio-

economic plight of these young women.[14] A repeat pregnancy during adolescence also increases parenting stress and child neglect,[14,47] and thus adolescent repeat mothers are at high risk of depression, anxiety and suicidal ideation.[14,48]

Similar to the views expressed by adolescent mothers in Uganda,[49] all the participants emphasised their need of financial support, independence, and educational attainment. Devito[40] and Vincent[50] comment that adolescent mothers perceive educational attainment as a highly valued goal. The participants also valued family support and the assistance of support groups, particularly as family support is a springboard for assisting them in the attainment of education and financial independence. This correlates with a study by Mulherin and Johnstone,[51] whose participants argued that family support would ease their transition to motherhood. The literature suggests that a lack of social support results in anger and punitive parenting behaviour among adolescent mothers,[52] and thus the influence of social support on the health of children should not be underestimated. Adolescent mothers who participated in a study by de Jonge[53] in Edinburgh also advocated for support groups. The benefits of support groups include improved self-esteem, improved parenting, and improved communication skills.[53]

The negative perceptions that society holds of adolescent mothers was lamented by the participants in the current study. They felt that they were treated as outcasts, strangers and contagious agents. The community would accuse them of being bad role models for younger girls and they found the discrimination and stereotyping they experienced overwhelming. Ngum Chi Watts et al.[23] also found that African Australian adolescent mothers experienced exclusion, rejection and disapproval in their communities.

Societal disengagement with adolescent mothers may occur due to the perception that adolescent childbearing is shameful and the personal failure of these young women.[25] Political discourse in the United States of America and the United Kingdom has generated the view that adolescent pregnancy is a catastrophe and that adolescent mothers are unsuccessful individuals.[54] A similar discourse has plagued South Africa after former President Zuma publicly commented that adolescent mothers should be separated from their children and be sent to Robben Island,[55] which served an infamous jail for political prisoners during the apartheid years. It is undeniable that negative social evaluations of adolescent pregnancy and motherhood impact the psychosocial well-being of young mothers. Adolescent pregnancy and motherhood is a topic that has been surrounded by moral, political and economic discourse,[54] and all the findings discussed above clearly illuminate the controversies associated with this phenomenon. In this context, statements such as the one uttered by the former president intensify the danger of widespread moral opposition to adolescent pregnancy and motherhood.[55]

Amongst all the dire consequences of adolescent pregnancy, financial resources appear to be the most prominent. The participants reported that their grandmothers, biological mothers, the paternal grandmother of the child and their partners provided financial and emotional support to various degrees. Some emphasised that their grandmothers were a positive influence in their lives. Similarly, African American grandmothers play a very important role in supporting parenting adolescent women.[56] A study by Wahn et al.[57] that was conducted in Sweden revealed that adolescent mothers regarded their own mothers as their saviours. Adolescent mothers in Swaziland also turned to their biological mothers for emotional and financial support.[25] This illustrates the importance of the mother-daughter relationship. Mothers of parenting adolescent women are a source of care, financial support and mentoring.[25] Sumo et al.[58] argue that adolescents mothers who have a difficult relationship with their own mothers are at high risk of depression. This situation can be detrimental to the well-being of these mothers and their children. Research has also shown that maternal grandparents often refer to the infant as the agent that connects the families.[58] Grandparents are generally sincere in their efforts to take responsibility for the infant as they view the infant as innocent and not responsible for the adolescent pregnancy.[59]

Little is known about paternal grandmothers' support for adolescent mothers and their children. Studies conducted by Van Zyl et al.[60] and Malindi[61] in South Africa noted that most adolescent mothers viewed their partners' parents as a positive source of support. Some participants in the current study also found that their partners' parents (particularly the mothers) were emotionally and financially supportive. This reinforces a finding by Chideya and Williams[62] that South African adolescent fathers are generally willing to nurture, provide for, and act as role models for their children. Fathers in the latter study acknowledged the financial assistance provided by their parents in caring for their children.[62]

The theme of difficulties in accessing healthcare services suggests that long distances and transportation costs, unsympathetic nursing staff, and limited stocks of medication impact young mothers. A growing body of literature has also revealed that barriers in accessing maternal and child healthcare services include distant geographical locations, long travelling periods, expensive transportation, and healthcare workers' negative attitudes.[63-66] Limited stocks of medication (or stock-out) has particularly been noted in several South African health districts.[67] Sumankurro[63] argues that running out of medication is a barrier to optimal maternal and child healthcare services in low and middle income countries.

The finding that nursing staff demonstrated a lack of empathy towards pregnant and parenting adolescent mothers is supported by earlier South African studies.[22,14, 60] Various participants described healthcare providers as disapproving and rude and they also felt mistreated by them. A study by

Govender et al.[14] among nurses in KwaZulu-Natal revealed that even nurses themselves acknowledged a lack of empathy, discriminatory attitudes, and mistreatment of adolescent mothers by their colleagues.

The participants desired healthcare information on postpartum depression, child development, nutrition, and the effects of using traditional medication to treat their children's illnesses. A study conducted in Thailand by Erfina et al.[68] also noted that adolescent mothers wanted to improve their knowledge of child nutrition, child growth and development, and infectious and chronic childhood diseases. Many South African nurses have insisted that health care workers should embrace the importance of parenting education for adolescent mothers,[14] particularly as they are highly likely to experience challenges with childrearing and postpartum depression. Depression has a negative impact on maternal health, foetal development and mother-infant bonding. A study by Hanley and Long[69] in a semi-rural part of South West Wales among young mothers who had been diagnosed with depression found that these mothers had little prior knowledge of the condition. In this regard, maternal health education should also encompass mental health information.

In South Africa, attention has recently focused on the concept of medical pluralism[70] which occurs when individuals utilise more than one medical system when seeking healthcare.[70] Such healthcare systems include traditional and faith-based systems. It was evident in this study that many participants had been consulting traditional healers and using or contemplated using traditional medication. In Africa, 80% of the population reportedly use traditional medication, particularly in rural African communities, and the prevalence of the use of traditional medication for maternal and reproductive health issues ranges from 21% to 79.9% on this continent.[71] According to Shewamene et al.,[71] traditional medication is commonly associated with a lack of formal education and low income. In the South African context, referring children to traditional healers is common.[72] In fact, traditional healers are sometimes consulted before a medical doctor.[72] Prompted by high rates of herbal intoxication in children, a study by Dambisya and Tindimwebwa[73] in the Eastern Cape among mothers and caregivers found that 57.3% of the respondents had used traditional remedies in the treatment of their children. Disconcertingly, statistics from the peadiatric department at the Umtata General Hospital in the Eastern Cape revealed that 40% of children admitted for herbal intoxication had died.[73] Herbal intoxication can cause severe liver and kidney damage.[73] The fact that the participants requested more information on the effects of using traditional medications is thus warranted.

On a positive note, the participants in this study shared their dreams and aspirations for the future. They envisioned completing their education and focusing on their dream careers and some verbalised the hope of contributing meaningfully to society.[50,74] Previous studies have shown that adolescent mothers can be

resilient and that they can persevere to achieve a brighter future for themselves and their children, and most consider that their future is interconnected with that of their children. A study by O'Brien Cherry et al.[74] in Indiana in the US found that all 52 of the participating adolescents aspired to provide a worthy future for their children by completing school and following a career. Adolescent mothers who had persevered through high school attributed their success to hope, confidence, determination, self-assurance, encouragement, intrinsic and extrinsic motivation, respect, and support from their teachers, alternative classes, the community, life skills programmes, and their peers.[74]

Strengths and limitations

Traditionally, studies on adolescent pregnancies focused on the experiences of first time adolescent mothers. The strength of this study can be attributed to the inclusion of both first time and repeat mothers. However, the study was confined to female participants only. It is acknowledged that adolescent pregnancy and parenting is not a gender specific problem and that the experiences of adolescent men also have important implications for health service delivery. Moreover, the study utilised only a few participants (N=18) and this resulted in only four focus group discussions. Another limitation is that the study was limited to one health facility in one provincial district. However, the adolescent delivery rate is high at this facility. In light of the limitations, the findings of this study may not be generalised and can be transferred only to a similar research setting.

Conclusions

Based on the findings, it was concluded that experiences of adolescent pregnancy and parenting are multifaceted. This argument is corroborated by Govender et al.,[14] who insists that adolescent mothers and their children require a multidisciplinary approach to healthcare. While researchers and policy makers have often viewed adolescent pregnancy and parenting as catastrophic and a societal failure, this study suggests that adolescent mothers envision a better future for themselves and their children, and the authors thus propose that support strategies should be strengthened to guide them on this journey. The findings enhanced our understanding of the medical and psychosocial barriers that stifle the future that adolescent mothers desire, and it was clearly illuminated that the healthcare needs of pregnant and parenting adolescents extend beyond information and knowledge about giving birth. A collation of evidence suggests that interventions that focus on comprehensive medical services, health education, health promotion, psychosocial interventions and school enrolment will have positive outcomes for adolescent mothers and their children.[4] Thus a key policy priority is the collaboration of various professionals from a variety of related sectors to assist adolescent mothers in achieving better health and psychosocial and socio-economic outcomes and to guide them on their way to a better future.

Declarations

Ethics approval and consent to participate

This study was approved by the Bioethics Research Committee of the University of KwaZulu-Natal (ref no: BFC553/16), the KwaZulu-Natal Department of Health (ref no: KZ_2016RP26_545), and the Chief Executive Officer of the district hospital. Written consent was sought and provided by all the participants aged 18 years and above, and consent was obtained from the parents and the participants who were under the age of 18 years.

-Consent for publication

Not applicable

-Availability of data and materials

The data used to elicit the findings of this study are available from the corresponding author upon reasonable request.

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Competing Interests

The authors declare that they have no competing interests.

Author Contributions

DG was the principal investigator, SN was the supervisor, and MT was the co-supervisor. All the authors contributed equally to the preparation of the manuscript.

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Tables

Table 1: Characteristics of the participants

Focus Groups (N=18)	Age categories		Number of participants who were first time adolescent mothers	Number of participants who were repeat adolescent mothers	Number of participants who dropped out of school after pregnancy
	<18 years	>18 years			
1 (5)	0	5	0	5	4
2 (5)	3	2	5	0	2
3 (4)	2	2	4	0	4
4 (4)	0	4	0	4	4
Total:	**5**	**13**	**9**	**9**	**14**

Table 2. The main themes that emerged with supporting verbatim quotes

Theme 1: The complexities of adolescent pregnancy

The theme 'complexities of adolescent pregnancy' underscored the difficult circumstances related to adolescent pregnancy. Factors such as unplanned and imposed pregnancies, partners' and families' reaction to the pregnancy, and psychological issues emerged as subthemes. Some participants experienced denial or rejection by their partners while others' partners were happy and accepted the reality of fatherhood. The families' reactions ranged from anger and disappointment to abandonment, the silent treatment, acceptance, and forgiveness. The participants also described experiences of psychological trauma such as suicidal ideation, guilt, and shame.

Subthemes	Quotes
Unplanned pregnancies	"My pregnancy was not planned. It just happened. We previously used protection during sexual intercourse but this time we forgot" (Snothando, 19 years old). "No, I did not plan to fall pregnant. In fact, everything happened so fast. It was my first sexual experience. I became ill and my mother took me to a private doctor. At the doctor's room, I was tested for pregnancy. The test was positive" (Harriet, 17 years old). "My pregnancy was not planned. My family had chased me away from home because I tended to misbehave. I decided to stay at my friend's house. At my friend's house, I had freedom and no one could control me. I did as I pleased and I got pregnant" (Amahle, 17 years old).
Imposed pregnancies	"I was not ready for a child but my boyfriend told me that his friends were teasing him about not having children. He wanted me to fall pregnant and give him a child. He said this would prove his manhood and this would secure our relationship" (Maya, 18 years old). "Yes, my pregnancy was planned. We never thought that I would fall pregnant so easily. His family had paid lobola (bride-wealth) for me. They wanted a child for their son. They even took me to the hospital for a routine check-up" (Tholothando, 19 years old). "I was in a long term steady relationship with my boyfriend. We started having sex in 2016. I had plans to further my tertiary education in Durban. My 26-year-old boyfriend became jealous and controlling. He impregnated me" (Joyful, 18 years old).
Partners' reactions to the pregnancy	"The father of my baby rejected me. He was concerned about the fact that I had a child with another man. He had no children and was questioning the paternity of the baby. He told me that he would wait for the baby to be born. Throughout my pregnancy I was alone" (Olwethu, 18 years old).

	“My boyfriend was very angry with me. He refused to talk to me. He said he was not ready for the pregnancy. He accepted the child only after she was born” (Puleng, 18 years old). “He didn’t accept responsibility for the pregnancy. He said that anyone could have impregnated me. It was a random sexual encounter and we were not in a relationship” (Jenny, 19 years old). “My partner was very excited. He was 25 years old and wanted a child. He accepted my pregnancy” (Yvonne, 16 years old). “The father of my child was happy because he wanted this child. He also felt that I would belong to him only after the child was born” (Nana, 19 years old).
Family members’ reactions to the pregnancy	My mother was initially very angry. She and my dad refused to speak to me for three months. But my mother eventually accepted the pregnancy. She gave me emotional support and took good care of me during my pregnancy. My father was persistently angry with me. He avoided me. He told my mother that he would not support me financially. He believed I was another man’s responsibility” (Joyful, 19 years old). “My mother was initially angry but she supported me eventually. My father stopped talking to me during the entire time of my pregnancy. He started talking to me once the damages (impregnation) had been paid for by my boyfriend” (Nana, 18 years old). “My family was angry and disappointed with me. My mother refused to speak to me. At a later stage, she accepted my condition and took very good care of me. My other family members also forgave me and supported me” (Smangele, 18 years old). “My family was very angry and ashamed of me. They refused to accept my pregnancy. I continued to live in the house but they refused to take care of me and the baby” (Thobeka, 17 years old). “My family chased me away. They were angry and ashamed that I got pregnant. They refused to support me emotionally and financially. I went to live with my boyfriend” (Amahle, 17 years old).
Psychological issues	“I attempted to kill myself when I found out that I was pregnant. I was scared, angry and overwhelmed. Abortion was on my mind but I was scared that my baby’s spirit would haunt me. My aunt found out that I was pregnant. After we had discussed the pregnancy issue, we decided to tell my other family members” (Smangele, 18 years old).

"When I became sick in March 2017, I suspected that I might be pregnant. I attempted suicide but I failed. Thereafter I took a pregnancy test. The test was positive. I attempted suicide again. This was another failed attempt" (Thobile, 19 years old).

"I felt so guilty and depressed. I had planned to commit suicide as that would have been an easier way to solve my problem. My grandmother prevented me from ending my life. I did not know if I wanted to keep the baby or have an abortion" (Maya, 18 years old).

"I had intense feelings of guilt and shame. I had previously attended the reed dance and I had been so proud of my virginity" (Harriet, 18 years old).

Theme 2: Participants' relationship with the father of the child and father-child interaction

This theme exposed the participants' relationship with the father of the child as well as the prevalence of father-child interaction. Various reactions emerged: the fathers were caring and supportive, some were abusive, others found it complicated, some had a non-existing relationship, others enjoyed the active involvement of the father, while others were left alone as the father of the child abandoned them.

Subthemes	Quotes
Caring and supportive	"The father of my child is very supportive and I like his attitude towards me" (Tholothando, 19 years old). "He is very caring and supportive. We are in a steady relationship" (Harriet, 17 years old).
Abusive	"The father of my child has a bad attitude [i.e., he is temperamental] and is rarely supportive. He uses vulgar language and shouts at me in public" (Snothando, 19 years old). "My child's father is aggressive towards me. The situation is at its worst when he is under the influence of alcohol" (Sbahle, 18 years old).
It is complicated	"He is very caring and loving but he is cheating on me. He is open about his affairs with other women. I have to accept it" (Olwethu, 18 years old). "I am in a complicated relationship. The father of my child is involved with me and another woman. His other partner is my neighbour" (Smangele, 18 years old).
The non-existent relationship	"There is no relationship between myself and the father of my child. Our relationship ended in a very ugly manner" (Puleng, 18 years old).

	"I have no relationship with my child's father. Our encounter was brief and we never kept in touch, even after my pregnancy" (Jenny, 19 years old).
The actively involved father	"He visits us regularly. He plays with the baby. He is also bonding with the baby. He provides for the baby financially" (Yvonne, 16 years old). "The baby's father visits us on a weekly basis and is actively involved in the baby's life. He also accompanies us on clinic visits" (Joyful, 18 years old).

Theme 3: The reality of life since the pregnancy and the onset of motherhood

This theme drew attention to the changes in the participants' lives since experiencing adolescent childbearing. The participants reflected on their changing priorities, a non-existent social life, loneliness, anxiety and stress, and the disruption of their schooling.

Subthemes	Quotes
Children need to become the first priority	"My responsibilities include putting the needs of my children first. Their emotional and financial needs are more important to me than my own needs" (Snothando, 19 years old). "As a young mother of two children, I prioritise their needs. In the past I was always concerned about my needs. Now my children are number one on the list" (Maya, 18 years old). "I have become mature in my thinking and I prioritise my baby's needs. My responsibilities have increased. I have to balance taking care of my baby and attending school" (Smangele, 18 years old).
A non-existent social life	"I am not allowed to socialise because my family does not help me to take care of my children. I don't have time to visit friends or go to parties. I have also been told by my family that I should not go out because I am an embarrassment" (Sbahle, 18 years old). "I don't have time for social activities. In fact, my social life is non-existent. My sisters will not assist in caring for my children if I want to go out with friends (Palesa, 18 years old).
Loneliness	"I feel lonely and isolated. I only have my mother and twin sister. I have no contact with friends" (Jenny, 19 years old). "I feel so lonely and isolated since my pregnancy and giving birth to my child" (Puleng, 18 years old).

	"I am lonely despite having a large family. I also avoid my family because we fight a lot at times" (Sbahle, 18 years old).
Disruption of schooling	"I am now concentrating on my children and their needs. Being a young mother has affected my studies. I chose to raise my children and I dropped out of school" (Snothando, 18 years old). "I dropped out of school during my first pregnancy. I never returned to school because it was hard to raise a baby and concentrate on school work. Besides, I could not afford a nanny (Olwethu, 18 years old).
Anxiety and stress	"Every day I am anxious and stressed about my children and their future. I am an adolescent mother and I struggle with all these responsibilities" (Maya, 18 years old). "It is very stressful because I am accountable for two lives. I have to balance motherhood and trying to care for my myself" (Yvonne, 16 years old). "I feel anxious most of the time. My responsibilities have increased. I feel stressed. I wonder if I am raising my child well. I fear for my child's health" (Harriet, 17 years old). "I find that life has become very stressful these days. I become worried about my future. Being a young mother is overwhelming" (Olwethu, 18 years old).

Theme 4: Parenting responsibilities

This theme demonstrated that the participants positioned themselves in a parenting role by accepting their responsibilities as nurturers and providers.

Subthemes	Quotes
Nurturer and provider	"I am responsible for making sure my children are happy. I am also providing for their needs by earning an income in my tuckshop. I take them to the clinic when they are ill" (Sbahle, 18 years old). "My responsibilities include supporting my child financially and providing him with love. I also believe that my responsibilities include his health and well-being" (Sphe, 16 years old). "I have to provide for another life emotionally, physically and financially" (Thobeka, 17 years old). "I have to take important decisions concerning my child. I have to provide for her emotional and physical needs" (Mary, 19 years old).

Theme 5: Sources of financial and emotional support

The participants referred to various sources of financial and emotional support, and this illustrated the prevalence of a supportive network of women in the lives of adolescent mothers and their children.

Subthemes	Quotes
Grandmothers	"My granny supports me emotionally and financially. I also use the child grant to survive financially. My grandmother gave me more advice than the healthcare workers about how to care for my children. She tries her best to assist me" (Snothando, 19 years old). "My maternal grandmother is very supportive. I can talk to her about my problems. She also buys clothes for me and my children because the child support grant is inadequate. I learnt from my grandmother how to care for my children. She taught me about home remedies that really work. She taught me how to bathe, dress and feed my children. She loves my children a lot" (Maya, 18 years old).
Biological mothers	"My mum is my biggest supporter. She tries her best to help us emotionally and financially" (Olwethu, 18 years old). "My mother assists me emotionally. My mother is very kind because we live on her grant. I could not apply for a child support grant because I don't have an identity document" (Jenny, 19 years old).
Partners' mothers	"My family at home do not give me any money because they consider my pregnancies to be my mistake. They do not support me emotionally either. So my partner's mother gives me money. She is also kind and understanding about my problems. I use the money to buy things for my tuckshop at home. It provides me with an income" (Sbahle, 18 years old). "My partner's mother is a very giving person. She assists me financially and emotionally. She always tries to find out what my needs are although she is also poor" (Palesa, 18 years old).
Partners	"My baby's father supports us emotionally and financially. I can contact him whenever I need nappies or baby formula" (Yvonne, 16 years old). "I would describe my partner as my rock. He supports me emotionally and financially. I am coping because of him" (Tholothando, 19 years old).

Theme 6: Parenting concerns

The participants expressed various concerns regarding raising their children. They perceived the following as their parenting concerns: the health and well-being of their child/children, procuring baby consumables, and

securing a future for their child/children.

Subthemes	Quotes
Health and well-being of the child/children	"I am most concerned about my child's health and well-being. Children are fragile and as a young mother you always wonder if you are doing everything correctly. I don't have the experiences of older mothers" (Sphe, 16 years old). "I am scared that my children will become ill. I am always worried that I may not be taking care of their health correctly" (Snothando, 19 years old). "The health and well-being of my children are my concern. My four-month-old child has severe eczema and I feel so helpless to see him in pain (Jenny, 19 years old).
Procuring baby consumables	"I think I worry most about not having enough food, clothes and nappies for my baby. I don't always have enough money for baby formula. I borrow [money] from my neighbour" (Puleng, 18 years old). "I am always concerned about not having enough products for my baby's needs. I often run out of money so I don't have enough baby formula and nappies. I buy cheap nappies and this causes a rash" (Thobeka, 17 years old).
Securing a future for the child/children	"I am scared that I will not satisfy my child's needs. I feel anxious about the future and wonder if I will be in a stable position to provide for all his needs as he develops" (Harriet, 17 years old). "I am concerned about the future. I don't know if I will be able to provide a secure future for my children. I am scared that I won't be able to meet the demands of my growing children. My partner is unemployed. My family refuses to take care of my children financially" (Palesa, 18 years old).

Theme 7: Difficulties in accessing healthcare services

The participants acknowledged that they experienced difficulties in accessing healthcare services for themselves and their children.

Subthemes	Quotes
Long distances to and from the clinic and transportation costs	"The clinic is very far from my house. I have to travel about 40 kilometers to my clinic. This is also costing me a lot of money" (Sbahle, 18 years old). "The clinic is very far from home. Taxi fares are expensive. It takes me two hours to reach the clinic. I always have to find someone to accompany me to the clinic. I was raped at the

	age of 10 years and since then I am scared to go to the clinic alone" (Jenny, 19 years old). "Transport to the clinic is expensive. The clinics are far and the mobile clinics are not efficient. The mobile clinics do not have enough medication" (Palesa, 18 years old). "The clinic is far from home and it takes two taxis to reach the clinic. The transportation costs are high and I borrow transport money. Transport delays cause you to reach the clinic late and then the nurses get angry with you" (Puleng, 18 years old). "I don't always have money for transport. The clinic is far from my home" (Mary, 19 years old).
Unsympathetic nursing staff at clinics	"The nurses turn you away if you reach the clinic at midday. They give you a return date. They are also very slow at the clinic" (Thobile, 19 years old). "The nurses become aggressive at the clinics when they see adolescent mothers. They scold you. They make fun of you. The queues are long and they make us wait" (Snothando, 19 years old). "Transport delays can't be controlled. We arrive late at the clinic and the nurses shout at patients even if it's not their fault. This makes me so scared to even go to the clinic" (Maya, 18 years old).
Limited medication at clinics ('stock-outs')	"Sometimes the clinic does not provide the necessary medication. They tell you to use home remedies" (Sphe, 16 years old). "It's difficult to get to the clinic and it becomes disappointing when they don't have medication for your child. They give you advice on home remedies" (Joyful, 18 years old). "We do not always receive medication at the clinic. We become so disappointed and we don't understand why the clinic is operating without medication" (Nana, 19 years old).

Theme 8: Negative experiences with healthcare providers

This theme revealed that the participants' experiences with healthcare workers at the health facilities they had access to were not always positive.

Subthemes	Quotes
Disapproving and rude	"The nurses do not approve of adolescent mothers. They think we are a burden to the healthcare system. They embarrass us in the queue. The nurses even gossip with each other about us" (Maya, 18 years old).

	"Doctors and nurses shout at adolescent mothers and complain that we are irresponsible having children at a young age" (Jenny, 19 years old). "The nurses embarrass us when we are sitting in the queue and also pinpoint us as adolescent mothers. They are rude when they speak to us. I feel sad because I want their help and not their judgement" (Sphe, 16 years old).
Mistreatment	"Nurses are not friendly. They treat you badly during labour because they think adolescent mothers are bad. In antenatal clinics, we are scared sitting with older mothers. We know that nurses will shout at us. They also shout at us when we take our babies for immunization. I feel that they are rough with our babies" (Olwethu, 18 years old). "The nurses treated me badly during my pregnancy. They embarrassed me at my first antenatal visit. The doctors can also be judgmental. They say things like 'adolescent mothers are very proud to fall pregnant at a young age'" (Snothando, 19 years old). "Nurses at the clinic treated me badly. If they don't have the medication we need, they tell us to buy it with our own money. I once told the nurse I didn't have money to buy the medication. She asked me then why did I have a baby if I didn't have money" (Thobeka, 17 years old). "I feel mistreated. Nurses shout at younger mothers. The nurses say that they don't have medication for the babies and they refuse to assist you if you missed the immunisation date" (Joyful, 18 years old).

Theme 9: The impact of an adolescent repeat pregnancy

Nine of the participants had a repeat pregnancy during their adolescent years. This theme exposed some effects of a repeat pregnancy on these adolescent mothers' lives.

Subthemes	Quotes
Increased financial hardship	"I need more money to raise two children. Both my children are still using diapers. The financial hardship has definitely increased. I am also owing people money" (Sbahle, 18 years old). "My repeat pregnancy has resulted in a financial burden for me and my grandmother. I need more financial assistance to raise my children. The financial problems do get worse for the entire family when a second baby comes unexpectedly" (Maya, 18 years old).
Increased	"I am much lonelier and more secluded. I have no time for socialisation. The time I have is

feelings of social isolation	only for both my children" (Mary, 19 years old). "My repeat pregnancy has made life very challenging. I feel secluded. I don't have a social life. I miss my mother who passed away because I have no emotional support (Palesa, 18 years old).
Feeling physically and emotionally drained	"I am physically and emotionally tired every day. I find it hard to balance my time between both children. They are both young and require my attention" (Snothando, 18 years old). "I have sleepless nights. I am tired even in the mornings. My children are both demanding of my time. I am emotionally overwhelmed with the responsibility of two children" (Tholothando, 19 years old).
A sense of guilt about spending more time with one child than with the other	"I feel like my eldest child is being neglected. I feel guilty as a mother. I leave him to play by himself sometimes because my second child is young" (Sbahle, 18 years old). "I feel that my repeat pregnancy has resulted in me having less time for my older child. I have time constraints. I feel that sometimes I forget that I have two children (Jenny, 19 years old). "I spend more time taking care of the new baby. It makes me sad that my eldest child doesn't get much attention" (Olwethu, 18 years old).

Theme 10: Problems experienced by adolescent mothers

The participants perceived the following to be their problems: financial constraints, difficulty to return to school, and exposure to a judgmental society. They felt that society regarded adolescent mothers as outcasts and criminals and that their condition was 'contagious'. They emphasised discrimination and stereotyping by society as well.

Subthemes	Quotes
Financial constraints	"Financial issues have been a huge problem in my life. I have to ask for money. I have learnt the hard way that raising a baby is costly" (Puleng, 18 years old). "I am not financially independent. The child support grant is inadequate and I cannot afford to buy much for my child" (Sphe, 16 years old). "I have financial problems. I don't have a child support grant. I have to borrow money from friends for baby formula and clothes. I don't have the support of my family" (Amahle, 17 years old).
Difficulty	"I have not been able to return to school because I don't have any support to look after my

returning to school	child. I am also very demotivated" (Thokeka, 17 years old). "I found it extremely difficult to return to school. I didn't have a nanny and I did not have the support of my family to return to school and nobody to look after my two children (Sbahle, 18 years old).
Exposed to mockery and judged by the community	"The community treats adolescent mothers differently from other adolescent girls. They want to isolate us from other adolescent girls who have not fallen pregnant. They tell them not to be friends with us. They complain that we are a bad influence" (Maya, 18 years old). "Community members complain about adolescent mothers and say they will influence other young girls to also misbehave. They compare us to other girls who are not adolescent mothers. They tell these girls not to associate with us. The stigma is overwhelming" (Puleng, 18 years old). "The community treats teenage mothers like criminals. They are not kind and use harsh words to describe adolescent mothers" (Yvonne, 16 years old). "The community isolates adolescent mothers. They don't want them to socialise with other young girls because they think we are a bad influence" (Thobeka, 17 years old). "The community stigmatises adolescent mothers. They embarrass us by calling us names. This treatment makes me feel aggressive" (Amahle, 17 years old). "There is mixed reaction in the behaviour towards adolescent mothers. Some think that teenage mothers are a bad influence on other girls and some are supportive and kind. I was told by some community members to drop out of school because I am a failure" (Sphe, 16 years old). "The community members enjoy gossiping about adolescent mothers. They consider us to be irresponsible and they verbalise that adolescents fall pregnant deliberately for the child support grant. They don't believe that we use injectable contraceptives" (Mary, 19 years old). "Members of the community gossip about adolescent mothers and tarnish our image further. They call us vulgar names and treat us worse than criminals" (Palesa, 18 years old).

Theme 11: The needs of adolescent mothers

With reference to their needs, the participants listed the following: financial support and independence, educational attainment, family support, and the assistance of support groups.

Subtheme	Quotes
Financial support and independence	"I want to be financially independent so that I can secure my future" (Sphe, 16 years old). "As a young mother, I need to become financially independent so that I can take care of my children and end my grandmother's financial burdens" (Maya, 18 years old). "I need more financial support because my mother's grant money is not enough to meet my children's needs" (Jenny, 19 years old).
Educational attainment	"I need to return to school and complete my matric. I also need emotional and financial support" (Amahle, 17 years old). "My greatest wish is to complete my matric and I need to go back to school (Mary, 19 years old). "I dropped out of school after falling pregnant. I need to return to school as I want to complete my schooling. I need to also attend university" (Nana, 19 years old). "I need to complete high school and focus on tertiary studies and finding a job" (Yvonne, 16 years old). "I need to finish my matric. I need a bursary to study further" (Snothando, 19 years old). "I need to improve myself academically by completing school and attending university" (Thobile, 19 years old).
Family support	"I need emotional and financial support from my family. Family support is important because adolescent motherhood can be difficult" (Harriet, 17 years old). "I want more emotional support from my family. They are still angry with me because I fell pregnant at a young age. I really need their support in order to progress in life" (Puleng, 18 years old). "I wish my family were more supportive. Their anger and resentment towards me have not subsided. I crave their affection for me and my children" (Sbahle, 18 years old).

	"I want to apologise to my parents. I want their forgiveness. I want their emotional and financial support" (Thobeka, 17 years old).
Support groups	"I need a support group that can help me cope emotionally. The loss of my mother is like a vacuum in my life" (Palesa, 19 years old). "I need a support group that helps adolescent mothers. I really need the motivation" (Olwethu, 18 years old). "I wish that I could talk to other adolescent mothers about my problems. I think I need a peer support group. It is difficult to open up to other peers who have not been in your shoes" (Maya, 18 years old).

Theme 12: The need for health related information

The participants agreed that they required health related information to make informed decisions.

Subthemes	Quotes
Postnatal depression	"I read in pregnancy magazines about postnatal depression. I still don't understand postnatal depression that well. I wish the nurses could teach us more about this condition because it affects women who have given birth" (Maya, 18 years old). "I would like to know about postnatal depression. Nobody explained this condition to me and how it would affect me and my baby" (Snothando, 19 years old). "I want more information on postnatal depression" (Sphe, 16 years old).
Child development	"I would like more information on child development" (Nana, 19 years old). "I would like more information on how to tell if my baby is growing well (Olwethu, 18 years old). "My child's development is important and I need information about normal child development" (Harriet, 17 years old).
Nutrition	"I would like more information about healthy eating and weight gain for the baby" (Sbahle, 18 years old). "I am interested in nutritional advice so that I can give my baby healthy food to eat. The nurse said my baby was underweight" (Puleng, 18 years old).
The effects of	"The elders advise us to use traditional medication for our babies. I would like the nurses

using traditional medicine	and doctors to advise us if traditional medication is safe" (Amahle, 17 years old). "I want to know if I can use traditional medication to treat my baby's fever" (Joyful, 18 years old). "Sometimes there is no medication at the clinic. My neighbours advise me to use traditional medication because they say it is more efficient. I want to know if traditional medication is safe for my baby" (Thobeka, 17 years old).

Theme 13: Dreams and future aspirations

The participants admitted that they had dreams and aspirations for the future. There was an overwhelming thirst for education, to have a good career, and to be a person who contributes to society.

Subthemes	Quotes
Education and career	"I want to complete high school and obtain a matric certificate. I will attend university to study towards a degree in social work (Nana, 19 years old). "I need to find a cooking school to provide the skills that I need to become a chef" (Jenny, 19 years old). "I want to become a successful lawyer. I want to give my child the life that I could not have" (Amahle, 17 years old). "I want to become a teacher and be financially independent" (Mary, 19 years old). "I have a great interest in food and nutrition. I want to become a dietician" (Joyful, 18 years old). "I want to go back to school so that I can complete my matric. I will then study to become a nurse" (Sbahle, 18 years old).
Contributing to society	"My dream is to become a medical doctor and help my community" (Thothando, 19 years old). "I want to prove to society that adolescent mothers also have dreams. My dream is to become a social worker and help educate young girls to make better choices in life than I did. I want to be able to serve my community and make my grandmother proud of me" (Maya, 18 years old).