

**THE BURDEN OF CARE EXPERIENCED BY FAMILIES WITH
TEENAGE MOTHERS IN A SELECTED TOWNSHIP IN
MPUMALANGA**

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DECLARATION

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Date

DEDICATION

I dedicate this study to my heavenly father who has been there for me and knew me before I was formed in my mother's womb.

ACKNOWLEDGEMENTS

- My heavenly father God who directs my path.
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ABSTRACT

INTRODUCTION

In South Africa, 30 per cent of teenagers admit to “ever falling” pregnant. Most teenage mothers live with family members, are unemployed and still attending school. Various forms of care provided include emotional care, financial care and physical health care including access to resources. Family members provide teenage mothers with care throughout antenatal and postnatal period. Families find themselves challenged with the burden to provide care for the teenage mother and baby, as pregnancy is unplanned.

AIMS/OBJECTIVES

The aim of the study is to explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.

RESEARCH DESIGN AND METHODS

Qualitative design, this method was used to explore and describe experiences of families with teenage mothers with regard to the burden of care in a selected township in Mpumalanga. A total number of seven families who care for teenage mother were included. Semi-structured interviews were conducted until data saturation was achieved. Data analysis was done using the eight steps of Tesch’s data analysis method, and in doing so ethical consideration and trustworthiness were ensured.

It emerged that families are burdened with provision of care to the teenage mother: socially, psychological and financially including meeting the physical health needs of teenage mother and baby. Recommendations in the study included the involvement of health experts to assist families on handling issues that emerged after teenage pregnancy. A need to formulate specific policies regarding the support of families with teenage mothers by relevant departments is eminent.

CONCLUSION

The conclusion made is that families need diverse support to provide care to teenage mother and baby.

KEY WORDS

- Burden of care
- Families
- Teenage mothers
- Township
- Mpumalanga

TABLE OF CONTENTS

DEDICATION	III
ACKNOWLEDGEMENTS	IV
ABSTRACT.....	V
KEY WORDS	VI
LIST OF TABLES	X
LIST OF ABBREVIATIONS / ACRONYMS	X
CHAPTER 1 INTRODUCTION AND BACKGROUND	1
1.1 INTRODUCTION AND BACKGROUND	1
1.2 PROBLEM STATEMENT	4
1.3 SIGNIFICANCE OF THE PROPOSED STUDY	5
1.4 RESEARCH QUESTION(S)	5
1.5 OBJECTIVES	6
1.6 CONCEPT CLARIFICATION	6
1.6.1 <i>Families</i>	6
1.6.2 <i>Teenage mother</i>	6
1.6.3 <i>Experience</i>	7
1.6.4 <i>Burden of care</i>	7
1.7 PHILOSOPHICAL ASSUMPTIONS	8
1.7.1 <i>Paradigm</i>	8
1.7.2 <i>Assumptions</i>	8
1.8 DELINEATION	9
1.9 RESEARCH METHODOLOGY	10
1.10 ETHICAL CONSIDERATIONS	10
1.11 DISSEMINATION OF RESULTS.....	12
1.12 CONCLUSION	12
CHAPTER 2 RESEARCH DESIGN AND METHODS	13
2.1 INTRODUCTION	13
2.2 RESEARCH QUESTION(S)	13
2.3 RESEARCH OBJECTIVES	13
2.4 RESEARCH AIM.....	14

2.5	RESEARCH DESIGN	14
2.5.1	<i>Exploratory research design</i>	15
2.5.2	<i>Descriptive research design</i>	15
2.5.3	<i>Contextual research design</i>	15
2.6	CONTEXTS	16
2.7	RESEARCH METHODS	16
2.7.1	<i>Population</i>	16
2.7.2	<i>Sample and sampling</i>	17
2.7.3	<i>Purposive sampling</i>	17
2.8	DATA COLLECTION	17
2.8.1	<i>Pilot study</i>	18
2.8.2	<i>Preparation phase</i>	19
2.8.3	<i>Interviewing phase</i>	20
2.8.4	<i>Post-interviewing phase</i>	21
2.9	DATA ANALYSIS	21
2.10	TRUSTWORTHINESS	22
2.10.1	<i>Credibility</i>	22
2.10.2	<i>Transferability</i>	23
2.10.3	<i>Dependability</i>	24
2.10.4	<i>Confirmability</i>	24
2.11	SUMMARY	24
CHAPTER 3 FINDINGS AND DISCUSSIONS		25
3.1	INTRODUCTION	25
3.2	DEMOGRAPHIC DATA OF FAMILIES	25
3.3	DATA DISCUSSION	26
3.4	SOCIAL BURDEN OF CARE	27
3.4.1	<i>Cultural practises regarding pregnancy outside marriage</i>	27
3.4.2	<i>Social impact on the family</i>	30
3.4.3	<i>Social impact on teenager's mother family</i>	33
3.5	PSYCHOLOGICAL BURDEN OF CARE	36
3.5.1	<i>Reaction of family members</i>	37
3.5.2	<i>Parents' emotions</i>	41
3.6	FINANCIAL BURDEN OF CARE	46
3.6.1	<i>Financial stability of families</i>	46

3.6.2	<i>Source of Income</i>	49
3.7	COPING WITH PREGNANCY AND OUTCOMES.....	51
3.7.1	<i>Coping mechanisms</i>	51
3.7.2	<i>Problems related to pregnancy</i>	54
3.8	CONCLUSION	58
CHAPTER4 CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS		59
4.1	INTRODUCTION	59
4.2	CONCLUSION	59
4.3	AIM OF THE STUDY.....	59
4.4	RESEARCH QUESTION	59
4.5	RESULTS OF THE STUDY	60
4.5.1	<i>Social burden of care</i>	60
4.5.2	<i>Psychological burden of care</i>	61
4.5.3	<i>Financial burden of care</i>	62
4.5.4	<i>Coping with pregnancy and outcomes</i>	63
4.6	RECOMMENDATION OF THE STUDY	64
4.7	LIMITATIONS.....	65
4.8	CONCLUSION	65
LIST OF REFERENCES.....		66
ANNEXURES.....		77
	ANNEXURE A: DECLARATION REGARDING PLAGIARISM.....	77
	ANNEXURE B: DATA COLLECTION INSTRUMENT.....	78
FINANCIALLY.....		78
SOCIALLY		78
	ANNEXURE B2: ULUHLA LOKUCALA LEMIBUZO	79
	ANNEXURE C1: PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT FORM	80
CONSENT TO PARTICIPATE IN THIS STUDY		81
	ANNEXURE C2: IMINININGWANE NGESIFUNDO KANYE NEKUSIBANDAKANYA	83
	ANNEXURE D: LETTERS OF APPROVAL	85
	ANNEXURE D: LETTERS OF APPROVAL	86
	ANNEXURE D: LETTERS OF APPROVAL	87

LIST OF TABLES

Table 3.1: Demographic data of families

Table 3.2: Themes, categories and sub categories

LIST OF ABBREVIATIONS / ACRONYMS

Abbreviation / acronym	Meaning
DOH	Department of Health
WHO	World Health Organisation

CHAPTER1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION AND BACKGROUND

Most of the time teenagers who become mothers still live with their families who provide for their needs such as emotional support, access to health care resources, schooling needs and financial needs (Udjo, 2014:504). In addition, the need to accommodate the new baby and the teenager partner's family puts social strain on the families (East & Chien, 2013:183). The demands due to being a teenage mother and her baby all add up to create a burden of care to families.

Teenage pregnancy is a global health, social and economic problem experienced differently by both developed and developing countries. A total of 8-15 per cent of teenagers globally gave birth before the age of 15 years in developing countries (Chandra-Mouli, Camacho & Michaud, 2013:8). Evidence from sub-Saharan Africa indicates that 35 per cent of teenagers between ages 15-19 years had an unplanned pregnancy whilst in unstable relationships (Mkhwanazi, 2009:83). South Africa also experiences an increased number of teenage pregnancies reported among the school-going age group, which is estimated at 30 per cent. Most teenage pregnancies are unplanned (Branson, Ardington & Leibbrandt, 2013:2; Jewkes, Morrell & Christofides, 2009:675).

Pregnant teenagers are dependent on the family for care provision for the baby, sometimes in a resource constrained environment due to unemployment and poverty experienced by many families in South Africa. The burden of care experienced by the family becomes more pronounced where family resources are restricted due to poor economic status (East & Chien, 2013:183). Scientific evidence on the burden of care experienced by families with teenage mothers indicates the following as the essential problems: financial constraints, increase in fights between siblings, emotional problems such as stress and the need to accommodate the new baby and the

teenager partner family (East & Chien, 2013:183). It is therefore necessary to explore and describe the burden of care experienced by families with teenage mothers in order to inform the practice and provide the needed support and care to such families.

Burden of care is a term that is used to describe a situation of “enduring stress and frustration” when providing care to a family member (Etters, Goodall & Harrison, 2008:423). There are subjective and objective burden of care. Subjective burdens of care imply the presence of secondary stressors such as an additional family member, emotional stress and low socio-economic factors. Objective burden of care refers to the primary stressors linked to the dependence and need of assistance of family members with provision of basic care for basic health needs (Pearlin, Mullan, Semple & Skaff, 1990:583).

When families experience teenage mothering, some do so with experiencing a minimal burden of care while some experience a major burden of care as early as the prenatal period (Brandon, Pitts, Denton, Stringer & Evans, 2009:201). The prenatal stage is very sensitive as mother-to-be may experience stress and additional emotional problems, which could increase the burden of care to the family. Consequently, after delivery the teenager’s relationship with her baby is crucial because they are both vulnerable; especially in poverty-stricken situations where negative social, emotional and health outcomes are likely to result (Chigona & Chetty, 2008:261).

On the other hand, burden of care experienced by families with teenage mothers is reported to be due to the acceptance of the new-born into the family. Birthing during the teenage stage is coupled with health problems that are probable for the mother and unborn baby. Teenagers who give birth may experience pregnancy associated complications such as low infant birth weight, infant mortality and preterm labour (Willie, Powel & Kershaw 2016:19). Family members assess the intensity of the complications that the teenage mother and her baby may experience, but they also experience feelings of joy, fear and worry for the teenage mother and baby (Frisman, Eriksson, Pernehed & Morelius, 2012:3297). Teenage motherhood creates health and

social problems for the family, including medical and psychosocial challenges in the teenager's life; this problem is experienced in both developing countries and developed countries (Moni, Nair & Devi, 2013:49).

Whether the families will experience more of the subjective or objective burden of care depends on several factors related to the teenager. The acceptance and adjustment of teenagers to be teenage mothers and the outcomes of the teenage pregnancy would determine the burden of care that will be experienced by the family. Instances where the teenager deliberately ignored the parental advice inflict guilt to the teenage mother and may affect coping with prenatal care. Relationships with partners may be relatively filled with uncertainty and anxiety. Some teenage mothers prefer not to show their partners how they feel about motherhood and changes at home, even though living with little or no support (Kershaw, Murphy, Lewis, Divney, Albritton, Magriples & Gordon, 2014:197).

The burdens of care in families with teenage mothers who are unemployed present financial demands to the family, some of these demands are addressed by the South African government. South Africa is a developing country that has introduced a well-developed social protection system; child support grants are one of the implemented programmes to curb financial demands. The aim of such a system is to assist children from poor families and teenage mothers of ages 0-18 years with a child support grant (Jewkes, Morrell & Christofides, 2009:675). Teenage mothers receiving child support grants are mostly unemployed, single parents and some have a low level of education, thus they need support as to how to use the grant money (Udjo, 2014:504). There is a general need to explore and describe the objective and subjective burdens of care experienced by families with teenage mothers in a selected township in Mpumalanga due to the teenage pregnancy rate in south Africa.

1.2 PROBLEM STATEMENT

For the period 2008-2009, the statistics of teenage pregnancies and teenage mothers in a selected primary health care facility in Mpumalanga where the researcher is employed was 30 per cent of total pregnancies. The researcher works in mother and child services and observed that the burden of care for some parents start early during their teenage daughter's transition to motherhood, as they accompany the teenager to the clinic for pregnancy confirmation. Some parents accompany the teenager to the antenatal clinic, during labour and to the post-natal visits at the clinic. Family members, who accompanied the teenager to these visits verbalised that teenage pregnancies are mostly unplanned and affect their limited resources, therefore they need additional support and structure.

Teenage mothers are faced with many responsibilities and decisions to make after having a baby, including: to pursue schooling or not, child care responsibilities and changes in social life (Moni, Nair & Devi, 2013:54). There is a need for a positive relationship between a teenager and her parents so as to create a valuable source of social support that is needed when teenagers become mothers and is going back to school (Harville, Madkour & Xie, 2014:287). A positive teenager relationship with parents creates a good base of teenager birth and parenting outcome, unlike a negative relationship that may magnify the burden of care experienced by the family during the prenatal, perinatal and post-natal period (Elsenbruch, Benson & Rucke, 2007:869).

The involvement of families to support the teenage mother is supported by Caldeira, Meringi, Oliveira, Domingo and Goncalves (2012:110), who found that mothers welcome the pregnant teenager and offers her emotional and affective support so that the teenager can ascend to motherhood with ease and safety. Teenage pregnancy causes burden to families, which lead to an additional number of family members, financial burden and social burden of care, however there is still limited information

regarding burden of care experienced by families with the teenage mothers in a selected township in Mpumalanga.

1.3 SIGNIFICANCE OF THE PROPOSED STUDY

The study might be of benefit to family members, the practice of family nursing and policy development departments. Regarding the family members, this study might benefit family members who are experiencing a burden of care as they will communicate and be aware of the burden of care they are experiencing during the interview. In family nursing practice, there might also be advancement regarding interventions to support families with teenage mothers. For policy development and implementation, the information from the study findings might guide the Mpumalanga Department of Health on addressing the care needed by families with teenage mothers.

1.4 RESEARCH QUESTION(S)

The research answered these questions:

Main question:

- What is the burden of care experienced by the families with teenage mothers in a selected township in Mpumalanga?

Two other questions asked:

- What is the financial burden of care experienced when caring for a teenage mother?
- What is the social burden of care experienced when caring for a teenage mother?

1.5 OBJECTIVES

The objectives of the study are to:

- Explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.
- Explore and describe the financial burden families experienced when caring for a teenage mother.
- Explore and describe social burden of care families experienced when caring for a teenage mother.

1.6 CONCEPT CLARIFICATION

The following concepts are included in this study:

1.6.1 Families

Families are small sets of groups of people with very close relations including marriage and kinship in social life (Hua, Guo, Han & Wei, 2017:21). In this study, families included people who are blood relatives, including teenager mother, father, brothers, sisters, aunts, grandparents, uncles who are residing with the teenage mother, share common interest and are providing care to a teenage mother and baby.

1.6.2 Teenage mother

Teenage mother is a female between the age of 13-19 years who is unmarried with an unplanned pregnancy (Seutlwadi, Peltzer, Mchunu & Tutshana, 2012:426). In this study, teenage mothers referred to females between the age of 13-19 years who would have given birth to a baby who is alive and the teenage mother is still living with her family members and depending on the family members for support.

1.6.3 Experience

Experience reflect on what a particular person really thinks or on what actually happened (Karapanos, Martens & Hassenzahl, 2012:850). In this study, experiences included the actual events that family members encountered during the teenage mother pregnancy and post pregnancy when the baby was born to date.

1.6.4 Burden of care

Burden of care is the situation of “enduring stress and frustration” by family members when providing informal and formal care to family member (Stensletten, Bruvik, Espehaug & Drageset, 2014:2). Burden of care is divided in to two categories namely subjective burden of care and objective burden of care, however in this study subjective burden was used. Subjective burden of care implies the presence of secondary stressors such as an additional family member, emotional stress and low socio-economic factors (Etters, Goodall, & Harrison, 2008:423). In this study, burden of care referred to families who have to provide care to the teenage mothers and baby, and experience the added burden of adjusting to the new born and teen mother financially, socially and psychologically.

- **Social burden of care**

This refers to the presence of secondary social stressors such as the age of the child, gender, school education, living status and the consuetude to take care of an individual (Awwad, Ghazeeri, Hannoun, Isaacson, Abou-Abdallah & Farra, 2012:1276). In this study, social burden of care referred to families who provided social care for teen mother and her baby.

- **Psychological burden of care**

Psychological burden of care refers to the presence of secondary psychological stressors such as emotional distress, anxiety and depressive feelings of family members (Awwad et al., 2012:1276). In this study, psychological burden referred to

the psychological impact that family members experienced while they cared for the teen mother and her baby.

- **Financial burden of care**

Financial burden of care refers to the presence of secondary financial stressors such as decreased family income and wage (Huang, Jin, Liu & Gao, 2015:5). In this study, financial burden of care referred to the financial impact that families experienced while adjusting to financial caring for the teen mother and her baby.

1.7 PHILOSOPHICAL ASSUMPTIONS

1.7.1 Paradigm

A paradigm is organising framework (Mertens, 2014:469) that enables researchers to examine the underlying belief systems that guide their work (Denzin & Lincoln, 2005:200). There are two paradigms that dominate nursing research known as positivism and post-positivism. Positivism research activity is directed at understanding a phenomenon and value objectivity, personal beliefs and biases are not considered. Constructivist paradigm is one type of post-positivism that says reality is not a fixed entity but a construction of individual's participation in research. Constructivism focuses on understanding the human experience as it is lived, through collection and analysis of qualitative materials that are narrative and subjective in nature (Polit & Beck, 2012:11). This study used a constructivist paradigm, as the researcher intended to collect narratives and subjective data by exploring the burden of care experienced by families with teenage mothers.

1.7.2 Assumptions

An assumption is a principle that is accepted as being true based on logic or custom without proof (Polit & Beck, 2012:720). The assumptions applied in this study were ontological, epistemological and methodological.

- **Ontological assumptions**

Ontological assumptions relate to the nature of reality, reality is multiple and subjective in a constructivist paradigm, as told by individual participants (Polit & Beck, 2012:13). The reality is that teenagers who fall pregnant and become mothers, are living with family members who in turn care for the teenager and the baby thus ending in burden of care.

- **Epistemological assumptions**

Epistemological assumptions are the structure of our knowledge rather than its content (Botma, Greeff, Mulaundzi & Wright, 2010:40). The epistemology is what we know and how we come to know through research study. The researcher generated new knowledge about the burden of care experienced by families with teenage mothers, the experiences of caring for a teenage mother and how families adapt to care for teenage mothers in a selected township in Mpumalanga.

- **Methodological assumptions**

Methodology outlines the rules and procedures that the researcher uses on how to investigate what she believes must be known (Polit & Beck, 2012:12). The researcher used a qualitative research design method in order to be able to explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.

1.8 DELINEATION

The study focused on family members who experienced a burden of care while living with a teenage mother. Only family members who cared for the teenage mothers who have given birth in 2015 were included in this study as they had experienced prenatal, delivery and postnatal care provision.

1.9 RESEARCH METHODOLOGY

In this study, qualitative design and methods were used to explore and describe research questions. The population were family members who were older than 18 years. Purposive sampling was selected in this study; semi-structured interviews were conducted until data saturation was achieved. Data analysis was done using the eight steps of Tesch's data analysis method. Research methodology are techniques that are adopted by the researcher in order to structure a study and to collect and analyse data relevant to answer a research question (Polit & Beck 2010:16). Research methodology will be explained in chapter 2.

1.10 ETHICAL CONSIDERATIONS

Permission was requested from the University of Pretoria research ethics committee before the study was conducted. The researcher requested permission from the primary health facilities' manager. Written informed consent was obtained from family members who cared for teenage mothers. The following ethical principles were applied in the study.

- **Beneficence**

Beneficence is the duty of researchers to minimise harm and maximise benefits (Polit & Beck, 2012:152). The researcher ensured that no harm was incurred by the participants by ensuring that interviews took place in a safe environment, either health facility or church attended by participants. The family members discussed with the researcher about home visits or conducting the interviews in order to eliminate unnecessary risk or discomfort. The researcher minimised participant's exploitation by providing participants with an overview of what the study was about and no emotional provoking questions were used. Painful experiences by teenage mothers as a result of families narrating their experiences were prevented by excluding all teenage mothers as participants. Families who showed signs of distress were referred to the

clinic social worker who had been informed about research study conducted (her contact number: 013 242 3906).

- **Respect for human Dignity**

Respect for human dignity included respect for human dignity and the right to full disclosure.

- **The right of self determination**

The researcher ensured that the participants in the study had the right of self-determination by allowing participants not to disclose information when they felt uncomfortable and no penalties were imposed on the participants when they withdrew from participating in the study.

- **The right of full disclosure**

Participants had the right to a full description of the nature of study conducted. The participant's rights to full description of the nature of the study was acknowledged in the study by the researcher who disclosed description of the study to the participants.

- **Justice**

The right to fair treatment and the right to privacy were included.

- **The right to fair treatment**

Participants should be treated fairly (Botma et al., 2010:220). The researcher ensured that all participants were treated fairly in the study; this included the use of a familiar environment for conducting interviews at the participant's churches and at the facility. Participants did not incur a financial burden as the appointments were made during the church time and clinic visits.

- **The right to privacy**

Respect for a person's privacy must be treated with anonymity and confidentiality, the researcher ensured privacy was maintained during interviews and participant's personal information was not included in order to protect their personal details and

identity of families. Interviews were conducted at suitable time for the families at the health facility or family church, coding was used to identify participants.

- **Procedure for protecting study participants**

Procedure for protecting study participants consist of informed consent.

- **Informed consent**

Informed consent means participants who have adequate information about the research, comprehend that information and have the ability to consent to or decline participation voluntary (Polit & Beck, 2012:157). The researcher ensured that all participants were informed about the study and that they understood the nature of study before signing consent to participate in the study. The informed consent form is attached as Annexure 3.

1.11 DISSEMINATION OF RESULTS

Dissemination of results is when research results are published and made known to the community and stakeholders for public viewing. A published research report can be made known to the public by either poster presentation or oral presentation (Botma et al., 2010:320). The dissertation was intended to be made known to the public through oral presentations at conferences and article publication.

1.12 CONCLUSION

The study was intended to assist in understanding the phenomenon of the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga. A qualitative design study method was used by the researcher to explore and describe the phenomenon researched. The research design and methodology is described in Chapter 2.

CHAPTER2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

In the previous chapter, an overview of the study was presented. The background, objectives and questions including ethical considerations were explained. This chapter will present the research design and methods. Chapter 2 describes the design used to conduct the study on the burden of care experienced by families who care for a teenage mother in a selected township in Mpumalanga.

2.2 RESEARCH QUESTION(S)

The research answered these questions:

- What is the burden of care experienced by the families with teenage mothers in a selected township in Mpumalanga?
- What is the financial burden of care experienced when caring for a teenage mother?
- What is the social burden of care experienced when caring for a teenage mother?

2.3 RESEARCH OBJECTIVES

The objectives of the study are to:

- Explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.
- Explore and describe the financial burden families experienced when caring for a teenage mother
- Explore and describe social burden of care families experienced when caring for teenage mother

2.4 RESEARCH AIM

The aim of the study was to explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga in order to inform health care providers to initiate needed interventions.

2.5 RESEARCH DESIGN

The researcher selected qualitative approach in order to do an in-depth exploration of experiences of families with teenage mothers regarding the burden of care. Qualitative research is the approach used for exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Richey & Klein, 2014:1). The researcher opted for qualitative research method because the objectives of this study were to explore and describe the burden of care experienced by families with teenage mothers, explore and describe the financial burden families experienced when caring for a teenage mother, and explore and describe social burden of care families experienced when caring for a teenage mother.

Research design is a guide that channel the researcher on how to collect, analyse and interpret observations, the guide is used systemically to design the development of and evaluate processes in the study with the aim of establishing an empirical basis for the study (Richey & Klein, 2014:1). Research design is a plan or blue print on how the researcher intends to conduct the research study (Strydom, Botha & Boshoff, 2015:2). It is also a task faced by a researcher in formulating research questions and planning to produce and analyse data required to answer the questions (Hammersley, 2014:107). The researcher used exploratory, descriptive and contextual research designs to explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.

2.5.1 Exploratory research design

Exploratory design applies in-depth exploration of a phenomenon (Polit & Beck, 2012:741). The researcher intended to explore the burden of care experienced by families with teenage mothers, as this was going to enable the researcher to gain in-depth knowledge about the phenomenon. The use of semi-structured interviews with probing questions enabled the researcher to explore the burden of care experienced by families with teenage mothers.

2.5.2 Descriptive research design

In this study, the research mostly has its main objective as people characteristics or circumstances that occur more frequently with a certain phenomenon (Polit & Beck, 2012:741). The researcher ensured that participants were given opportunities to express themselves in a natural manner or according to the way they perceived the phenomenon. The researcher did not give input on the participants' account of how the phenomenon was described. The findings describe the phenomenon as it was experienced.

2.5.3 Contextual research design

The research design focuses on a single event or phenomenon and its structural coherence (Botma et al., 2012:195). Contextual research design weaves or bind together the whole text of work circumstance that forms the setting of an event (Leidner, 2016:3). Family groups fitting the inclusion criteria were approached and appointments were arranged with them. The research was conducted in a township in Mpumalanga. Participants were identified in churches and primary health care setting where interviews were conducted.

2.6 CONTEXTS

The research context is the physical location and conditions where data collection is done (Polit & Beck, 2012:743). The research was conducted in a primary health care setting in a township in Mpumalanga where there was a noticeable increase in the number of pregnant teenagers who were living with their family members. The primary healthcare facility operates from 07h00 till 16h00 and the monthly headcount of all clients is 3000 to 3500. At this facility, services such as immunisation for under-fives, antenatal care and post-natal care and treatment of chronic and minor ailments are rendered. The facility is managed by one medical doctor, four professional nurses, one auxiliary nurse, two clerks, two counsellors and two general workers. The family interviews were conducted at the families' selected churches, as this was the place where participants were comfortable and in the primary health care setting.

2.7 RESEARCH METHODS

Research methods are techniques adopted by the researcher in order to structure a study and to collect and analyse data relevant to the research question and ensuring rigour in research (Polit & Beck, 2012:199). The research methods used in this study are population, sample, sampling, data collection and data analysis.

2.7.1 Population

Population is all the individuals or objects with common, defining characteristics (Polit & Beck, 2012:59). Population is also described as all the elements that meet the sample criteria for inclusion in a study (Botma et al., 2012:6). The population in this study involved all families of teenage mothers in the selected township who visited the primary health centre, and other family members visited the primary health care facility to support the teenager during antenatal, labour and postnatal care.

2.7.2 Sample and sampling

Sampling is the process of selecting participants to represent an entire population so that inferences about the population can be made (Polit & Beck, 2012:275). Purposive sampling is the researcher's judgement in selecting participants (Polit & Beck, 2012:739). Purposive sampling was used in this study to select families, the sample in this study included family members who can speak and write English or Nguni languages. The families who were living with a teenager when she became pregnant or gave birth in 2015 and who provide care to the teenage mother and baby were sampled in this study.

2.7.3 Purposive sampling

Purposive sampling is when researcher has situated knowledge about the field to be studied and researcher has rapport with members of targeted population (Barratt, Ferris & Lenton, 2015:5). Purposive sampling was used in this study to select families that are caring for teenage mothers in order to describe and explore the burden they endured when caring for teenage mothers as they experienced the phenomenon. The researcher included seven families as sample and stopped data collection as data saturation was reached.

2.8 DATA COLLECTION

Data collection is the gathering of information to address a research problem (Polit & Beck, 2012:725). The main purpose of data collection was to explore and describe the burden of care experienced by families with teenage mothers. Family members with teenage mothers were recruited at the local health facility and church. Families attending the same church were requested to participate during family interviews and family members who agreed to come to the health facility where the researcher was employed were interviewed. Two families were interviewed in the primary health care

facility. A neutral venue was arranged as the setting as recommended by the ethics committee after getting permission from the minister and the church leader respectively. Family members were requested to sign an informed consent form at the facility before an appointment was made to secure a place in the church. All family members agreed to be interviewed at church during days similar to the church service using one of the offices in the church where a safe environment was created for family interviews. Semi-structured family interviews were conducted, audio recorded and field notes were written. A moderator was used for data collection to exclude biasness by the researcher. In depth data on the study focus was generated through the conversational and interactive mode of the interviews that the moderator employed (Polit & Beck, 2012:725).

2.8.1 Pilot study

Pilot study is a small-scale version of the whole study (Botma et al., 2012:284). The researcher approached two families from the families who meet the selection criteria and semi-structured interviews were conducted after they gave consent to the interviews in the primary health care facility. The pilot study was done to enable the researcher to gain knowledge on how to access participants, to test the research question and to assist the researcher to gain interview skills. Questions asked were: 'what is the burden of care experienced by the families with teenage mothers in a selected township in Mpumalanga', as a main question and two probing questions namely: 'what is the financial burden of care you experienced when caring for a teenage mother' and 'what is the social burden of care you experienced when caring for a teenage mother'. The questions that were used during the pilot study were used during data collection and not changed, the pilot study proved that the researcher was going to collect enough information during data collection and fulfil research objectives and aims. Results were analysed and were not included in the sample.

2.8.2 Preparation phase

Preparation of interviews was done as follows:

- **Negotiating entry**

The researcher was granted permission to conduct the study by the University of Pretoria ethics committee, a Christian church minister and by the primary health care facility manager in a selected township Mpumalanga. The researcher then introduced herself to the health care users in the primary health care facility waiting area and the congregants after church service and explained the research topic, purpose of the study and selection criteria.

- **Recruiting**

After gaining entry in the primary health facility an introduction of the researcher was done during the plenary in preparation for data collection. The researcher went to a health care facility waiting area and addressed the population about the study that she intends to conduct. Voluntary prospective participants (family members) who qualified to partake in the study were taken to a private room where the purpose and introduction of the study was outlined. The identified family members were explained that the interview will be with two or more family members over 18years living with teenage mother. Same procedure was followed in the recruitment of participants from the church.

- **Preparation for the venue**

The date, time and number of participants expected to attend the interviews were communicated with the minister of the church and the clinic manager who identified a room to be used. The date, time and number of participants expected to attend the interviews were communicated with the participants. When the participants arrived,

they were given chairs to sit on in the general waiting area and were offered drinking water. The participants were two or more members of families experiencing burden of care due to teenage mother and the baby.

Preparation for equipment

The researcher purchased an audio tape, pen, scribbler book, pencil, rubber and highlighter in preparation for the semi-structured family interviews and field notes that the researcher was going to capture.

- **Moderator**

The moderator had a Master's degree and experience on conducting semi-structured interviews. The moderator read the proposal first before conducting the semi-structured family interviews.

- **The researcher's role**

The researcher's role is to listen actively (Dempsey, Dowling, Larkin & Murphy, 2016:483). The researchers worked in the community in which the research study was conducted. The main role of the researcher was to organise the interviews and take field notes while the moderator conducted the semi-structured interviews.

2.8.3 Interviewing phase

Semi-structured interviews were used in order for the researcher to gain more knowledge about the phenomenon being studied. The researcher greeted the participants and introduced the moderator to the participants. The moderator's role was explained to the participants in order to create trust and to assure them of their safety. The consent form was already signed by the participants. Interviewing equipment such as the audio tape was explained to the participants, highlighting the importance of gathering accurate information. The moderator asked the main question: What is the burden of care experienced by the families with teenage mothers

in a selected township in Mpumalanga. Probing is to get more relevant information from the respondent than their initial response (Polit & Beck, 2012:310). The moderator used probing questions when she needed clarity on what the participants were saying. These questions were: What is the financial burden you are experiencing when caring for a teenage mother? What is the social burden of care you experienced when caring for a teenage mother? Limited responses from the participants encouraged the moderator to probe the participant for more answers; this was perpetuated by responses from participants such as “lyah” with no additional response. The moderator then asked the participants to elaborate further on the questions asked. Audio recordings and field notes were collected and the researcher then thanked the participants for their time.

2.8.4 Post-interviewing phase

After the moderator noticed that data saturation was reached, she thanked the participants. Referral information was provided to participants that she identified needed referral to a social worker and primary health care facility after what was said by the participants during the interviews in order to address needs identified. The moderator and the researcher then discussed their findings after each interview and the researcher listened to the audio tape for audibility and completeness (Botma et al., 2012:214) and wrote field notes about observations made during interviews.

2.9 DATA ANALYSIS

Data analysis is the systemic organisation and synthesis of research data (Polit & Beck, 2012:745). It is conducted concurrently with gathering data; it must be systematic, sequential, verifiable and continuous (Botma et al., 2010:221). Tesch's method of data analysis (Botma et al., 2012:223-225) was used. The following steps were followed: After semi-structured interviews, the researcher used the field notes and audio tapes for process of verbatim transcription for data analysis. The researcher read the transcripts to make sense of the whole. Similar themes and topics were

placed into groups as they refer to the same information and they were assigned to generate general themes. Themes formulated were developed into different categories and sub categories. With the assistance of a supervisor, co-supervisor and the moderator, then the researcher decided on four themes, nine categories and 19 sub categories.

2.10 TRUSTWORTHINESS

Trustworthiness is the degree of confidence qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2012:745). In this study, the following criteria were used credibility, transferability, dependability and confirmability.

2.10.1 Credibility

Credibility is confidence in the truth of data and interpretation of data (Polit & Beck, 2012: 585). The researcher in this study ensured credibility by allocating time to spend with participants so as to reach data saturation. The holistic approach of the study allowed the researcher to collect data until all arising questions were answered. The researcher ensured credibility by applying criteria developed by Guba and Lincoln (1985) namely: prolong engagement, persistent observation, triangulation, member checking and peer debriefing.

- **Prolong engagement**

Prolong engagement is when the researcher creates and spend sufficient time collecting data (Polit & Beck, 2012:589). During the study, the researcher spent 30-40 minutes with the participants in order to build trust and rapport with them. The researcher used audio recordings in order to avoid misinformation.

- **Persistent observation**

Persistent observation focuses on the relevancy of conversation concerning phenomenon being studied (Polit & Beck, 2012:589). Soon after the interviews were concluded, the researcher made field notes about their observations on non-verbal language displayed by participants that included crying, exhaling and stopping midsentence.

- **Triangulation**

Triangulation assist in capturing more complete, credible findings and interpretations of a phenomenon (Polit & Beck, 2012:590). Multiple data sources were utilised by the researcher in this study, including: audio tapes, writing field notes to capture the theme of data to back up the audio recording, using participants with different age groups and collecting data multiple times.

- **Member checking**

The researcher consulted the participants about interpretations of and conclusions about the data that the researcher made during data collection to find out if they confirm the researcher's findings (Polit & Beck, 2012:590). Feedback was given to the participants by the researcher about the interpretations made of the study and was confirmed by participants.

- **Peer debriefing**

Peer debriefing involves consultation with peers and the discussion of various aspects of the study (Polit & Beck, 2012:594) The researcher consulted the moderator who is more experienced in data collection and conducting interviews and also consulted her supervisors who are senior researchers.

2.10.2 Transferability

Transferability is the extent to which findings can be transferred to or have applicability in other settings or groups (Polit & Beck, 2012:585). The researcher ensured that the

findings of this study are applicable in other studies by providing a detailed description of the design, methods and findings so that it may be possible for other researchers to use the findings.

2.10.3 Dependability

Dependability is the stability of data over time and condition (Polit & Beck, 2012:585). The researcher ensured that by utilising the audio recording when conducting semi structure family interviews, data was to be dependant and consistent in order to ensure stability. The researcher stored the data in a safe place.

2.10.4 Confirmability

Confirmability is the potential of congruence between two or more independent people about the data's accuracy, relevance or meaning (Polit & Beck, 2012:585). The researcher ensured accuracy of data by using field notes and audio tapes.

2.11 SUMMARY

On the topic of the burden of care experienced by families with teenage mother, the researcher used both subjective burden of care and objective burden of care. The qualitative method was selected for the study with the aim of exploring and gaining in-depth knowledge about the phenomenon. Data collection was done and data analysis will be discussed on next chapter.

CHAPTER 3

FINDINGS AND DISCUSSIONS

3.1 INTRODUCTION

In Chapter 2, the research design and methods used in this study were described. In this chapter, the findings are discussed and literature control to support the findings is integrated. The study objective was to explore and describe the burden of care experienced by families of teenage mothers in a selected township in Mpumalanga.

3.2 DEMOGRAPHIC DATA OF FAMILIES

A total of seven families participated in the interview process, they were all from a selected township in Mpumalanga and they all had teenage daughters who were mothers. A total of 19 family members from the seven families participated in the study, they consisted of the teenage mother's siblings, parents, uncle and aunts. The table below was divided into the sections, namely the ages of teenagers per family, family composition and number of family members to represent the demographic data of participants and number of families sampled.

Table 3.1 Demographic data of families

Ages of teenagers per family	Families composition/ participants from families	Number of members per family	Number of family members sampled
17yrs	Uncle, Aunt, 3 Nieces	6	2
16yrs	Father, Mother, Uncle, 2 siblings	6	2
14yrs	Mother, Uncle, 5siblings, 2 grandchildren	10	4
16yrs	Stepfather, Mother, 2 siblings	5	2
15yrs	Father, Mother, Aunt, 4 siblings and 1 grandchild	9	3
14yrs	Aunt and 3 siblings	5	2
13yrs	Mother, 6 siblings, 1 uncle	8	4

3.3 DATA DISCUSSION

It was evident from data analysis that the families experienced different types of burden of care. The holistic picture that emerged from the holistic study conducted was that all families were burdened with providing care to the teenage mother, some with minimal or almost no support, however the teenage mother and baby were provided care according to available resources. Four themes emerged, namely social burden of care, psychological burden of care, financial burden of care and coping with pregnancy and outcomes.

Table 3.2 Themes, categories and subcategories

Theme	Category	Subcategories
Social burden of care	Cultural practices regarding managing pregnancy outside marriage	<ul style="list-style-type: none"> • Non-acceptance of the pregnancy • Acceptance of pregnancy
	Social Impact on family	<ul style="list-style-type: none"> • Forced grand parenting • Social stigmatisation by the community members
	Social impact on teenager's mother family	<ul style="list-style-type: none"> • Parenting burden • School drop out
Psychological burden of care	Reaction of family members	<ul style="list-style-type: none"> • Anger and hurt • Disappointed and embarrassed
	Parents emotions	<ul style="list-style-type: none"> • Reflecting on own parenting experiences • Termination of pregnancy as an option • Using religion as a reason
Financial burden of care	Financial stability of families	<ul style="list-style-type: none"> • Financial status of families • Food security for the family members
	Source of income	<ul style="list-style-type: none"> • Social grant • Informal business

Theme	Category	Subcategories
Coping with pregnancy and outcomes	Coping mechanisms	<ul style="list-style-type: none"> • Family support • Diverse coping mechanism
	Problems related to pregnancy	<ul style="list-style-type: none"> • Teenage behavioural changes experiences • Family member's experiences of pregnancy complications of teenager

Discussions of findings will refer to families included in the study as participant's families. The holistic approach in the study emerged with different experiences by family's members included in this study.

3.4 SOCIAL BURDEN OF CARE

The first theme that emerged was social burden of care experienced by families with teenage mothers. There were three categories namely: cultural practices regarding pregnancy outside marriage, social impact on family, social impact on teenage mother.

3.4.1 Cultural practises regarding pregnancy outside marriage

The first category of the theme social burden of care was cultural practices regarding pregnancy outside marriage. This category had two subcategories namely: Non-acceptance of the pregnancy and Acceptance of pregnancy.

- **Non-acceptance of pregnancy**

This sub category outlined social burdens of care faced by family members of teenage mothers when the father's families did not accept pregnancy. The sub categories included unfulfilled cultural practices that must be followed by family members when an unmarried teenager is pregnant. These practices are adhered to and followed by the teenage mother's family. Failure by the teenager's partner to honour their parenting role and pay the damages were interpreted as not acknowledging the

pregnancy or non-acceptance of pregnancy and teenage family members take responsibilities to provide care to mother and baby. The cultural practices were communicated by family members as follows:

Family 3: (Mother) *"I went to inform them when my daughter was two months pregnant. According to our culture, I sent delegates to go and inform the boy's family about the pregnancy. The boy rejected the pregnancy saying it's not his. The boy's family then said, they will come and see the child once born to see if he looks like them. The child was born. Then I sent another delegate to inform them that the child has been delivered. The grandmother responded that they will come and see the child when he is 3 months. Now the child is 18 months and has never seen their faces in my family."*¹

Family 4: *"[Father and mother] went to the boy's family and asked him in front of his parents and he said no. His family members are bullies, they like fighting iyah and the boy's father is in another church and we were also in another church so our religion clashed and we ended up fighting so if they did not want my child therefore I also did not want theirs. That is how it was."*

The findings indicated that families adhered to cultural practices regarding the handling of the pregnancy occurring outside marital union. The families were disappointed as the teenager's partner's families did not support the teenager or accept the pregnancy based on the response from their son. The teenage girl's family had to live with the disappointment and care for the baby alone. Cultural practices are the basic world view and life ways of a group of people, this lifeway's expectations must be adhered to and fulfilled because they determine interventions needed (Lewin, Hodgkinson, Wates, Prempeli, Beers & Feinberg, 2015:143). If cultural practices are unfulfilled, teenage mother's families take on responsibilities and the additional burden of care for the teenager and her baby.

¹ In the interest of authenticity, all quotes are presented verbatim and no amendments were made to language or grammar.

Family members, more especially the maternal baby's grandparents, become involved in cultural practices and traditions that are specific to that family's culture. Family members try to ensure that those cultural practices are adhered to and fulfilled as part of the care of the teenage mother and her baby (Iseki & Ohashi, 2014:157). When those cultural practices were unfulfilled and not adhered to by the teenage partner's families after the teenager fell pregnant and had a baby, it may decrease family members' self-esteem and increase their burden of care. In this study, some of family members of the teenage mother were disappointed, as the teenage mother's partner did not accept the pregnancy.

- **Acceptance of the pregnancy**

Acceptance of the pregnancy is the second subcategory for Theme 1 of the social burden of care. Unlike the findings regarding non-acceptance of teenage pregnancy by partner's family, other families did accept the teenage pregnancy when reported by the teenage girl's family. Family members of the teenager who were burdened with social care expressed how they came about to accept their teenage daughter's pregnancy; due to the fact that families negotiated with the teenage girl's sexual partner's family and reached an agreement, families had to negotiate their differences after the teenage daughter fell pregnant for the second time. The following quotes affirm how the partner's family members came to accept the teenage pregnancy:

Family 5: (Mother) *"At the end we talked and everything became better because after the birth of the second child they could see that he was from that family."*

Family 6: (Aunt) *"We went to the family to talk to them and he accepted the pregnancy and admitted that he was responsible for the pregnancy."*

With this family, there was a disagreement about accepting the pregnancy, however, after the teenager delivered they were supportive despite this not being expected by parents. The following quotes affirm how partner's family members came to accept the teenage pregnancy:

Family 4: (Mother) *“When the child came they were very supportive and accepting. When my daughter gave birth, we were all there, they bought some stuff, they did something I did not expect from them and till now they are still supportive.”*

It became clear based on the findings that some of teenage mother partner’s family members accepted the teenage pregnancy. This was characterised by the family meetings that were held by the two families and the agreements that they reached. In the families where the teenager was pregnant for the second time, families accepted the second pregnancy. When family members accept the teenage pregnancy and child, it creates a more secure attachment to the child (Riesch, Anderson, Pridham, Lutz & Becker, 2010:9). Teenage pregnancy has generally become more acceptable as family members started accommodating the pregnant teenager (Phaswana-Mafuya, Tabana & Davis, 2016:421). The paying of damages by the father of the child illustrate acknowledgement and is symbolic acceptance of impregnating the teenager and accepting full responsibility for the child (Bhana & Nkani, 2014:339). Family members believed that when damages were settled financially, the additional burden of care will be less for them. Family member’s interventions and accepting the teenage child assist in the wellbeing of the teenager and the attachment with her child.

3.4.2 Social impact on the family

The second category for the theme social burden of care was the social impact on family. This category emerged with two subcategories, which are Forced grand parenting and Social stigmatisation by the community members.

- **Forced grand parenting**

Teenager’s family members outlined that they did not expect the teenager to become a mother but they couldn’t neglect the teenager and her baby once the child was born. Consequently, they were forced to look after the teenager and her baby. Families were never certain about who the father of the teenager’s baby is. The partner of the

teenager denied that he was the father, however when drunk he verbalises that he is the father. The following quotes affirm the added social burden of care experienced by teenager's parents and family members:

Family 3: (Mother) “[The father] *acknowledges fathering the baby when he is drunk only, had to be strong for my daughter, I told her that I don't want her to end up having miscarriage because of stresses. I am still supporting her even now.*”

Family 7: (Mother) “*I thought of chasing her out where would she have gone so I took it as spilled water that you cannot take back. I looked after her.*”

Irrespective of availability of resources to some family members, the maternal grandmother is forced to provide support. The care additional to grand parenting included emotional and psychological care of the teenage mother. In this study, numerous factors contributed to the burden of care on paternal grandparents. In some instances, the father's family was poor, while sometimes the father was using alcohol excessively and were unable to provide care. Grandparents play an important role in the life of their grandchildren, whether burdened with responsibilities of caring for their teenage children or not. Teenage mothers may have problems looking after their children and their own wellbeing, resulting in the teenage mother's parents assuming all responsibilities of care for both the teenager and her baby (Qambatha & Mayeye, 2013:54). More interaction occurs between grandparents and their grandchildren when grandparents offer to assist with their grandchildren when the teenage mother experiences a crisis when raising a child and have no knowledge of raising a child (Dunifon, 2013: 55). Then family members become forced to care for that child additional to their traditional grand parenting role.

- **Social stigmatisation by community members**

The second subcategory for the category social burden is social stigmatisation the community members. Knowingly and unknowingly, families of the pregnant teenager are being stigmatised by other families as teenage pregnancies are a taboo or

disgrace to the family. Family members expressed the discrimination and gossip they endured from community members after their teenage daughter fell pregnant. The additional social burden of being ostracised from the community or social setting that they were used to, was a social problem to families. The following quotes affirm social stigmatisation as expressed by families:

Family 5: (Mother) *"They laughed and said how come she can be pregnant in this family while her aunt is a professional nurse; they were saying why she didn't provide family planning for her."*

Family 2: (Mother) (Sigh) *"there were talking amongst themselves saying my child was young to be pregnant and to drop from school and that hurt me so I kept quiet."*

Family 3: (Mother and sister) *"Talks continued from the community's members and her peers, saying that she's a drop-out and got a child from grade 6."*

Family members faced stigmatisation from community members who were talking amongst themselves and laughing at family members for having a teenage mother. The social burden of care was characterised by family members being laughed at after their teenagers dropped out of school or having a family member with professional knowledge regarding pregnancy prevention who did not assist with services such as family planning. Teenage mothers also face challenges such as a lack of support from individuals, institutions, including educational, social, cultural support (Gyesaw & Ankomah, 2013:774).

Even though one third of teenagers become young mothers, their child births in the community are often accompanied by social stigmatisation and community imposed sanctions (Rosenberg, Pettifor, Miller, Trirumurthy, Emch Afolabi, Kahn, Collinson & Tollman, 2015:929). Teenage mothers face social stigmatisation, which force them to rely solely on their family members for support and add to the family burden of care. Teenage mothers and their families are two to three times more likely to be victims of

abuse and at significant risk of community and interpersonal violence exposure and ridiculed by the community after falling pregnant and having a baby (Hodgkinson, Beers & Hewin, 2014:115). Family members may be ridiculed by the community members who may interpret the teenage mother's parents as failures with regards to their parental skills. Similar to findings in this study, families with teenage mothers were stigmatised moreover if it assumed or known they possessed knowledge on teenage pregnancy prevention.

Some peers discriminated against the teenager who was pregnant. The teenager might be isolated and her parenting skills might be affected due to discrimination. Teenage mothers' social support, including their peers, may stop interacting with them after the pregnancy and this may force the teenager to turn to their family members for support. Stigmatisation by community members greatly affect the teenagers' ability to develop child rearing and parenting skills (Hodgkinson et al., 2014:115). This resulted in the teenage mother's older family members having to raise the teenager's child, adding to the family social burden of care.

3.4.3 Social impact on teenager's mother family

Social impact emerged as the second category for the social burden of care theme, there were two subcategories related to the teenage mother's side, being Parenting burden and School drop-out.

- **Parenting burden**

The parenting burden on the teenage mother's side emerged as the first sub category. The teenage mother's family had to take responsibility for looking after and raising the teenager's baby without the assistance of teenage partner's family. Sometimes the grand parents need to be relieved of care and the other family members such as aunts stepped in. Thus, it became a burden to the extended family as teenagers lacked parenting skills and were still young. The following quotes affirm the added burden of care experienced by the teenager's parents and family members:

Family 1: (Uncle) *"This child is my sister's child so err! Her mother phoned us because she was with her and told us that this child had an affair with a certain man at home and the teenager eloped with the man to the area where I am staying. But the man did not disclose to this child that he is a married man when he took her from home to this area, so my sister from home phoned me and requested that we take her and live with her and the teenager had a baby."*

Family 4: (Mother) *"All [these] stuff; it will be my responsibility when the child was sick because the boy family normally do not stay with child it is normally the girl's family who raise the child."*

Family 6: (Aunt) *"It is very painful because I am the only elder she has now. I am the only aunt she and her siblings have and I can't leave because no one is going to look after them."*

Teenage mothers attest to the fact that they did not receive any form of support, social, psychologically and financially from the family of their baby's father. The teenager and her extended family members had to take full responsibility of the teenager's baby and this contributed to the burden of care in the teenager mother's family. Humans have a child bearing system where children's' mothers receive help in raising their offspring, most likely from family members (Sear & Coall, 2011:82). It has become a common practice that family members of the teenage mother's baby, including extended family members, are raising the baby without the father's involvement (Qambatha & Mayeye, 2012:51). It emerged from this study that the most powerful influences on the teenage mother were her parents and family members. This makes it easier for the teenage mother to entrust her child's wellbeing and care to her own parents and family members (Wisnieski, Sieving & Garwick, 2015:144). The teenage mother's family experienced a parenting burden as the teenager lacked skills and needed help with parenting to ensure the baby's wellbeing.

- **School drop-out**

The second subcategory of social impact on teenage mother's side was school drop-out by teenage mothers, however teenage mothers are able to go back to school dependent on family resources. Some family members found it hard to take their teenage daughter who had become a mother back to school; they attested that they did not have sufficient means to take her back to school because of financial reasons, despite their wish to see her going back to school. Other family members decided to take their teenage daughters out of school after she had her second baby in addition the decision was based on the teenager's health. The following quotes affirm decisions taken by the family that resulted in school drop-out as expressed by the families:

Family 1: (Uncle) *"She was schooling at home but since she is here with us I do not think she will continue with schooling. She is not going back to school. She will need money to raise her baby and money for school so (pause) you see she won't go back to school."*

Family 2: (Mother) *"I wanted her to continue with school."*

Family 5: (Mother) *"I let her continue with her schooling actually she is having her second baby because she fell pregnant again after delivering the first baby so I stopped her from going to school after that. The first one she delivered in December via C-section and she passed her final exams."*

Family 6: (Aunt) *"Eish!" It was difficult because she is an orphan, pregnant and schooling so she had to leave school."*

Two outcomes are possible for teenagers that become pregnant, which include returning to school or not. Family members expressed their different reasons why they decided to take their teenage daughters out of school; it became apparent that in most families, the decision for the teenager to discontinuing with schooling was made by the family members and not by the teenage mother herself. The burden of care that

forced the families to decide for the teenage mother not to continue with schooling included the financial burden, social burden on the teenager who was pregnant for the second time, teenage mothers who were orphans and teenage mother's health status. The findings in this study are not unfamiliar as most teenage pregnancies are unplanned and mistimed, leading to teenage mothers dropping out of school as reported by Sarnquist, Sinclair, Mboya, Langat, Paiva, Halpern-Felsher, Golden, Maldonado and Baiocchi (2016:297).

Family members make decisions about the teenage mothers' schooling career, whether to continue with schooling or to drop out of school. It is confirmed that the additional burden of care experienced by families of teenage mothers attributed to the difficulties for family members who often angrily give up on teenage mothers who fail to take their schooling plans seriously (Bhana & Mcambi, 2013:11). Due to the unplanned pregnancies, most teenagers are enrolled in high school and drop out of school during pre-natal care and some teenagers dropped from school during post-natal care (East & Chien, 2013:183).

It is also evident that pregnant teenagers are often dependent on the family for taking care of the baby while they go back to school to finish their schooling. It became difficult to provide for schooling, sometimes due to a resource constrained environment related to unemployment and poverty experienced by many families in South Africa. The teenage mother's family members are burdened to look after the teenager's child while she is attending school due to their economic status. It emerged in this study that family members took a more active role in the decisions concerning the future of the teenager who are pregnant.

3.5 PSYCHOLOGICAL BURDEN OF CARE

Psychological burden of care on families with teenage mothers emerged as the second theme, with two categories namely: Reaction of family members and Parent's emotions.

3.5.1 Reaction of family members

Reaction of family members emerged as the first category of the psychological burden of care with two subcategories namely: Anger and hurt and Disappointment and embarrassment.

- **Anger and hurt**

The first sub-category for reaction of family members was anger and hurt. Parents expressed the angry moments they experienced when they discovered their daughter's pregnancy by describing emotions such as shocked and disappointment as the teenage mothers added to their emotional health problems. Some family member's experienced emotional pain that made them cry as their emotional health was destabilised by the teenage mothers because of the increased emotional health care demands the child and teen mother will require from the family.

Family members seemed to have given up on some teenager's wellbeing after giving birth at such a young age and concluded that since the teenager have given birth some families had to concentrate on the additional burden of looking after the teenager's baby rather than concentrating on the teenager's wellbeing. In this study, parents experienced anger and hurt, together with disappointment. The following quotes affirm the anger experienced by the families:

Family 1: (Uncle) *"Yes, at first we were angry, more especially with the married man, but what can we say."*

Family 3: (Mother) *"then I decided to buy a pregnancy test and test her. When it came back positive I was shocked, disappointed, powerless and angry. I didn't know what to do, I was hurt."*

Family 4: (Mother) *“Iyah! It is the type of anger I experienced, you see sometimes to be too angry is not allowed because it forces you to take action without thinking things through and you will end up making mistakes that you will regret.”*

Some families were actually hurt because they were not expecting the teenage pregnancy to happen to their families. They were actually hurt by their teenage daughter’s behaviour as expressed in the following quotes:

Family 1: (Uncle) (Folding hands) *“We were hurt and not happy, iyah.”*

Family 2: (Mother) *“I was hurt really bad (pause) and I wanted her to continue with school, even now I am still hurt because she is not on family planning because they say that you start family planning six weeks after delivery.”*

Family 3: (Mother) *“All he does, he acknowledges fathering the baby when he is drunk only. But when he is with friends he would say it’s not his child. I even told him that we are not interested in his money; he is welcomed to come to see the child because I see it hurts my daughter to hear him talk like that. She’s been hurt from her pregnancy, now even 18 months after the child is born, it’s hurting me (moment of silence, crying).”*

Family 5: (Mother) *“Eish I was hurt because I was not expecting her to fall pregnant.”*

It became clear based on the findings that family members of teenage mothers became angry and hurt, as teen mother and child’s healthcare demands psychologically burdened them. This psychological burden was characterised by powerlessness, shock and anger. The psychological burden of care was worsened as the family members did not know what to do, while the teen mother and child needed emotional support too. The behaviour of the partners of the teenage mothers contributed to the hurt and anger, especially an alcoholic father who ended up talking negatively and it was a shock that the male who impregnated the teen in one family was married. The anger and hurt of family members are also evident in the study

conducted by East and Chien (2013:9), who concluded that mothers and family members of the parenting adolescent treated her harshly and with anger, and often “shouted”, “criticised” or “slapped” them.

Teenage mothers in the study conducted by Hill, Maman, Groves and Moodley (2015:1) expressed stress and instability in their relationships with their family members due to devastation and hurt that family members experience during antenatal and postnatal period and after the teenager disclosed the pregnancy to family members.

In this study, the anger and hurt was fuelled by the fact that the male who impregnated the teen in one family was married and this embarrassed the family. James, Van Rooyen and Strumpher (2012:194) attested that the parents of teenagers experienced feelings of hurt, disappointment, anger and embarrassment after discovering that their daughter was pregnant. Anger, hurt and embarrassment may emotionally burden the family and lend them to be powerless to manage the psychological burden of care they are confronted with.

Teenagers experienced that their parents or partners were devastated and hurt by the unexpected pregnancy and family members projected feelings of devastation, hurt and an additional burden within the families after their teenage daughter has given birth. Bhana and Mcambi (2013:11) discovered that the devastation and hurt experienced by family members of teenage mothers resulted in the teenager dropping out of school and this led to difficulty in coping with school work for teenage mothers, as angry and hurt parents left them on their own.

- **Disappointment and embarrassment**

Disappointment and embarrassment emerged as the second subcategory of reaction of family members. Family member’s reactions discovered during interviews were diverse, those family members who felt disappointed and embarrassed expressed that the fact that their daughter was pregnant humiliated them and some wished they were

dead. The following quotes affirm the disappointment and embarrassment as expressed by the families:

Family 3: (Mother) *“I was so sad and disappointed.”*

Family 4: (Mother) *“But I nearly died because it felt like I was in labour again about to deliver a baby (pause) (then exhale). I didn’t know what to say and the way she humiliated me.”*

Family 5: (Mother) *“So (inhaling) I was disappointed very much.”*

Family 7: (Mother) *“I was embarrassed because I felt like a mother who failed to discipline her child.”*

Family members expressed the different types of emotions they experienced after discovering their teenage daughter’s pregnancy, the different emotions came in the form of disappointment and embarrassment. Emotion is a strong private feeling, personal, concerns, circumstances and mood that emerged as a certain type of social relationship (Bookwala, 2016:1). Family members felt these personal feelings of embarrassment, disappointment, humiliation and feelings of death after discovering the teenage pregnancy because they had not expected the teenager to fall pregnant. After the initial shock of discovering the teenage pregnancy, they started experiencing these different emotions, which then lead to other parents questioning their parenting skills and abilities. Some parents perceived themselves as failures in their parenting skills.

Teenage mothers describe stress and emotional instability in their relationships with family members during pregnancy and postpartum periods, teenage mothers face many negative reactions from family members who were disappointed in them during pregnancy as well as post-natal (Hill et al., 2015: 3). Family member’s experienced different emotional reactions as a result of the teenage pregnancy and emotions

impacted negatively on the teenage mothers who sensed the emotional instability in their families. These negative emotions added to the family's emotional burden of caring for the teenager and her baby.

The teenage mother's parents felt embarrassed, disappointed and experience feelings of self-blame because of the teenager's pregnancy (Maputle, Lebesse & Khoza, 2015:146). Self-blame emerged in the findings of this study as some mothers questioned their parenting skills. Self-blame adds to emotional stress and might affect the care provided to the teenage mother and baby.

3.5.2 Parents' emotions

Teenage mother's parents experienced different emotions, this category emerged with three subcategories were parents were forced to reflect on their own parenting skills, termination of pregnancy as an option and using religion as a reason.

- **Reflecting on own parenting experiences**

Teenage mothers were forced to reflect on their own parenting experiences, and this emerged as subcategory for the category parent's emotions. Teenage mothers were forced to reflect on their pregnancies during teenage phase and identified the hardships they experienced, such as having a child out of wedlock and marrying a different man. These thoughts brought back memories and emotions to the teenager's parents that impacted on their psychological wellbeing. Some tried to avert that their daughters will experience the same disappointments as they did, however they failed. One mother was already scared of what her daughter will experience later in life. The following statement represent the parent's reflections:

Family 4: (Mother) *"You wish she could get educated and be independent, grow up and meet a husband without having any child. I got into marriage with her and I sat*

her down and told her how it feels to get into marriage with a child not born in the marriage. I know the pain and I didn't want her to go through the same mistake. I was lucky enough to get a man who is so caring and loving, who took her in as his own, treated her like his own such that she didn't know he was not her father up until I sat her down when she was old enough and explained to her. I didn't want her to repeat the same mistake as I did. The pain of getting into marriage with a child not from the marriage is, number one: you and your husband can agree with each other concerning the child and he would love the child as his own but there is the family which will always be pointing at you and the child and when they do visit, you can actually see them saying this child doesn't belong to this family and when we attend family gatherings, my child is neglected."

Family 5: (Mother) *"I even explained the circumstances that I conceive her in, I was also very young when I fell pregnant with her. Even though I had finished my matric but I wanted to continue so I couldn't that is why I used to tell them to go school and finish school first. So (inhaling) I was disappointed very much. I couldn't even understand how she fell pregnant because I told her everything and there was nothing she didn't know."*

Teenage pregnancy turns to force the parents to reflect on their own experiences. At times, it may be difficult for teenagers to connect her own experiences with her parent's experiences. On the other hand, parents may find it difficult to understand the repetition of events that happened to them through their own children. Those parents who are teenage parents themselves experienced added pain when finding out that their teenage child was pregnant. They reflected on their own experiences and associated teenage pregnancy as failed parenting on their site even though they alerted their daughters on teenage pregnancy prevention.

There is a cross system spill over, where teenager parents reflect and stress about their parenting and this causes psychological stress and changes in family adjustments (East & Chien, 2013:2). Parents viewed their own pregnancies as a mistake they made and how they did not wish for their own teenage daughters to fall

pregnant (Salami & Ayegboyin, 2015:455). In this study, parents reflect on their own experiences and decided to make their teenager's parenting journey not as stressful as their own parenting experiences (Singh & Hamid 2015:278).

- **Termination of pregnancy as an option**

The termination of the pregnancy as an option emerged as family members took an active role in decisions regarding the teenage pregnancy. Family members were burdened by the pregnancy outcomes and had to think about termination of the pregnancy as an option. However, as their social belief of no termination of pregnancy and their own subconscious belief of having to live with the knowledge and self-blame of deciding for their own teenage daughter to terminate the pregnancy, opposed such option. Teenagers find themselves forced to keep the baby because of their parent's coercion. The coercion is either because of religious beliefs or the expectation brought by their social customs. Termination of pregnancy is not easily acceptable according to the community customs and is still a taboo according to some religions. The following quotes supported this sub-category:

Family 2: (Mother) *"They said these happen here on earth and there is nothing I can do about it because you cannot tell her to abort the baby (sigh) what if she dies."*

Family 3: (Mother and sister) *"We just accepted all that was thrown at us. I told my children that we needed to be strong and accept our situation, rather than thinking of aborting the child."*

Family 4: (Mother) *"My husband was no longer working and I was also not working and we were having two young children in the house so she told me that she is aborting the baby and I said never, you are not aborting this baby, it will eat what we are eating in the house. It was so painful (exhale) we lost appetite for the whole week."*

Family 5: (Mother) *"I wouldn't have thought of anything because whatever you decide as a parent you will find that the child grows up and do well in school and you may find*

that she want children and she no longer falls pregnant then she will blame you as a parent so I would never think of abortion if she was going to do that then she was going to abort outside with her friends and not with me.”

Most of the family members claimed responsibility for the outcome of the teenager's pregnancy and abortion was ruled out as option. Family members expressed their resolution that the teenager will not terminate the pregnancy. Parent's reaction after discovering the pregnancy was to keep the baby and the teenager was not given an opportunity to decide on whether to abort the pregnancy or not. Pregnant teenagers consider their family's advice and support concerning the termination of pregnancy and other pregnancy issues (Loke & Lam, 2014:1). The teenager's family members take an active role in the outcome of the pregnancy, especially with regards to the decision concerning termination of the pregnancy. Most teenagers are coerced regarding the decision on pregnancy termination. Teenagers who fall pregnant experience fear, guilt and worry about how their parents are going to react to the pregnancy and as such, end up with no decision-making power. The teenager's parents and sexual partners at times put pressure on the teenager's pregnancy and contribute to their resolution decisions concerning pregnancy outcomes such as not terminating the pregnancy (Loke & Ham, 2014:421).

Family members influence the pregnant teenager when she is pregnant and may sway the teenager's decision about the termination of the pregnancy. Lee, Chou, Chen, Weng and Hiu (2014:1) discovered that pregnant teenagers prefer abortion rather than keeping the pregnancy, approximately half of teenager's pregnancies end in abortion. It was however established internationally that one of the reasons why teenagers abort is fear of their parent's reactions and shame. In this study, parents overlooked the rights of teenagers of access to termination of pregnancy without parental consultation.

- **Using religion as a reason**

Family member's use God and religious stand as to rationalise decisions regarding pregnancies. Families referred back to God and believed that their religious stand was going to assist them as a coping mechanism after they discovered that their teenager was pregnant. Their religious stand was used to cope with the responsibility of naming the teenage mothers' child and accepting the child within the families. The following quotes affirm the families' religious believes in coping with the teenage pregnancy:

Family 4: (Mother) *"Good fruit and he is her fruit from God and that is why I gave him that name. No matter what as parents we make mistakes and from there forgive the child and find out what the child has learnt from everything and not stick to the past. Everything has happened and we need to cope and move on because what is important is where we are going and not where we are coming from."*

Family 5: (Mother) *"I kept on asking myself how she conceived the second baby. But since I am a Christian I told myself that God has a purpose for these children."*

Family 7: (Mother) *"I put everything upon God, even though it was painful at first but I am used to it now and we are coping, People should just accept this situation in their homes for there is nothing they can do, God is not stupid he will set you free from such difficult. Like me I am free from it is no longer stressing me because I learn to accept the situation and I was able to live with it."*

The findings indicated that family members used their religious stand to cope with caring for the teenage mother and her child and that family members relied on their religious stand in order to cope with experiences of having a teenage mother within their families. Mothers of children felt blessed or being blessed as way of coping with the teenage pregnancy (Christofides, Jewkes, Dunkle, McCarty, Shai, Nduna & Sterk ,2014:947). Families used their religious belief as way of accepting the teenage mother and her pregnancy within the family. Young women used their religious stand to cope with the decisions taken (Hallfors, Iritani, Zhang, Hartman, Luseno, Mpofu &

Rusakaniko, 2016:183). Families used their religious stand as a coping mechanism to lessen their burden of teenage pregnancy and its outcome within the family setting.

3.6 FINANCIAL BURDEN OF CARE

The third theme was Financial burden of care. The financial burden of care theme emerged with two categories namely: Financial stability of families and Source of income. Four subcategories emerged, namely: Financial status of families, Food security for the family members, Social grant and Informal business. Financial constraints that teenage mothers faced impacted negatively on the long term economic stability and success of families. Most families burdened by teenage pregnancy in this study were financially disadvantaged. Some families had limited resources, small scale farming and some were without permanent employment. In some instances, extended families were living on social grants provided by the government.

3.6.1 Financial stability of families

Financial stability of families emerged with two subcategories namely: Financial status of families and Food security for the family members.

- **Financial status of families**

The financial status of families was influenced by health issues of family members who were bread winners in their respective families. Health problems forced some family members to leave work and stay at home, while there was an added burden of care as a result of teenage pregnancy that added financial strain on families. In some families, there was no source of income at all, as noted from the following quotes:

Family 2: (Mother) *“We are raising her child but financially it is very difficult because my husband is not working.”*

Family 7: (Mother) *“Financially it is difficult because I resigned without notice to my employers as I was afraid to tell my employers about my child situation because I could not tell anyone at the time people simply do not care.”*

The findings indicated that family members were financially deprived when the teenager fell pregnant. The teenage mother and her child worsen the financial situation because there was more demand. Teenager pregnancy demands more financial resources therefore greatly influence the financial and social status of the family (Johns, 2011:122). Teenage mothers are associated with the inability to acquire the necessary resources to care for their children, adding to the financial burden of family members. Family members have to care for the financial needs of the teenager and her baby. This is supported in a study where it was discovered that teenage pregnancy has been associated with economic disparities and poverty at the individual, household and neighbourhood lower levels (Minnis, Marchi, Ralph, Biggs, Combellick, Arons, Brindis & Braveman, 2013:2).

Financial pressure is positively linked to adolescent problem behaviour and depressive symptoms (Taylor, Budesco, Gebre & Hodzic, 2012: 1242). Teenage pregnancy forced families to make alternative decisions to lessen the financial burden that the family members were faced with, in order to accommodate the teenager and her baby. Teenage mothers are often associated with inability to acquire the necessary resources to care for their offspring, this becomes an additional financial burden to family members and society. Family members then continue to experience the financial burden of care for the teenage mother and her child (Langley 2016:155). Teenage motherhood and behavioural changes emerged as an additional factor that contribute to family financial deprivation and burden.

- **Food security for the family members**

The third sub-category of financial stability of families was Food security for the family members. Due to the low socio-economic background of the families, they were struggling to make ends meet. The social grant was too little to sufficiently provide for

them for the whole month. Unemployment was another worrying reason for the families as they couldn't secure a sustainable job to feed their families. Even in families where one member was working, it was difficult to provide food for the whole month. The following quotes affirm this sub-category:

Family 3: (Mother) *"You won't believe me, there is nothing in the cupboards and in the fridge as we speak. There is nothing, I don't want to lie. There are days where we go without food"* (wiping tears from the eyes).

Family 6: (Aunt) *"Food was not that difficult because my grandmother was alive at that time; after she passed away it became very difficult."*

Family 7: (Mother) *"Ah! It is just that in life you get used to the situation during the month we would eat whatever but end off! I would try to buy mealie meal for the children then we will sleep with full tummies."*

Household food insecurity is associated with a lack of access to a diet of sufficient quality and quantity necessary for productive and healthy life. An inappropriate diet affects adolescents and their infants, which may lead to diseases such as anaemia and other diseases (Fischer, Shamah-Levy, Mundo-Rosas, Méndez-Gómez-Humarán & Pérez-Escamilla, 2014:2066). Household food insecurity has been linked to the promotion of inexpensive, highly palatable foods that are energy dense. Most households have need for food the beginning of the month and food scarcity at the end of the month, which further promote ill health and poverty in the families. In this study, the additional burden within the family forced them to depend on highly palatable foods that are energy dense such as mealie meal. While sometimes they had nothing to eat, some families run out of food towards the end of the month (Hussain, Baker, 2012:203).

Family members contribute monetary assistance to the teenage mothers by for example paying for food, housing and child care (Sumo, Dancy, Julion & Wilbur,

2015:444). It emerged that family members were struggling financially and the added burden of the teenager's baby made the family's financial burden even more strenuous, as such some families did not have a sustained food supply. Poverty and lack of food security was the root cause of occurrence of teenagers becoming pregnant in a study conducted by (Madumo, Havenga & Van Aswegen, 2015:194). However, this was not mentioned by participants in this study.

3.6.2 Source of Income

The source of income category had two subcategories, namely Social grant and Informal business.

- **Social grant**

Source of income emerged as the second category for financial stability of families. Social grant emerged as the first subcategory for source of income. Participants in this category were seen as having difficulties in maintaining a living wage due to either being unemployed or working with minimal wage that couldn't support the family fully because they were only dependent on social grant money. Social grant emerged as the first subcategory. The following quotes confirm the sub-category:

Family 3: (Mother) *"We only survive with the social grant money. I must see to it that the baby has clothes, pampers and food. (Sigh). So, this year, I had to make another call, seeing my situation at home, I decided that she must stay at home and breastfeed her baby."*

Family 7: (Mother) *"We are relying on child social grant."*

The findings indicated that some family members of teenage mothers relied on social grant money as a means for survival. Section 27(1)(C) of the 1996 Constitution stipulated the right to social security: "Everyone has the right to have access to social security including, if they are unable to support themselves and their future

dependents". It also stipulated that a South African single parent or caregiver with income of not more than R2600 per month, qualifies to receive social grant for her children (Udjo, 2014:840). Family members have to continue relying on social grants as the financial means that they had before the teenager gave birth and this increases the financial burden on the family members because of the lack of added financial means (Lewin et al., 2015:139). Social grant money as a source of income to provide, becomes insufficient for the whole family as means of survival and this leads to an additional burden of care on the family members.

- **Informal business**

Informal business emerged as second subcategory of Source of income. Some family members relied on informal businesses as way for survival, the informal businesses were used as way of employment and living wage for the whole family. The following quotes supported the subcategory:

Family 1: (Uncle) *"Yes, I am self-employed, I am buying everything for the child, it is tough but I am trying to push life because there is nothing I can do."*

Family 1: (Uncle) *"Me and my wife we sell handmade brooms in the streets and it is not the same as sitting and doing nothing while we have to feed the children."*

Family 2: (Mother) *"It is very difficult because I am short sighted, I have difficulty seeing, but we are having a small gardening in our yard and we are eating vegetables from there."*

Family 4: (Mother) *"Iyoh! As I mentioned that my husband was retrenched from work... I was the bread winner by then selling Russians and the life we lived was that when I received small amount of money we will then share food."*

The findings indicated that due to financial constraints, teenage mother's families faced an impact on the long term financial instability and success of the whole family

as they depended on small scale farming. Informal business is economic and material means that are used to improve the quality of family lives (Rogerson, 2011:999). Informal businesses are untaxed, unregulated informal economies that has the potential to spread income and generate employment for family members (Woodward, Rolfe 2011:66). This lack of financial stability within the family setting impacted negatively on the sustained care and provision to the teenage mother and her child (Robling, Bekkers, Bell, Butler, Canning's-John, Channon, Martin & Gregory, 2016:146). It is true that teenage mothers are more likely to be in need of family financial support from families as reported by (Smith & Roberts 2011: 1054). This leads to failure to improve the family financial status and an increase financial burden.

3.7 COPING WITH PREGNANCY AND OUTCOMES

Coping with pregnancy and outcomes emerged as the fourth theme in this study. It had two categories namely Coping mechanisms and Problems related to pregnancy. Five subcategories emerged, namely: Family support, Diverse coping mechanism, Teenage behavioural changes experiences and Family member's experiences of pregnancy complications of teenager.

3.7.1 Coping mechanisms

Coping mechanisms emerged as one category for coping with pregnancy and outcomes. Family members had to go through different experiences while caring for the teenage mother and they developed coping mechanisms. Coping mechanisms is where the practical contact of family members with the teenage pregnancy and motherhood, including all observations of acts or events that took place during antenatal period and post-natal period (Poh, Koh & He, 2014:544). The researcher observed events in this study that families used as coping mechanisms involved family support, families witnessing teenager behavioural changes, family members dealing with teenage pregnancy associated complications and hospitalisation during antenatal and postnatal periods.

- **Family support**

Family members experienced support amongst the family in order to adjust to the burden of care for the teenager during pregnancy and after pregnancy. They developed coping mechanisms in order to adjust to the teenage pregnancy and this included; support one another and the teenager when the pregnancy was discovered in the families, extended family members supported the teenage mother in caring for her. Family coping mechanisms and unity was affirmed by the following quotes:

Family 1: (Uncle) *“When she arrived she phoned us and her older sister my other nephew with her husband took her and stayed with her but they complained that the pregnant nephew is troublesome.”*

Family 5: (Mother) *“I have a brother and my older sister who are assisting me.”*

Family 6: (Mother) *“She is my sister daughter but my sister passed away, it was just me and my grandmother who were looking after her during her pregnancy.”*

Family is a most influential social institution, it is mainly characterised by provision of guidance, support and a sense of belonging to its members. Through family relations, members learn about morals, values, discipline, respect, responsibility and integrity (Tunde Charles, Aigbovu & Ajayi, 2013:5635). Family members relied on one another for taking care of the teenage mother and her child and in instilling family morals and values to the added family member.

Family support systems such as mentoring interventions and guidance of teenage by older more experienced family members who are care givers including aunts, uncle, sisters and grandparents are needed. These experienced care giver address some of the particular risk factors associated with teenage pregnancy and motherhood (Mezey, Robinson, Gillard, Mantovani, Meyer, White & Bonell, 2015:527). Family members attempted to curb the added burden of care within the family by assisting one another.

Immediate and extended family members become involved in the teenage mothers' life and in the life of her child (Smith et al., 2011:1054). Extended family members assist the teenage mother's family in caring of her and her child.

- **Diverse coping mechanisms**

Family members adopted diverse coping mechanisms after the initial shock of discovering that their teenage daughter is pregnant, but eventually some family members found positive coping mechanisms to accept the pregnancy. Some families had mixed reactions to pregnancy and became forced to cope and accept the pregnancy situation. The following quotes outline the way families accept the teenage pregnancy and motherhood:

Family 4: (Mother) *"I would laugh and say them 'My Blessing is coming' 'Can you imagine? It was so painful but I would laugh and each time I got to the house I would cry just to get rid of the pain. I would cry and cry inside my house then after that I would wear a smile and then go to church and I continued participating at church one hundred percent and remember the bible says anyone who thinks they have no sin, is fooling them. Even myself I know I have a sin and keeping on frustrating my child was not good. I knew that they also had their own sins."*

Some family members never abandoned the pregnant teenager:

Family 5: (Mother) *"I can say that as parents do not abandon your children when this situation comes even if they disappoint us it is the same because if you abandon them where will they go. It is just that we have to handle this situation together and assist each other so that she can learn from her mistakes."*

Family members had to find coping mechanisms that were going to assist them in coping with the teenage mother in their families. Outside family support is provided as community and others accepted the pregnancy and provided advice and support to teenagers (Rukundo, Abaasa, Natukunda, Ashabahebwa & Allaih, 2015:4). In most

instances family members were forced to accept and cope with the teenage pregnancy after the adolescent gave birth (East & Chien, 2013:10). Families used diverse coping mechanisms to accept the teenage mother and her child. Coping mechanisms included talking positively about the teenage mother child, some family members even referring to the child as their “blessing” that was coming. Other family members used their parenting instinct of caring as coping mechanism for their teenage daughter pregnancy and not chasing the teenage mother out of their family setting.

3.7.2 Problems related to pregnancy

Problems related to pregnancy emerged as the second category for coping with pregnancy and outcomes. Problems related to pregnancy had two subcategories namely: Teenage behavioural change and Family member’s experiences of pregnancy complications of teenager.

- **Teenage behavioural changes experiences**

Family members experienced behavioural changes in the teenager after her pregnancy was discovered. Different behavioural changes of teenager were experienced by families; one teenager took more responsibility in her role assisting with the burden of caring for her baby, while other teenagers regressed to more distractive behaviours after pregnancy. The following quotes affirm the changes in teenage mother’s behaviour:

Family 3: (Mother) “*She started changing her behaviour.*”

Family 5: (Mother) “*Our relationship is right but she fears leaving the children with me because she feels like she is handing me with her burden more especially when she wants to go to town.*”

Family 6: (Aunt) *“I cannot say that she went back to school because even now she may be asleep where she is because she was out drinking all night, after pregnancy she never worked hard at school again.”*

Teenage mother's behaviours changes either for the better or for the worse. Teenage pregnancy is associated with socioeconomic and health inequalities including a higher risk of deprivation, emotional difficulties and behavioural changes (Lappalanti, Gissler, Mentula & Heikinheimo, 2013:3). Certain behavioural changes related to teenage pregnancy are due to unemployment, being poorly educated, single parenting and psychological distress (Lehti, Hinkka-Yli-Salom, Cheslack-Postava, Gissler, Brown & Sourander, 2015:523).

Teenage mothers make negative associations between executive function and mothering, some teenage mothers show signs of being less affectionate, have fewer positive facial expressions and reduced verbal and emotional responsiveness to their babies. However, it may depend on the teenage mothers' age, the older she gets the less negative behavioural changes are displayed (Chico, Gonzelez, Ali, Steiner & Fleming, 2014:1027). Some family member's observed behavioural changes from the teenager after pregnancy. Such as being less sensitive and show less maternal interest in their children once they are born (Chico et al., 2014:1029). In this study, one teenage mother was drinking and leaving her child in the care of parents as a sign of deteriorating behaviour as a mother.

- **Family member's experiences of pregnancy complications of teenager**

Family members experienced pregnancy complications of the teenage and had to support her and her baby throughout antenatal and postnatal care of the teenager. The following quotes affirm experiences of family members who experienced caring for teenage daughter with complications.

Family 4: (Mother) *“During this time, she would call the child's father and family to report to them that the child was sick and they would tell her that they do not have*

money to give to her to take the child to the hospital. So, from time to time I would catch her crying and that was the moment we reconnected as now it was up to me to make a plan on how to take the child to the hospital.”

Family 7: (Mother) *“At six months, she complained of pains and I let her feel the pains intentionally because I thought she was looking for attention but when I realised that she was serious I decided to call an ambulance which took her to the hospital where she delivered her baby. It was painful because I had to support her and the baby throughout their hospital stay because the child was placed in an incubator.”*

The findings indicated that some teenage mothers experienced pregnancy complications such as premature birth and a sick child. Thus, family members were faced with the burden of caring for the teenage mother’s health complications due to pregnancy. The complications of teenage pregnancy occurring between the ages of 11-18 years is higher, especially preterm delivery. Teenage mothers face complications such as premature birth and having sick child, but these risks are reduced if the teenager have access to health care during antenatal period and during delivery (Adel, Rahma, Majeda & Nadia, 2016:91). Teenage pregnancy is mostly associated with pre-term birth and risks faced by the teenager is divided into two categories namely maternal complications including mode of delivery complications and neonatal outcomes (Lappalanti et al., 2013:3). It emerged that some of the teenagers who fell pregnant and became mothers experienced complications such as premature birth and having sick child after delivery and family members had to take on the added burden of caring after them.

- **Field notes**

During and post interviews, the researcher made notes that were used to ensure data authenticity, these notes included: field notes, observational notes, personal notes and methodological notes.

Field notes are a written or narrative account of what the researcher sees, feels, and experience during data analysis (Botma et al., 2012:217). Soon after each interview process with the participants, the researcher wrote down field notes on what she felt and saw. These notes included observation notes, personal notes and methodological notes.

- **Observational notes**

Observational notes are an objective recording of multiple forms of observed data by the researcher, which include description of physical setting, observed events and participants dialogue (Botma et al., 2012:217). The researcher made observational notes about the observed data, including participants honouring their appointment and their nonverbal language during the interviews. Participants displayed a lot of emotional cues when they talked about discovering the teenage pregnancy and events that occurred after the child was born. The researcher also observed that some participants were holding back on the information about their teenage daughter being pregnant, to such an extent that the moderator had to use probing questions.

Theoretical notes were used by the researcher in trying to make sense of what is going on (Botma et al., 2012:218). This included the participant's ability to honour their appointment and that initially some participants were scared of talking about their experiences of burden of care for teenage mother.

- **Personal notes**

Personal notes are the researcher's comments about her own feelings while working in the field (Botma et al., 2012:218). The researcher was able to remain objective during the interviews because of the participant's positive outlook about the interviews and also the moderator's confidence that she conveyed while conducting the interviews. To the researcher, it emerged during interviews that most teenage mothers are cared for by female family members.

- **Methodological notes**

Methodological notes are reflections about strategies used in the observation (Botma et al., 2012:218). The researcher used the strategy of showing respect to participants, greeting them and explaining about the study conducted and this created a trusting relationship between the participants, moderator and researcher. This strategy worked for the researcher whilst in the field.

3.8 CONCLUSION

The burden of care on families with teenage pregnancy: This study proved that families become burden with care for teenage mother and her child, whether physically, financially or socially.

CHAPTER4

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

Previous chapters of the study on the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga detailed the explorative and descriptive qualitative study that was conducted. Semi-structured interviews were conducted with seven families in a selected township in Mpumalanga; these families were purposively selected as participants. The interviews were audio-taped and Nguni language was used, data collected was transcribed and analysed by the researcher, moderator and senior supervisors.

4.2 CONCLUSION

Chapter four consist of conclusions derived from the findings of previous chapters on study of the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga. Conclusions of this study were based on the aim of the study, research questions and results of the study. Other titles include recommendations of the study and limitations of the study. The study focused on the aim and research question in order to explore and describe burden of care experienced by families with teenage mothers in a selected township in Mpumalanga. The questions were answered therefore the objectives of the study are attained.

4.3 AIM OF THE STUDY

The aim of the study is to explore and describe the burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.

4.4 RESEARCH QUESTION

The research answered these questions:

- What is the burden of care experienced by the families with teenage mothers in a selected township in Mpumalanga?

- What is the financial burden of care experienced when caring for a teenage mother?
- What is the social burden of care experienced when caring for a teenage mother?

4.5 RESULTS OF THE STUDY

Results of the study were derived from the main themes that emerged during data collection and data analysis, namely social burden of care, psychological burden of care, financial burden of care and coping with pregnancy and outcomes.

4.5.1 Social burden of care

Social burden of care emerged as one of the themes with three categories namely: Cultural practices regarding managing pregnancy outside marriage, Social impact on family and Social impact on teenage mother's side. Sub-categories that emerged from this theme are Non-acceptance of the pregnancy, Acceptance of pregnancy, forced grand parenting, Social stigmatisation by the community members, parenting burden and Dropping out of school.

Results

Family member's experienced unfulfilled cultural practises were the teenage mother's sexual partner failed to recognise the teenage mother's child by paying damages to her family for impregnating her. Non-acceptance of the pregnancy was a challenge that families came across because partner families refused to acknowledge the child born by the teenager and failed to fulfil the cultural obligations expected of them. Participants were bullied and assaulted by the teenage partner's family during confrontations about the pregnancy. Other participant's challenges were verbal abuse they endured from the teenager partner's family once pregnancy was discovered. Families also had suspicions they harboured towards the teenager partner who appeared to be deceiving the teenager in the relationship until later on when she became pregnant. Participants also disclosed that the teenage partner's family accepted the teenage pregnancy. The teenage mother's parents experienced feelings of being forced to become grandparents after the teenage became a mother. The

teenage mother's family members also experienced the social burden of having to care for the teenager's child with little or no support from the teenage mother's partner's family. Other reasons that enforced their decisions were that the teenager was falling pregnant for the second time in a short space of time.

With regards to social stigmatisation by the community members, family members faced stigmatisation from community members about the teenager who had fallen pregnant whilst still at school. Other family members faced blame from community members for not assisting the teenager with family planning or protective measures against pregnancy. Family members were also persecuted by people from their religious circles who condemned and blamed them for having a pregnant teenager in their homes and family members blamed themselves for the teenager pregnancy and felt like they were the ones who failed to raise their child properly and in a right way.

Lastly, family members prevented the teenager from schooling because she had added an extra mouth to feed in the family so she had to work in their informal small scale business as way of adding funds and sustaining the family. Family members were burdened with the decision to take the teenager out of school after her child was born. The main concern that enforced their decisions to prevent the teenager from attending school were poverty and that they had no substitute food to provide for the child while the teenage mother was still at school and breastfeeding her child.

4.5.2 Psychological burden of care

The psychological burden of care theme emerged with two categories namely: Reaction of family members and Parent's emotions. Subcategories that emerged were: Anger and hurt, Disappointment and embarrassment, reflecting on their own parenting experiences, Termination of pregnancy as an option and Using religion as a reason.

Results

The anger and hurt experienced by family members was the first sub-category from the psychological burden of care. The participants in the study were angered by the discovery of the teenager's pregnancy and their anger was directed towards their teenage daughter for falling pregnant. Other participants were hurt and felt painful emotions after discovering their teenager's pregnancy, the hurt was caused by the teenager by falling pregnant whilst still at school and their expectation was for her to finish with her schooling first. Other painful emotions were ignited by the discovery of the teenager's sexual partner, who appeared to be an older married man. Other participants were hurt because the teenager fell pregnant for the second time in a short period of time whilst still young, schooling and school fees had already been paid for the year. The participants in the study were hurt because they were single parents and knew the difficulties of having an additional mouth to feed in the family.

The teenage mother's parents were also forced to reflect on their own parenting experiences. Decisions regarding the termination of the pregnancy and the rights of the pregnancy were taken from the teenager by family members who assumed responsibility of deciding on the pregnancy outcomes. Family members insisted that the teenager keep the pregnancy, mainly because of their religious beliefs that were against the termination of the pregnancy and because of fear of the teenager dying during the abortion process or after the abortion.

4.5.3 Financial burden of care

The financial burden of care theme had two categories namely: Financial stability of families and Source of income. Sub-categories that emerged were: Financial status of families, Food security for the family members, Social grants and Informal business.

Results

The financial status of the family and the participant's financial status was from a low socio-economic background or poverty stricken, since most families relied on food

from their small-scale farming in their plot of land. The families stayed with extended families of more than four members per family. They were all living from the social grant provided by the government and relied on the social grant to feed the whole family. Some families faced the unemployment of the breadwinner in their respective families. A major source of income for family members in the study was child grant money from government and informal small scale businesses performed on the informal dwelling of family members. Family members were receiving assistance from the teenager's partner families even though they also had limited resources. Families also dependent on social grants as their means of food security at the beginning of the month and won't have other means of replenishing food during the course of the month.

4.5.4 Coping with pregnancy and outcomes

The coping with pregnancy and outcomes theme had two categories namely: Coping mechanisms and Problems related to pregnancy. Four theme sub-categories that emerged were: Family support, Diverse coping mechanisms, Teenage behavioural changes experiences and Family member's experiences of pregnancy complications of teenager.

Results

Families also prevented the teenager from schooling because the teenager had antenatal and postnatal complications and had delivered a pre-matured baby.

The teenage mother's families experienced support from their extended families in looking after the teenage mother and her child. Other family members experienced the teenage mother's behavioural changes after she fell pregnant. Coping mechanisms differed from one family to the other, because other teenagers had added responsibilities of assisting in their respective families by looking after their children while other teenage mother's changed behaviour and dropped out of school. Family

members also experienced the burden of care of teenage mothers who had complications and had to care for the teenage mother and her child.

4.6 RECOMMENDATION OF THE STUDY

The burden of care experienced by families with teenage mothers in a selected township in Mpumalanga can be addressed at three levels: family members, family nursing practice and policy development departments. There are several recommendations pertaining to the burden of care. The following recommendations are discussed below:

- **Family members**

Participants still have limited knowledge regarding referral systems to social workers, psychologists, child grant services and home affairs. Family members were recommended to enquire about available resources. Family members who deal with pain and anger should seek assistance in health care facilities when the need arises and should accompany teen for antenatal care visits.

- **Family nursing practice**

Family nursing practitioners should make use of the available policies and guidelines when monitoring and providing services to teenagers and family members in order to provide holistic care to teenage mothers and their families. Health care providers should identify families with teenage mothers during antenatal visits in the primary health care setting to refer families in need of support to ward based outreach team services for further management. Specific social and psychological programmes for family members with pregnant teenagers or teenage mothers must be put in place as a way of providing support and assistance. Health service providers should refer family members to social workers for social support, SASSA for child financial support and psychologist for psychological support. Health care providers should improve health education to family members when they accompany teenage mothers for consultations.

- **Policy development health departments**

To put specific health policies in place that addresses the social, financial and psychological burden of care for family members who experienced living with a pregnant teenagers or teenage mothers.

4.7 LIMITATIONS

- **Interviews setting**

Family members who were booked for the interviews, cancelled last minute.

- **Participant's effects**

The interviews were semi-structured and due to the nature of the topic the participants were interviewed on, it became emotional for them and there was a possibility of participants withholding information.

- **Data collection and analysis**

The participants included in the study were from a low economic background and it was hard to generalise the findings with parents of teenage mothers living in high socio-economic areas.

- **Implications of the study**

The study was conducted in one province and the end results cannot be generalised nationally. Semi-structured interviews were conducted and data collection was time consuming.

4.8 CONCLUSION

In this study, it became evident that family members become burdened with care socially, psychologically and financially once their teenage daughter falls pregnant and bears a child.

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ANNEXURES

ANNEXURE A: DECLARATION REGARDING PLAGIARISM



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

I understand what plagiarism is and am aware of the university's policy in this regard

I declare that this work is my own original work. Where other people's work has been used (either from a printed source, internet or any other sources); this has been properly acknowledged and referenced in accordance with departmental requirements.

I have not used work previously produced by another student or any other person to hand in as my own.

I have not allowed, and will not allow, anyone to copy my work with the intension of passing it off as his or her own work.

Dumisile Ncongwane

ANNEXURE B: DATA COLLECTION INSTRUMENT



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Main question:

- What is the burden of care experienced by the families with teenage mothers in a selected township in Mpumalanga?

Probing Questions

Financially

- What is the financial burden of care experienced when caring for a teenage mother?

Socially

- What is the social burden of care experienced when caring for a teenage mother?

ANNEXURE B2: ULUHLA LOKUCALA LEMIBUZO



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Uhlangabezane njani nesimo sokunakekela intombazana encane ezithwele lapho ekhaya, wazizwa njani mawuthola ngokuzetwala kwalentombazana

Zezimali

Nihlangabezane njani ngezezimali kuze nikhone kunakekela lentombazana

Emuphakathini

Nihlangabezane njani nomuphakathi ngokunakekela lengane enomtwana

ANNEXURE C1: PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT FORM

TITLE OF STUDY: The burden of care experienced by families with teenage mothers in a selected township in Mpumalanga.

Dear Participant,

1. INTRODUCTION

You are invited by the researcher to participate in the research study of the above mentioned title. Participants are advised to ask questions about the study in order to fully understand what is been studied. Contact person is Mrs D Ncongwane.

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of the study is to explore and describe how families experienced the burden of care when their teenage family member became a mother. Family members are a good source of information because they have experienced burden of care for teenage mother.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

Family members will be interviewed about their experiences of burden of care for teenage mother at health facility or family member's church office. Notes will be written down; audio tape will be used for recording interviews and observation made by the interviewer. The researcher is requesting from participants to use audio recording during the interview which will be kept anonymous as no name calling will be used.

4. RISK AND DISCOMFORT INVOLVED

The interview will last for sixty minutes per family and there are no risks involved when participation in the study. However, if any family experience signs of distress will be referred to the clinic social worker at 013 242 3906 as arranged.

5. POSSIBLE BENEFITS OF THE STUDY

There are no benefits intended in the study, however knowledge will be gained on how families experience burden of care for their teen daughter who becomes a mother

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Participation in the study is voluntary. Participants are allowed to terminate their participation at any time during the interview process. Data received from participants that have withdrawn will be removed from the study.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

Study approval from the ethics committee of the health science at the University of Pretoria. Telephone number 0123541330

8. INFORMATION AND CONTACT PERSON

Contact person for this study is Mrs D Ncongwane phone number 0827767134 or supervisor Dr S Mataboge at 0123541073

9. COMPENSATION

No compensation intended for this study.

10. CONFIDENTIALITY

Participants' information will be kept confidentially; no names of persons or addresses will be mentioned in the study during presentation of the research findings or research journals. All information in this research study will be kept confidentially.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that I have been notified about the nature, process, risk and benefits of the study. I have read and understood from the above leaflet about the study. I am aware that my personal information will not be mentioned in the study. I am participating willingly and voluntarily in the study, I understand that I can terminate my participation any time when I do not feel comfortable and there are no penalties that I will pay.

Participant's name _____ (Please print)

Participant's signature: _____ Date

Investigator's name _____ (Please print)

Investigator's signature _____ Date

Witness's Name _____ (Please print)

Witness's signature _____ Date

ANNEXURE C2: IMINININGWANE NGESIFUNDO KANYE NEKUSIBANDAKANYA

1 Isicalo

Wamukelekile kulesisifundo, uvumelekile ukubuza imibuzo. Umuntu ongaqhumana naye wu make D Ncongwane

2 Umgomo walesifundo

Ukuthu sifune, siqhaze ngemindeni enobunzima bekunakekela insha yamantombazane anabantwana

3 Kuqhaza ngekuqhubeka kwalesifundo

Imindeni iyakubuzwa ngezindlela abasisebenzisayo kanye nobunzima abahlangabezana nabo uma benakekela izingane ezinabantwana, Imvume yokusebenzisa iwayilensi eyizothatha imininingwane yalesifundo iyacelwa kuzihlobo ezizo hlanganyela kulesisifundo

4 Ukungakhululeki Kanye nobunzima

Imibuzi izothatha li hora elilodwa, akukho ubunzima enibekelwe bona uma nibuziwa ngemibuzo

5 Okuzozuzwa kulesifundo

Akukho okubekelwe ukuzuzwa ngalesifundo

6 Amalungelo omuntu ozabe ephonswa ngemibuzo

Kuhlanganyela kulesifundo kuzowenziwo ngumuntu ufunayo akekho ophocelwe ukuhlanganyela. imininingwane ezotholakala kulesifundo yomuntu osulile kulesifundo nayo izosulwa kulesifundo

7 Lesifundo siyitholile imvume

Lesifundo sizothola ivume kubase ethics committee of the health science at the University of Pretoria

8 Imininingwane

Make D Ncongwane 0827767134

9 Inzuzo

Ayikho inzuzo kulesisifundo

10 Imfihlo

Amagama abantu abazohlanganyela kulesifundo azogcinwa ayimfihlo angeke embulwe esiveni

Imvume yokuhlanganyela kulesifundo

Mine ngiyavuma ukuhlanganyela kulesifundo labasichazile ngaphezulu. Ngiyazi kuthi igama lami Kanye nokuphathelene nami angeke kuveziwe. Ngihlanganyela ngevume yami akekho angiphoccelele kuthi ngihlanganyele.

Igama lomuhlanganyeli.....

Kusayina

Igama lomcoci wezinkulumo.....

Kusayina.....

Igama lalobhekile.....

Kusayina.....

ANNEXURE D: LETTERS OF APPROVAL



Lighthouse Christian Church

Erg 7743 Extension 23
Mhluzi
Middelburg
1053

P.O.Box 3187
Middelburg
1050

Tell: 013 241 6016
Cell: 083 5332 536
website: www.coremembers.co.za

Date: 03/08/2016

RE: APPROVAL LETTER FOR RESEARCH STUDY INTERVIEWS TITLED, THE BURDEN OF CARE EXPERIENCED BY FAMILIES WITH TEENAGE MOTHERS IN A SELECTED TOWNSHIP IN MPUMALANGA.

The Applicant Dumisile Ncongwane is granted the permission to conduct Interviews in our church regarding the following topic: THE BURDEN OF CARE EXPERIENCED BY FAMILIES WITH TEENAGE MOTHERS IN A SELECTED TOWNSHIP IN MPUMALANGA. She is expected to interview only ten families and the interviews will take a minimum of 30-40 minutes per family. Violation of such terms will result in discontinuation of the interviews progress in our church.

We believe that the Study process will contribute in building the community and the church as a whole.

For queries contact: Mrs T.J Magagula.

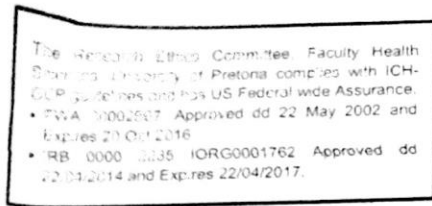
Contact No:(083 264 3981)


.....

Lighthouse Christian Church
P.O. Box 3187
Middelburg 1050
2016-08-03
Bishop M. Magagula
Cell: 083 533 2536
Website: www.coremembers.co.za

LIGHTHOUSE CRHISTIAN CHURCH

ANNEXURE D: LETTERS OF APPROVAL



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

18/08/2016

Approval Certificate New Application

Ethics Reference No.: 262/2016

Title: THE BURDEN OF CARE EXPERIENCED BY FAMILIES WITH TEENAGE MOTHERS IN A SELECTED TOWNSHIP IN MPUMALANGA

Dear Mrs Dumisile Ncongwane

The **New Application** as supported by documents specified in your cover letter dated 4/08/2016 for your research received on the 4/08/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 17/08/2016.

Please note the following about your ethics approval:

- Ethics Approval is valid for 3 years
- Please remember to use your protocol number (**262/2016**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharm, PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 356 3084 ✉ deepeka.behari@up.ac.za / fhsethics@up.ac.za 🌐 <http://www.up.ac.za/health/ethics>
📍 Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60, Gezina, Pretoria

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ANNEXURE D: LETTERS OF APPROVAL

MPUMALANGA PROVINCIAL GOVERNMENT

8875
Makatane street
South Africa



Tel: 013 -2423906/05

Department of Health

Ext 6 Clinic

Departement van Gesondheid

Litiko Letemphilo

Umyango Wezamaphilo

ENQ: N Mazibuko
Tel: 013242 3906

Date: 2016/08/02

TO: DK Ncongwane

From: N Mazibuko

SUBJECT: Approval letter to conduct study in the facility

This letter serves as an approval for the research study titled: THE BURDEN OF CARE EXPERIENCED BY FAMILIES WITH TEENAGE MOTHERS IN A SELECTED TOWNSHIP IN MPUMALANGA to be conducted in the facility.

We believe that this study is going to assist in the services provided by the Mpumalanga health department in Mpumalanga.

Thank you

