HIDDEN REALITIES

LIVED EXPERIENCES WITH TEENAGE PREGNANCY, MOTHERHOOD, AND HIV IN BOTSHABELO, SOUTH AFRICA

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Abstract

Hidden Realities: Lived Experiences with Teenage Pregnancy, Motherhood, and HIV in Botshabelo, South Africa

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This study is based on nineteen months of ethnographic fieldwork in Botshabelo township, South Africa. I relied on narrative inquiry and narrative analysis to explore teenagers' stories, and make sense of the powerful experiences embodied therein. I worked with 88 young women (pregnant teenagers and young mothers who were HIV-negative or HIV-positive) to explore teenage pregnancy and young motherhood. This dissertation offers three major theoretical contributions.

First, pregnant teenagers and young mothers in this study talk about being chastised for becoming pregnant outside marriage, before finishing school, and while being unemployed. Other people reprimand and punish these young women for transgressing a moral order that has eluded most of the people around them, even their own mothers. This punishment is reputational and gives rise to a punishing discourse that is related to the idea that key sources of moral value – marriage, education, employment - are under threat in this community. This sense of 'morality

being under threat' creates a context of fragility, which in turn exacerbates the punishment and social sanction that these young women carry. This punishment gives way to a multifaceted stigma linked to being a teenager, being a young mother, and (for some teenagers) having HIV. This stigma has an arc-like trajectory. It begins with a positive pregnancy test, and peaks when the baby bump becomes obvious. By the time the baby is born, however, this stigma moderates.

Second, this context of fragility begs for repair. As a result, most of these young women perform rituals of repair by hiding in the house, using blankets, and following medical routines. These are ways to protect unborn babies, clear the slate, and offer penance for the sin that is teenage pregnancy. Repair is a major component of the huge responsibility these young women bear for moral salvage. The process of repair - through acts of deference, discretion and redemption - helps these young women suture relationships with their families. Like stigma, repair has an arc-like trajectory. The shock of teenage pregnancy slowly gives way to the incorporation of both mother and baby into the life of the family. When families help with childcare, some teenagers can return to school.

Third, most of these pregnant teenagers and young mothers are taught to follow a prevalent and aspirational moral order (what other people say) instead of the prevailing social order (what other people do). I use 'other people' to refer to nurses, neighbours, school teachers and/or kin. Most teenagers' mothers teach their pregnant daughters to hide in the house in order to avoid 'witches' who prowl in the community. Moreover, pregnant teenagers are 'not allowed' to attend school because school principals and teachers forbid it. Furthermore, other people denounce teenage pregnancy outside the sanctity of marriage. Many of the people who espouse

these lessons, however, have not finished high school, were pregnant teenager themselves, and have never been married. The contradictions in the lessons other people give these pregnant teenagers and young mothers expose a gap between how teenagers *should* live (prevalent moral order) and how teenagers *actually* live (prevailing social order). It is in this space, this gap, that 'good' teenage mothering occurs.

This dissertation adds to a growing body of literature exploring what life is like for pregnant teenagers and young mothers (who are HIV-negative or HIV-positive) in South Africa. This study contributes to the fields of public health, childhood and youth studies, and sexual and reproductive health. The stories described herein are not necessarily about pregnant teenagers and young mothers who are heroic. These are stories about pregnant teenagers and young mothers who are incredibly courageous, as they try to make the most of the way things turn out.

615 words

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Definitions

Throughout this dissertation, I use the term ‘others’ to describe the people inhabiting the social world, neighbourhood or “community of practice” (Anyidoho, 2010:324) that is the small area of Botshabelo where I worked. ‘Others’ broadly describes community members, nurses, neighbours, teachers, friends and/or family members. Furthermore, I use the terms ‘pregnant teenager,’ ‘teenage mother,’ and ‘young mother.’ The latter term (‘young mother’) broadly describes teenage mothers and young adult mothers in their early twenties. I learned these terms during my fieldwork, that is, these were the same words used by participants and translators. I believe these terms reflect the respective social values attached to the teenage pregnancy and young motherhood experiences (Macleod, 2003). Where I write about ‘teenagers,’ I am pointing to meanings of girlhood or childhood. Where my language includes ‘mothers,’ I am indicating meanings of young motherhood, womanhood or adulthood. The specific meanings of these experiences are beyond the scope of this research. I only explore these meanings superficially when they are analytically useful. All the young women in this study had experienced teenage pregnancy, even if they were older than twenty during my fieldwork. The youngest participant was 16 years old. The oldest participant was 50 years old.

The chapters reference scholarship in various academic fields. This is a testament to the sociomedical and ethnographic nature of my study topic. Furthermore, I cite research conducted in in various regions of the world. Many references, however, come from research conducted in the United States. This is largely because there is limited (qualitative) work on HIV-positive pregnancy and HIV-positive motherhood that has been conducted in South Africa. In my **Literature review,** I make special note of the growing South African scholarship on this topic

(Long, 2009; McMahon, 1995; Sandelowski & Barroso, 2003a:473; Sanders 2008; Stinson & Meyer, 2012). By exploring HIV-positive pregnancy in different global regions or situations, I am not normalising pregnancy or motherhood as monolithic experiences. On the contrary, this dissertation is evidence that pregnancy and motherhood are increasingly complex experiences. Neither am I comparing the social climate of pregnant teenagers and young mothers who live in different countries. I acknowledge that pregnant teenagers and young mothers in different social situations describe pregnancy and motherhood according to their temporal, spatial, and contextual situations (De Fina, 2003; Riessman, 2014). I refer to this rich and diverse scholarship to explore specific themes related to pregnancy, motherhood and HIV in the hopes that this scholarship can bolster my empirical findings in Botshabelo.

I. Introduction

South Africa carries the greatest burden of HIV in the world (AVERT, 2020a; AVERT, 2020b; AVERT, 2020c, AVERT, 2020d; AVERT, 2020e). Teenage girls and young women bear the greatest weight of this burden (UNAIDS, 2011a; UNAIDS, 2011b; UNAIDS, 2016a; UNAIDS, 2016b). The HIV burden exacerbates the social stigma and school-related discrimination that many pregnant teenagers face in South Africa. The socio-health challenges associated with teenage pregnancy require us to "listen to pregnant women living with HIV" (D'Auria, Christian & Miles, 2006; Hutchison & Kurth, 1991; Kurth & Hutchison 1991:20-21; Turan & Nyblade 2013:2537). Understanding HIV-positive teenage pregnancy is pertinent not only because qualitative knowledge on this topic is limited, but also because teenage pregnancy is prevalent. In developing regions of the world, such as Sub-Saharan Africa for example, 20% to 40% of teenage girls are mothers or pregnant (Atuyambe et al., 2008; Gyesaw & Ankomah, 2013:773; World Health Organization, 2009). Now more than ever, research exploring teenage pregnancy and young motherhood in the context of HIV is a worthy area of focus. Such research will contribute to the fields of public health, childhood and youth studies, and sexual and reproductive health.

Few developing countries are better suited to explore HIV-positive teenage pregnancy than South Africa. The country has one of the highest teenage pregnancy rates globally with 77 live births per 1000 teenagers, 15-20 years old, each year (Statistics South Africa, 2017a; Statistics South Africa, 2017b). Nationally, one in five pregnant teenagers in this same age group is HIV-positive (Jewkes et al., 2001). These data compare to the birth rate for the same age group in a developing country like Ghana: 60 live births per 1000 teenagers (Ghana Statistical Service,

2011; Gyesaw & Ankomah, 2013). This is higher than the birth rate in a developed country like the United States: 22 live births per 1000 teenagers (Hamilton, Martin, & Osterman, 2016).

Exploring HIV-positive teenage pregnancy in South Africa is also analytically fascinating. Public health discourse in South Africa, as in many other countries, has "demonised" motherhood and "pathologised" teenage pregnancy (Leclerc-Madlala, 1999; Logan Kennedy et al., 2014; Meleis & Im, 2002:208). In turn, teenage pregnancy discourse has stigmatized young mothers (Cunningham & Boult, 1996:693; Chohan & Langa, 2011; James et al., 2012:191; Mkhwanazi 2012, 2014a). HIV stigma compounds this stigma, making it multifaceted. As such, multifaceted stigma can interact with the "intersecting identities" shaping teenage pregnancy in intriguing ways (Liamputtong, 2006; Ngum Chi Watts et al., 2015).

This study is situated in Botshabelo township. This township is located in the Mangaung district of South Africa's Free State province. Statistical data from 2014 show that more than one in ten pregnant teenagers (12.9%) 15-19 years old had HIV in Mangaung (Free State Department of Health, 2014:16; National Department of Health, 2009). Almost three in ten (28.1%) pregnant women 20-24 years old had HIV in the same year. This suggests that antenatal HIV prevalence increases as teenagers get older. The HIV prevalence in Mangaung is especially problematic given high rates of teenage pregnancy in the Free State province. In 2017, this province had the second highest number of teenage pregnancies in South Africa (Choane, 2017).

Many pregnant teenagers in Botshabelo have parents who contracted HIV as the AIDS epidemic took hold of South Africa in the 1990s. Other teenagers were raised in communities with high HIV prevalence rates. Today, in the fourth decade of HIV/AIDS in South Africa, some of these teenagers are starting their own families. What is life like for these pregnant teenagers and young mothers? How do these young women behave in their communities? How does HIV influence teenage pregnancy and motherhood, if at all?

This study is an ethnographic exploration of teenage pregnancy, young motherhood, and HIV in South Africa's Botshabelo township. This dissertation focuses on four threads that weave these experiences together. In my empirical chapters - **Discovering and disclosing teenage pregnancy, Being a pregnant teenager, Familial care, Dimensions of teenage mothering** – I show how these four threads intersect and interact. The first thread is the way others perceive, and interact with, pregnant teenagers and young mothers in this study. I use 'others' when I refer to community members, nurses, neighbours, friends, and family members. What do others do or say to these pregnant teenagers and young mothers, during and after pregnancy? The second thread is the way these pregnant teenagers and young mothers perceive, and interact with, others. How do they respond to others? What do they do or say? The third thread is the way these pregnant teenagers and young mothers perceive themselves. How do they make meaning of being young, pregnant, and unmarried? What happens to their dreams and aspirations? The fourth thread is the way these pregnant teenagers and young mothers perceive their babies. How do they talk about, and act around, their unborn babies? How do they interact with their newborn babies, when these babies seem to be a source of punishment and pain?

My empirical chapters set the stage for the final analysis in my **Discussion Chapter.** Herein, I reiterate my conceptual argument: despite the stigma and punishment linked to teenage pregnancy, pregnant teenagers and their families endure pregnancy and prepare for motherhood. Also in this chapter, I present the major theoretical contributions of this dissertation. That is, teenage pregnancy threatening sources of moral value, the arcs of stigma and repair during teenage pregnancy, and teenage mothering situated in the gap between a prevailing social order and an espoused moral order. I briefly explore these contributions below.

In this study, I found that other people - community members, nurses, neighbours, friends, kin - relentlessly chastise pregnant teenagers and young mothers for becoming pregnant outside marriage, before finishing school, and while being unemployed. The reputations of these young women are forever marred as a result of the punishing discourse linked to teenage pregnancy. They are 'punished' because teenage pregnancy threatens key sources of moral value in this community such as marriage, education, employment, and physical well-being. This social sanction includes a multifaceted arc-like stigma that is linked to being a teenager, being a young mother, and (for some teenagers) having HIV. This stigma waxes as pregnancy progresses and begins to wane after the baby is born and welcomed into a teenager's family.

Teenage pregnancy threatens key sources of morality and, in doing so, teenage pregnancy creates a context of fragility. This sense of fragility contributes to the responsibility pregnant teenagers and young mothers carry to achieve moral salvage and reconcile with their families. That is, the disappointment and scandal linked to teenage pregnancy creates a need for repair. Hiding in the house, wearing blankets in public, and prioritising medical routines are rituals of

repair. These acts of deference, discretion and redemption are part of an arc-like process of repair through which these young women repent for the calamity that is teenage pregnancy. Repair brings with it a sense of reconciliation and acceptance in most households. Some families accommodate their teenage daughters. These families seem to make sense of teenage pregnancy with peace and understanding. Someway, somehow, they overcome the disappointment, stigma, and punishment that seems to cycle through generations. Families' conceptions of themselves as valuable entities that overcome challenge have some semblance of being restored. The arc of repair influences the arc of stigma. The latter seems to wane, and becomes more gentle as the new baby arrives. With newfound support from their families, some young mothers work hard to take care of new babies and return to school. In some ways, these acts continue the process of repair.

Community members and kin teach pregnant teenagers and young mothers to follow a prevalent (and espoused or aspirational) moral order instead of replicating a prevalent social order. The former is suggestive of what this society expects from pregnant teenagers and young mothers. The latter describes what these pregnant teenagers and young mothers see other people do. Most pregnant teenagers and young mothers must learn to live at the uncomfortable intersection between a prevalent moral order (what other people say) and a prevailing social order (what other people do). This intersection is riddled with contradictions as other people do one thing yet teach teenagers and young mothers another. That is, others socially condemn these pregnant teenagers and young mothers for actions that are closer to the social norm than others would like to admit. Others scold these pregnant teenagers and young mothers for disobeying a moral order. Yet most other people (especially teenagers' mothers) are often guilty of the same thing.

For example, most pregnant teenagers are punished for becoming pregnant (and not being able to finish school) when school principals and/or teachers forbid them from attending school (Bhana et al., 2010; Mkhwanazi, 2014a). A pregnant teenager is deprived of the very thing that others expect from her - an education. This punishment is a slur on her social reputation. She becomes the object of pernicious gossip in her neighbourhood. Her position in her community is that of a 'bad girl' and not a 'good woman.' When she obediently stays at home and away from school, she shows that she 'accepts' this punishment. Her behaviour is an act of deference, discretion and remorse. This act is a ritual of repair that is part of a process of familial reconciliation.

Another example of contradiction hints at the issue of marriage. Other people scold teenagers because they are pregnant yet unmarried. Elders teach teenagers that childbearing before marriage can degrade one's social status, while childbearing after marriage elevates it. Yet marriage rates have been declining in South Africa at least for the past decade (Department of Health, 2007; Mlotshwa et al., 2017; Schatz et al., 2011; Statistics South Africa, 2013; Statistics South Africa, 2018). This suggests that pregnant teenagers are being blamed for the decline of an institution (marriage) that began before they were born. Alternatively, the social expectation that marriage can 'save' a pregnant teenager might be interpreted as families pressuring teenagers to recover this institution that is a key source of moral value.

These contradictions expose a gap between how pregnant teenagers and young mothers *should* live and how they *actually* live. It is in this space, this gap, that "good" teenage mothering

occurs (Badinter 1981; Mercer, 1985; Mercer, 2004; Walker 1995). Both the process of repair and the arc-like stigma are crucial mediators for this performance of mothering.

This dissertation contributes to emerging scholarship exploring what life is like for (HIV-negative and HIV-positive) pregnant teenagers and teenage mothers. To date, there is limited research on this topic, especially in the South African context (Long, 2009a; Long, 2009b; Josephine, 2019; Stinson & Myer, 2012:43). Understanding how teenagers experience pregnancy, motherhood, and HIV can illuminate how teenagers make healthcare decisions that affect antenatal and postnatal care. This can bolster existing public health interventions (Adejumo et al., 2015; Callahan et al., 2017; Helleringer, 2017; National Department of Health, 2015a; National Department of Health, 2015b).

Moreover, this research adds to the qualitative scholarship on gender studies, youth studies, and sexual and reproductive health research exploring the "normalisation" (Sandelowski & Barroso, 2003a:476) and not pathologisation of HIV-positive pregnancy. This study contributes to a growing body of work on this topic (Greene et al., 2016; Kaye, 2008; Logan Kennedy et al., 2014; Meleis & Im, 2002; Sandelowski & Barroso, 2003b; Sidani & Braden, 1998).

II. Theory and methodology

Situating my field site

This research seeks to understand experiences of teenage pregnancy and teenage motherhood, in the context of HIV. I worked with teenage teenagers and young mothers (15 to 20 years old) in Botshabelo township.

Botshabelo is situated in the Free State, one of South Africa's nine provinces. The Free State is landlocked with mostly dry vegetation (Free State Department of Health, 2014; Free State Department of Health, 2018; Statistics South Africa, 1998; Statistics South Africa, 2018a; Statistics South Africa, 2018b; Statistics South Africa, 2018c). The Vaal River and Bloemhof Dam make up the northern border, while the Oranje River and Gariep Dam guard the south. The Drakensburg and Lesotho Mountains can be seen in the east. The North West and Northern Cape provinces lie to the west. More than 2.8 million people live in 946,000 households in the Free State province. As far as official demarcations go, this province is divided into nineteen districts. Mangaung is the most populated district. Mangaung district is divided into three sub-districts: Botshabelo, Thaba Nchu, and Bloemfontein (Olaleye et al., 2016). In reality, however, there are no borders between these districts and most people know each of them intimately. A thorough pre- and post-democratic history of Botshabelo township is beyond the scope of this study, although I explore some of these details in the chapter on **History and context.** Broadly speaking, in the South African context, "townships" were historically underprivileged areas with poor living conditions (Butler, 2010). Millions of Black South Africans lived in townships after they were forcefully displaced from other areas in the 1950s. Today, many Botshabelo

residents have better living conditions and infrastructure. The township is the second most populated area in the province, after the province's capital Bloemfontein. National census data show that there are approximately 182,000 people living in Botshabelo township although there are many more people who travel between Bloemfontein and Botshabelo (Statistics South Africa, 2020). Botshabelo is home to almost a third (28%) of its province's population (Mangaung Municipality, 2018:43). Botshabelo is considered the second most populated township in the country, after Soweto in the Gauteng province (Mangaung Municipality, 2018:43).

Botshabelo is officially divided into twenty-one geographical sections. I worked across five township sections. Throughout the dissertation, all locations have been anonymized to protect participant identities. I purposively identified these five sections for my fieldwork. I considered size and antenatal clinic infrastructure (Frith, 2011; Statistics South Africa, 2018a; Statistics South Africa, 2018c). Hlano Section is one of the smaller township sections with approximately 3,600 inhabitants. By contrast, Robedi Section is one of the larger sections with more than 21,000 people. The Robedi clinic also provides primary care to people living in Tshelela section. Finally, Leshome Section has one of the largest clinics in Botshabelo. This clinic provides care for people across many other sections including Robong section. Together, these five distinct areas – Hlano, Robedi, Tshelela, Leshome, and Robong sections - make up the fieldsite for this DPhil research.

Theoretical background

This research aims to explore teenage pregnancy and motherhood in the context of HIV. I approached this work qualitatively, and drew on feminist discourse and ethnography. Yet this research is primarily rooted in narrative inquiry. I chose narrative inquiry because this theory encourages 'coproduced' and 'reflexive' research based on multiple, in-depth interactions. This theory helped me understand the nuances of experience communicated through rich and meaningful stories.

Qualitative research

Qualitative methods can help a researcher understand the depth of an experience or story (Mishler, 1986; Polkinghorne, 2005; Riessman, 2014:138-142). Some scholars suggest that qualitative work is intended to study the "experiential life of people" (Polkinghorne, 2005:138) or the "life-world" of individuals (Schwandt, 2001:84). Such work prioritizes an iterative process of gathering information, through spoken word and holistic observation (Sherman & Webb, 1988).

A few examples of qualitative work with pregnant teenagers and teenage mothers include research in the United States (Ellerbee, 1990; Flanagan, McGrath, Meyer, & Coll, 1995; Lesser, Anderson, & Koniak-Griffin, 1998; Ray, 1997), Australia (Benson, 1996), China (Liao & Hsia, 1999), and Canada (Mykietka, 1998). These qualitative studies use in-depth interviews and participant observation to build trust with vulnerable participants (Clemmens, 2003; Ely et al., 2003; Sandelowski & Barroso, 2003a; Sandelowski & Barroso, 2003b). Moreover, qualitative

research methods have proved useful when exploring "sensitive" areas of research (Gill, Stewart, Treasure, & Chadwick, 2008; Kaye, 2008). These studies suggest that qualitative work can be limited in so far as it cannot be scaled-up or generalised at the population level. Despite these limitations, qualitative methods are well-suited for this study as these methods allow for trust-building and the exploration of

> …experience as it is 'lived' or 'felt' or 'undergone.' (Sherman & Webb, 1988:7)

This DPhil work is based on understanding the experience of each teenager's pregnancy and motherhood journey in a small participant pool.

Feminist discourse

Feminist works encourage research that is produced "for women rather than about women" (Bloom, 1998; Creswell, 1998; Guajardo, 2008; Keller, 1985). I acknowledge that feminist theories span vastly diverse debates and perspectives, including Collins (1991) "matrix of domination." This matrix is an intersecting network of oppressive social factors including race, gender, and age (Crenshaw 1989, hooks 1984, Nash 2008, Chodorow, 1978; Collins, 1991; Dill, 1988; Dill, 1994; Gilligan, 1982; Glenn, 1994; Green, 1990; Naples, 1991; Naples, 1992; Sack, 1994; Zinn & Dill, 1994). Because of these problematic matrices, Collins (1994) argues that it is "not enough to add women of colour" to current theories on pregnancy and motherhood. Instead, researchers must unravel the "matrices differentiating experience" according to women's self-reported, subjective stories (Hackl et al., 1997; Lather, 1991; Smith,

1987). By incorporating feminist theories, I prioritised teenagers' voices and perspectives in an effort to make this research "non-extractive" (Enria, 2016:321). Feminist theories have been used in previous work exploring teenage pregnancy (Deans Lake, 1999; Guajardo, 2008), HIV-positive motherhood (Barnes et al., 1997; Tangenberg, 2000), and participatory research (Maguire 1987). This DPhil work stands alongside feminist scholarship aiming to situate teenagers as "active producers of their own lives" (Keller, 1985).

Ethnography

I approached this research using ethnographic methods. In so doing, I focused on the "fieldwork-theorist" (Clifford, 1981) and the "ethnographic present" (Fabian, 1983). Ethnography prioritises "being there" to ensure a certain a good understanding of data and context (Geertz, 1988; Richards, 1998). Importantly, this research was not an ethnography: it aimed to be "ethnographic" (Wolcott, 1988:202). Ethnographic work can be limited in so far as researchers intentionally 'seek out' participants and conversations that are relevant to the study (Angotti & Sennott, 2015:448). Furthermore, there is a risk that these conversations might be based on what participants think researchers want to hear (Angotti & Sennott, 2015:449). Despite these limitations, ethnographic methods were well-suited for this DPhil study. This work focused on the specific experience of teenage pregnancy and young motherhood, which I believe necessitated purposive sampling among a vulnerable participant group. Recruiting a relatively large group of teenagers, spending in-depth time with a few of them, asking open-ended questions and triangulating my data reduced some concern that teenagers were only telling me what I wanted to hear. Moreover, ethnographic methods have influenced extensive research with HIV-positive youth in South Africa (Hodes, 2017a; Hodes, 2017b; Jewkes &

Wood, 1999; Jewkes, Vundule, Maforah, & Jordaan, 2001; Jewkes, Morrell, & Christofides, 2009; Leclerc-Madlala, 1996; Leclerc-Madlala, 1997; Leclerc-Madlala, 1999a; Leclerc-Madlala, 1999b; Mkhwanazi, 2012; Mkhwanazi, 2014a; Mkhwanazi, 2014b; Mkhwanazi, 2014c; Preston-Whyte, 1993; Preston-Whyte, 1994; Preston-Whyte, Abdool Karim, & Zondi, 1991; Preston-Whyte & Zondi, 1989, Preston-Whyte, Zondi, Mavundla, & Gumede, 1990; Varga, 1997a; Varga, 1997b; Varga, 1998; Varga, 1999; Varga & Makubalo, 1996; Wood & Jewkes, 1997; Wood & Jewkes, 1998; Wood & Jewkes, 2001; Wood, Maforah, & Jewkes, 1996; Wood, Maforah, & Jewkes, 1998). These studies relied on interviews and participant observation in order to achieve a "fully embodied participation and/or presence in the field" (Sandelowski, 2002; Thornton, 1983a; Thornton, 1983b). I used similar research methods for this DPhil study as they helped me negotiate Clifford's (1983) sense of "allochronism," which can be another limitation of ethnographic work (Fabian 1983 in Birth 2008:6). Employing an ethnographic framework and immersing myself in my fieldsite helped me reduce what development theorists call "othering" as much as possible (Petros et al. 2006:68).

> Negative othering involves the exploitation of power imbalances in relationships such that one gains at the expense of others. (Petros et al., 2006:68)

Narrative inquiry

This research is primarily rooted in narrative inquiry. This theoretical foundation encouraged me to pay attention to context*,* instead of only content. Narrative inquiry is the "study of experience as a story and is a way of thinking about experience" (Connelly & Clandinin,

2006:375). I used narrative inquiry so the lived "experience" and the "story itself" became the objects of my investigation (Polkinghorne, 2005; Riessman, 2014:2). This theory allowed the 'construction' of stories about - and with - teenagers (Ely et al., 2003; Labov, 1972; Labov, 1982; Labov & Waletzky, 1967; Riessman, 2014; Tesch, 1990).

Experience is influenced by - and produced in - the context of relationships and socio-political factors (Kaye, 2008; McMahon, 1995; Phipps-Yonas, 1980; Preston-Whyte et al., 1990; Riessman, 2014; Stinson & Myer, 2012). As such, each story has important context based on "sequential and temporal ordering" (De Fina, 2003:13) and "spatial ordering" (Riessman, 2014:5). For this particular research, this meant that I worked hard to understand the meaning and context of each teenager's story (Hymes, 1964; Polletta, 2006; Wenger, 1998:53). Paul Farmer (2004) suggests that interpreting a story without its situated context is like seeing only the puddles, and not the clouds or rainstorm that provoked them (2004:309).

Speech, manifesting in narrative, alerted me to the complexities of teenage pregnancy. How someone feels about and perceives her social world came out in the words she spoke. By paying close attention to what she said, I paid attention to her experience. Often, teenagers did not have an 'accurate' or objective understanding of the context influencing their lives. Yet this narrative work prioritised their subjective, not objective, interpretations. These interpretations scaffolded the context for their stories.

Narrative theory is useful when working with individuals in stigmatised or vulnerable groups (Hendry, 2007; Plummer, 1995). In Botshabelo, teenagers face stigma because they are young

and pregnant, or young and HIV-positive and pregnant. This has been explored in many settings including the United States and Australia (Clemmens, 2003; De Souza, 2004; Ingram & Hutchinson, 2000; Logan Kennedy et al., 2014; Long, 2009; Sandelowski & Barroso, 2003a; Sandelowski & Barroso, 2003b). Narrative work encourages a vulnerable participant to share incredibly personal experiences because she remains the owner of her story. For this research, teenagers were able to "tell their stories on their own terms" without losing control of the research process (Ion et al., 2016:185). Bamberg and McCabe (1998) emphasise this:

> With narrative, people strive to configure space and time, deploy cohesive devices, reveal identity of actors and relatedness of actions across scenes. They create themes, plots, and drama. In so doing, narrators make sense of themselves, social situations, and history. (Bamberg & McCabe, 1998:iii)

Narrative inquiry opens up forms of telling about experience, not simply the content to which language refers. We can ask the following questions: "why was the story told *that* way? How did the local context and research relationship shape *this* account? What broader social discourses are taken for granted by the participants" (Riessman 2014:4 emphasis in original; Riessman 1993, 2008). Focusing on teenagers' stories helped me "place women's voices and experiences at the centre of the research" (Ion et al., 2016:185). Narrative inquiry has been used in various research settings. For example, some scholars have used narrative to explore teenage pregnancy and teenage motherhood (Smith Battle, 1995, 1996; Smith Battle & Leonard, 1998; Varga & Brookes 2008), HIV-positive motherhood (Greene et al., 2016; Ion et al., 2016, Josephine 2019), and narrative therapy (Brown et al., 2008) among other topics.

A necessary aspect of narrative inquiry is the discrepancy between storytelling and interpretation. This is a contested issue in the literature (Arnheim, 1969; Devitt & Sterelny, 1987; Gendlin, 1962; Polkinghorne, 2005; Riessman, 2008). During my fieldwork, there were often differences between how a teenager told a story, and how I interpreted her experience. I have two comments about these differences.

Firstly, I found that recognising these differences inspired fruitful discussion between participants and interpreters. Moreover, during my analysis, I included a "range of suggestions" or a "constellation of meanings" to reflect these discussions (Barnes et al., 1997; Riessman, 2008:14).

Secondly, these differences highlighted my personal biases. That is, the tension between what I "know and believe" and what I "observed" (Guba & Lincoln, 1989; Sharp, 1988:5). My lived experiences differ from most teenagers' experiences. I am Indian, unlike the teenage teenagers at my fieldsite who are Black. Furthermore, I am a middle-class South African woman who has had privileged access to international education opportunities and mentorship. My race, class and knowledge have shaped my experiences while working and studying in foreign countries. By "bracketing" these lived experiences, I became more aware of my preconceived biases influencing ideas about schooling and teenage pregnancy (Giorgi, 1985). I used 'bracketing' to 1) separate these biases from what I observed and learned from teenagers and their families, and 2) recognise how these biases shifted during fieldwork. Over time, I saw myself becoming protective of the young women I met, their babies, and the stories their families entrusted to

me. My previous notions about why pregnant teenagers do not finish school were replaced with real stories of young women who are forced to hide in their homes because teachers and family mandate it. 'Bracketing' my bias did not mean erasing my own experiences. Indeed, the power of narrative work is revealed in the version of a story that has found its place as participant and researcher collaborate. In order for this collaboration to take shape, both participant and researcher must present (often flawed) parts of themselves to each other. Bracketing cannot exclude or erase bias completely. I believe bracketing should, instead, be used to spotlight bias and highlight its confounding effects on interpretation and analysis.

One limitation of using narrative inquiry was that I could not speak Sesotho fluently. Sesotho is widely spoken in Botshabelo (Statistics South Africa, 2018). Narrative methods pay such close attention to *how* things are said, not only *what* things are said. Language and translation complicate this analysis process, especially when participants are asked to share deeply personal experiences. This was certainly the case for this research. For some teenagers, our discussions were the first times they voiced experiences with HIV and teenage pregnancy. To combat this limitation, I encouraged teenagers to explain their meanings when interpreters were translating. Often, the back-and-forth between teenagers and interpreters provided rich discussions. For example, teenagers used various metaphorical terms to talk about 'abortion' such as 'have it on top' or 'cancelling' or 'have it done'. Discussing these terms helped me understand the stigma and feeling linked to abortion. Moreover, an interpreter's presence made teenagers feel comfortable while they were learning about me. Catherine Riessman addresses translation as a challenge for narrative inquiry: "Meanings are problematic and ambiguous, most obviously because of translation…" (Riessman, 2000a:134). She suggests that the

"strength and consistency" of an argument across participants can justify "the examination of interview transcripts that are not in the native tongue" (Riessman, 2000b:117-118). To combat this limitation, I studied Sesotho. I learned relevant "kin terms" so I could maintain "ethnographic authority" in the field (Clifford, 1983:125; Mead, 1930). Yet most, if not all, teenagers spoke English during interviews and conversations. Only some parts of their deeply personal stories were in Sesotho, and needed translation. The teenagers with whom I worked all spoke English even though most people (84%) in Botshabelo speak Sesotho as a first language (Free State Department of Health, 2014; Free State Department of Health, 2018; Statistics South Africa, 2019a).

Fieldwork

Some teenagers did not share their most personal stories in the first or even tenth meeting. Spending time with teenagers was the best way to counter any shyness and distrust. I therefore spent as much time as possible in the field (Table 1).

Table 1. D.Phil. Timeline

Month					Activity
Oct	2017	-	Feb	2018	Literature review. Discussions with practitioners.
Mar	2018	-	Apr	2018	Ethics applications.
May	2018	-	Jul	2018	Observation period in field.
Aug	2018	-	Nov	2018	Recruitment. Fieldwork.
Dec	2018				Data analysis.
Jan	2019	-	Sep	2019	Fieldwork.
Oct	2019	-	Apr	2020	Data analysis. Write-up and revision.
May	2020	-	Aug	2021	Write-up and revision. Finalise dissertation.

Vulnerable participants

Before fieldwork started, I needed to understand the nuances of working with pregnant teenagers, and teenage mothers. I had phone conversations with several practitioners and researchers (Appendix A). Many of these practitioners work with young people, and HIV-positive people in South Africa. Our discussions prepared me for ethical and practical challenges during fieldwork. I learned how to identify, and negotiate access with "gatekeepers" including nurses, doctors, neighbours, and relatives (Ely et al., 2003:20,23). Most importantly, these practitioners helped me understand that pregnant teenagers and teenage mothers face many kinds of stigma. This makes them particularly vulnerable during research. The South African National Department of Health and the National Health Research Ethics Committee highlights this:

> South African research ethics committees must pay special attention to protecting the welfare of certain classes of participants, such as minors (this includes children and adolescents), pregnant women, prisoners, … and people from vulnerable communities. (Van Zijl et al., 2004:20)

This DPhil research concerns an especially vulnerable group. Participants are teenagers *and* pregnant. Some participants are teenagers *and* pregnant *and* HIV-positive. Most teenagers are vulnerable because they are young, responsible for unborn babies, and (sometimes) ill. They sit at the messy intersection of three vulnerabilities (Figure 1). It was important for me to consider how each part of a teenager's identity – her age, her pregnancy, her HIV status – made her vulnerable. One implication of these vulnerabilities meant that recruitment, obtaining informed

consent, and conducting interviews required on-going negotiation. Furthermore, constant ethical considerations and reflections were important to mitigate risks for, and protect, the teenagers.

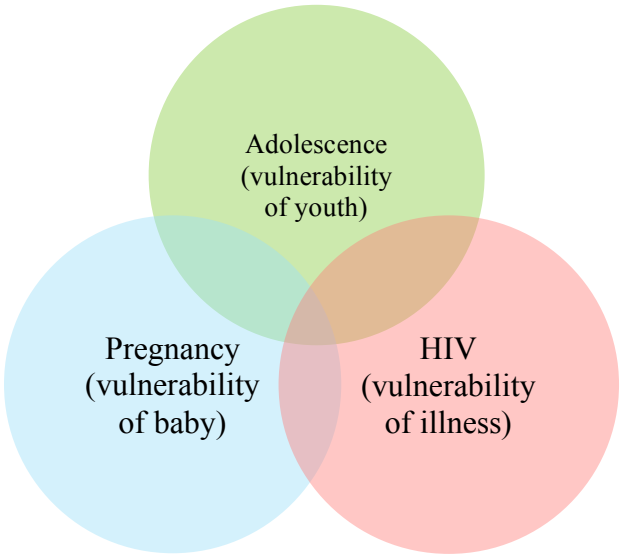

Figure 1. Three intersecting vulnerabilities

To further understand these vulnerabilities, and prepare for fieldwork, I was granted ethical approval to spend three months (May to July 2018) observing in my fieldsite. I believe this three-month observation period helped me ease into, and not "crash" into, the field (Ely et al., 2003:22). This period served as a "dress rehearsal" for my fieldwork (Ely et al., 2003:19). I started acclimating to my fieldsite, and building a new network of relationships. Moreover, I learned more about the very real traumas and joys of teenage pregnancy, and the empathy necessary to understand these. On most days, I spent time observing nurses, clinic administrators, and community health workers. I talked to these professionals when they were not attending to patients. I also observed how teenagers experience clinics. As such, I learned

more about approaching and working with vulnerable teenage teenagers. I by-hearted culturally appropriate phrases that convey respect and sincerity (Appendix B).

Working with interpreters

A Sesotho interpreter was present at most interviews to translate in real-time. This allowed for cohesive and relevant question prompts. Moreover, interpreters knew some of the teenagers personally, or through their social networks. Ethics committees encouraged me to work with an interpreter who was female, Black, and living in Botshabelo.

An interpreter's presence seemed to make some teenagers more comfortable. However, I worried that other teenagers did not share certain information because an interpreter was present. Potential judgement and stigma added to social desirability bias (Mooney et al 2018). To combat this, I tried to spend (at least some) time alone with teenagers. I arrived early, or stayed later, when we had scheduled meetings. When I was alone with teenagers, some of them shared things they did not wish to discuss in an interpreter's presence. Teenagers could explore things they had not yet considered, or could not discuss elsewhere. Moreover, I reached out to teenagers on Whatsapp and called them on the phone. Some teenagers responded well to these forms of communication. In these spaces, I encouraged teenagers to ask interpreters for clarification when they said they could not properly express themselves in English. When we next met, I gently reminded teenagers to clarify meanings with interpreters, if they wished to.

My being an English-speaker often benefited this research. Speaking English was the hallmark of my presence as a stranger. I was an "outsider" in the field (Clifford, 1983). My outsider status

meant that I was not privy to township gossip. Some teenagers felt more comfortable reflecting on deeply personal experiences with me. Furthermore, English offered a degree of anonymity and confidentiality. Most teenagers spoke English when they wanted to share sensitive experiences that inquisitive, nearby ears could not always understand. However, I was still a 'stranger'. I worked hard to foster a "sense of trust and safety" to encourage reflection and exploration (Schulman-Green et al., 2011).

During initial discussions with community leaders, I learned about the high unemployment rate in the township. This is especially challenging for young women. My employing two local interpreters created an opportunity for employment (Appendix B). This was often suggested to, or required of me.

I discussed appropriate payment with the Community Advisory Group to ensure fair compensation based on market-related, part-time employment rates (Appendix B). This part-time employment was specific to the fieldwork period. An interpreter would receive part-time wages and learn research skills. In addition to paying both interpreters, I also provided them with airtime and cellphone data so we could communicate regularly. Sharing weekly meals was an important part of building the researcher-interpreter relationship.

I worked with two female interpreters who lived in different areas of Botshabelo. Letsoba is 21 years old. She is HIV-negative. She had her first baby when she was a teenager. Mammako is 50 years old. She is HIV-positive. She is an HIV counselor at her clinic, but had been laid off just as my fieldwork started. Mammako had her first child when she was a teenager. She learned

about her HIV status during this time. As fieldwork progressed, Letsoba and Mammako confided some of their own experiences with pregnancy, and motherhood. Their perspectives were especially salient. I asked them to consider formally 'participating' in this research. Both women agreed. We formalised this with the necessary informed consent protocol.

I disclose the HIV statuses of both these women to contextualise their anecdotes, which appear throughout this dissertation. Each of these women narrate their own stories about teenage pregnancy, young motherhood and HIV based on their unique social positions. Letsoba is a young mother who is close to the schooling system on account of her being in high school in the last three years. On the other hand, Mammako is an older woman with a social reputation as a clinic counselor. Nurses know her and work with her. I found that most teenagers and young women respected Mammako enough to attend (and never miss) research appointments. This was not always the case for participants in Letsoba's neighbourhood who often missed or rescheduled our meetings. Given the social role of matriarchs like Mammako in this community, I was concerned about two things.

First, I worried that discussions with teenagers were censored if they happened in Mammako's office. I therefore asked to visit teenagers in their homes as soon as they felt comfortable. Most teenagers seemed more at ease in their homes. I found that they could share their opinions more readily, especially when Mammako was catching up with relatives in the house.

Second, I was aware that there were prior social connections between interpreters and participants for this study. Both Letsoba and Mammako worked closely with me during

recruitment. This work used purposive sampling and snowball sampling as its primary recruiting methods, which will be discussed in the next section. This meant that the first few participants were teenagers known to my interpreters. Teenagers were the daughters of neighbours or the nieces of friends. Although all teenagers had provided informed consent, there was a risk that they were attending our appointments out of respect to Mammako and her relationship with a teenager's relative. To explore this type of social coercion, I paid close attention to my conversations with teenagers, that is, where our meetings took place, what teenagers said, how long teenagers chose to stay. I found that some teenagers seemed genuinely interested in the research. These teenagers invited me to their homes even when the matriarchs were not present. They were animated during our phone calls or Whatsapp text conversations. They rarely (if ever) missed our meetings. There were a few teenagers who seemed less interested in the research. These teenagers only met me at the clinic, where they were accompanied by a relative. Our discussions never made it passed pleasantries. They did not respond to phone calls or text messages. Over time, our meetings were less regular until they stopped. I understood this as withdrawing from the study. These teenagers were excluded from the study after Mammako and I discussed their participation. The respective data were excluded and destroyed. I encouraged these teenagers to contact me if they wished to meet again. I spoke to these teenagers' relatives at the clinic and thanked them for supporting the study.

Recruiting teenagers

Recruitment was a time- and energy-intensive process that spanned several months (Table 1). This is consistent with other research involving pregnant teenagers (Gyesaw & Ankomah, 2013; Lingen-Stallard et al., 2016; Ngum Chi Watts, Claudine, Liamputtong, & McMichael, 2015).

In the South African context, pregnancy and motherhood is a "sensitive area of research," which can make participant recruitment quite challenging (Ngabaza & Shefer, 2013:108).

Purposive sampling was my primary method for recruitment (Polkinghorne, 2005:139). Polkinghorne (2005) reminds us that "the unit of analysis in qualitative research is experience, not individuals" (2005:139). I pursued "information-rich cases" (Patton, 1990:169). That is, I carefully chose teenagers whose stories could "fill out the structure and character" of experiences with teenage pregnancy and motherhood (Merriam, 2002; Mkhwanazi, 2010; Polkinghorne, 2005:139; Vale, 2015:190-191). Teenagers were not randomly selected for this research. Their experiences are not representative of a population. I am more interested in lived experiences, and less interested in how experience is "distributed" in a population (Polkinghorne, 2005:139). Working across five township sections, however, provided some diversity of experience.

I also used "snowball sampling" (Polkinghorne, 2005:141; Turan & Nyblade, 2013:2536). That is, I initially recruited a small group of teenagers. Teenagers in this group introduced me to other pregnant teenagers. I tried to meet 'new' teenagers together with their already-recruited friends. This made some teenagers more comfortable. Yet other teenagers insisted on meeting me alone. After initially meeting 'new' teenagers, and enrolling them in the study by obtaining informed consent, I gauged HIV status during follow-up meetings. This was important so I could avoid unintentionally disclosing someone's HIV status to their friends.

Both sampling methods helped me avoid unintended disclosure: exposing a teenager's HIV status because she was associated with me. These methods also seemed to reduce the risk of unforeseen disclosure: another participant disclosing a teenager's HIV status. Other scholars have highlighted these risks (Patton, 1990:169; Regan-Kubinski & Sharts-Hopko, 1995:330). I tried to avoid unintended and unforeseen disclosure with two strategies. I met teenagers in the privacy of antenatal waiting rooms (not the general waiting room in the clinic). Secondly, I asked antenatal nurses to help me with recruitment. I explain both strategies below.

In Botshabelo, pregnant teenagers are extremely vulnerable in their communities. It is not easy to 'find' or recruit teenagers. They are elusive, and nearly invisible. During fieldwork, I would hear about them – from nurses and older women at the antenatal clinic - but hardly ever see them. Most teenagers try to 'hide' in their houses during pregnancy. They aim to avoid the incessant admonishing and scrutiny from community members. This is part of the stigma they endure, which became a key theme in my dissertation. Teenagers usually leave the house for antenatal clinic appointments. I therefore met most prospective participants at the clinic. I spent time in the antenatal waiting room. This is where I talked to teenagers about the research, answered their questions, and (eventually) explained the informed consent process to teenagers who were eager to participate.

Recruitment continued throughout fieldwork. Some teenagers left the township, and then returned weeks later. Other teenagers introduced me to prospective participants months after fieldwork had 'officially' started. This was, at times, frustrating. Yet, when all things aligned

in just the right way, the recruitment process was tremendously rewarding. I met some incredible young women who were willing to share parts of their lives with me.

At first, nurses were extremely cautious about me and the research. After observing some of my first meetings with teenagers, however, nurses saw that I could offer a space for teenagers to talk about their depression, anxieties, worries, and excitement. Some nurses told me that they saw the research as a form of 'counseling'. They were eager for me to support their teenage patients.

In some cases, recruiting started with antenatal nurses. That is, nurses introduced me to teenagers. A few nurses agreed to help me with recruiting. First, a nurse would speak to a pregnant teenager about the research. To prevent unintended and unforeseen disclosure, the research was framed as work exploring 'teenage pregnancy and support'. HIV was not mentioned outside of private conversations with teenagers. The nurse would gauge initial interest. Thereafter, if the teenager was interested in the research, the nurse would ask me to meet with her the next day. Teenagers were not pressured or coerced to meet me immediately. A teenager may have agreed to meet me only because she was afraid of upsetting the nurse. I did not want to jeopardise the nurse-patient relationship, especially during the critical antenatal care period. Scheduling a meeting for the next day gave a teenager some agency: she could miss or attend our meeting without the nurse knowing.

Usually, there were many people – nurses, interpreters, already-recruited teenagers who introduced me to 'new' teenagers - present for an introductory meeting. This made logistics

more precarious. There were many times when 'new' teenagers did not show up to our meetings, or left because their already-recruited friends did not arrive on time. Sometimes nurses took annual leave or vacation, unbeknownst to me. Without nurses, some introductory meetings could not take place. I used these introductory meetings to schedule an interview for the following day. While nurses were sometimes present during introductions, the only people in the first interview were myself, an interpreter and a prospective participant.

All in all, I recruited, and conducted initial interviews with 88 teenagers and young women. I worked in-depth with 30 of these individuals. Their demographic information is included in Table 2 below. All information has been anonymised accordingly.

Purposive selection has been used in other qualitative work with vulnerable individuals in the United States (Polkinghorne, 2005:140, Sanders 2009, Sanders 2008), the United Kingdom (Lingen-Stallard et al 2016), and South Africa (Chigona et al., 2007; Josephine, 2019; Mkhwanazi, 2010; Nkani & Bhana, 2010; Scorgie et al., 2015; Swartz, 2009; Visser et al., 2012; Zembe-Mkabile et al., 2015). This selection method is consistent with "iterative sampling" (Polkinghorne, 2005) or "theoretical sampling" (Glaser & Strauss, 1967). Snowball sampling has been used in other work with vulnerable individuals and teenagers in Ghana (Gyesaw & Ankomah, 2013), Australia (Ngum Chi Watts et al., 2015), Kenya (Ronen et al 2017, Turan et al., 2008), and South Africa (Ngabaza & Shefer, 2013; Stinson & Myer, 2012).

I have excluded some teenagers from this table: Pumza, Boleta, Naledi, Mpho, Maki, Botho, Paballo, and Vero. I spent time with these pregnant teenagers, and teenage mothers, during my

observation period in 2018. During this time, I did not have ethical approval to formally collect data or identifying (demographic) information. Yet some of these initial conversations planted the seeds for my key themes. I reference some of these conversations, and the teenagers who shared their stories, in this dissertation. I include the limited demographic details I obtained when relevant.

Table 2. Demographic information for participants

Township section	Pseudonym	HIV status	Relationship status	Age	Highest education level	Birth parity	Household information			
							Guardian	Monthly income (ZAR)	Size	Income per person (ZAR)
Robong	1. Metsi	Negative	Engaged	23	BA degree	Primipara	Mother	-	5	-
Leshome	2. Mmami	Negative	Single	18	Grade 12	Primipara	Both parents	2,000	3	667
	3. Nyefolo	Negative	Dating	17	Grade 10	Multipara	Mother	400	5	80
Hlano	4. Kananelo	Positive	Dating	19	Grade 10	Primipara	Orphan	-	5	-
	5. Lehakwe	Positive	Dating	20	Grade 12	Primipara	Mother	-	4	-
	6. Lerato	Positive	Dating	19	Grade 9	Primipara	Grandfather	-	5	-
	7. Mammako	Positive	Single	50	Grade 12	Primipara	Both parents	-	1	-
	8. Seipati	Negative	Dating	19	Grade 12	Primipara	Mother	-	7	-
	9. Sibongile	Negative	Dating	16	Grade 11	Primipara	Mother	-	5	-
Robedi	10. Alice	Negative	Married	16	Grade 11	Primipara	Both parents	-	2	-
	11. Baby-Boo	Positive	Married	26	Grade 11	Multipara	Mother	18,000	2	9000
	12. Barbie	Negative	Dating	17	Grade 11	Primipara	Mother	600	2	300
	13. Bohlale	Positive	Single	19	Grade 12	Primipara	Mother	1,000	6	167
	14. Dineo	Positive	Engaged	23	Grade 12	Primipara	Mother	2,800	4	700
	15. Grace	Negative	Dating	20	Grade 12	Primipara	Mother	1,500	5	300
	16. Lavas	Negative	Dating	20	Grade 12	Primipara	Mother	-	3	-
	17. Lebo	Negative	Dating	17	Grade 10	Primipara	Orphan	-	5	-
	18. Letsoba	Negative	Dating	23	Grade 12	Primipara	Orphan	-	6	-
	19. Mahlony	Positive	Married	27	Grade 12	Primipara	Mother	2,600	3	867
	20. Maipato	Positive	Dating	19	Grade 12	Primipara	Both parents	2,320	5	464
	21. Mamphofu	Positive	Dating	21	Grade 8	Primipara	Orphan	4,000	5	800
	22. Maphoza	Negative	Married	19	Grade 11	Primipara	Orphan	3,900	2	1950
	23. Masoso	Negative	Single	20	Grade 10	Primipara	Orphan	1,200	7	171
	24. Moki	Negative	Dating	17	Grade 11	Primipara	Mother	7,000	6	1167
	25. Nani	Negative	Dating	19	Grade 11	Primipara	Mother	1,500	4	375
	26. Nthabiseng	Positive	Dating	20	Grade 12	Primipara	Mother	-	3	-
	27. Popi	Negative	Married	20	Primary school	Primipara	Grandmother	3,000	5	600
	28. Puleng	Negative	Dating	20	Grade 11	Multipara	Mother	3,500	7	500
	29. Roni	Negative	Dating	19	Grade 8	Multipara	Mother	1,400	5	280
	30. Sphola	Negative	Dating	20	Grade 11	Multipara	Orphan	400	3	133

The Relationship status data describes whether a teenager was married, dating, or single during her pregnancy. Teenagers used marriage in the broadest sense. Sometimes, being married meant that a teenager wore an engagement ring while she planned her wedding. At other times, being married meant that a teenager was waiting for an official proposal. Her boyfriend was earning money to pay *lobola* or bridewealth. Some teenagers used the terms fiancé and husband interchangeably. Week to week, some teenagers referred to their partners as boyfriend or ex-boyfriends. Relationships were constantly in flux. These data report the relationships during each teenager's pregnancy. In the subsequent empirical chapters, I will argue that teenage pregnancy is considered scandalous largely because teenagers are unmarried. I found that teenagers who are engaged, waiting for a fiancé to pay lobola, and/or partnered but not legally wedded are usually considered to be unmarried.

The Age data describes the age of teenagers during my fieldwork period. I had ethical approval to explore teenage pregnancy among teenagers 15 to 20 years old. Because I used layering and triangulation, I worked with pregnant teenagers, young mothers, and older mothers. All teenagers had been pregnant when they were younger than 20, even if they were older than 20 during my fieldwork. For this research, the youngest participant was 16 years old. The oldest participant was 50 years old.

The Birth parity data reports a teenager's history with childbirth. That is, how many pregnancies a teenager experienced when she was 15 to 20 years old. She may have had more children in her adult years. This data is not included in the table. For this research, 'primipara' describes a teenage teenager who has one child, or is pregnant with her first child. 'Multipara' describes a

teenage teenager who has many children, or is beyond her first pregnancy. For this research, almost all the participants (89%) were primiparas during their teenage years. All multiparas in the participant group were pregnant with their second babies.[1]

The Guardian data describes a teenager's legal guardian, at the time of her pregnancy. Orphaned teenagers told me that their grandmothers or older sisters were their legal guardians.

The Income data refers to each teenager's (self-reported) monthly household income. Many teenagers chose not to share this information. They told me that they wanted this to remain "confidential." Government welfare - pensioner grants, child support grants, disability grants – contribute to what most households earn in a month (Makiwane, 2010). The South African Government has established three national poverty lines that consider food and non-food consumption in a household (Stats SA NPL 2019:3). As of 2019, households at the *extreme poverty line* earned up to ZAR561 per person per month. This converts to approximately USD33 or GBP26 per person per month. Households at the *lower-bound poverty line* earned ZAR810 per person per month. This converts to approximately USD47 or GBP37 per person per month. Households at the *upper-bound poverty line* earned ZAR1227 per person per month. This converts to approximately USD72 or GBP57 per person per month. For this research, eighteen teenagers provided household income information. Ten out of eighteen households live below the extreme poverty line. Two families live above the upper-bound poverty line.[2]

[1] See Varga 1998 and Woldesenbet et al. 2015 for more specific definitions of parity.
[2] Currency conversions were calculated using www.exchangerates.org.uk.

Interview and observation

In narrative work, interviews are more about the types of "purposeful conversations" that unfold, and not the types of questions asked (Bogdan & Biklen, 1982:135). Narrative inquiry is an "on-going process" of "relational storytelling" (Ion et al., 2016; Kvale, 1996:5-6; Ritchie & Lewis, 2003; Vale, 2015:137). This "relational activity" requires active listening and empathetic questioning (Riessman, 2014:3).

Instead of using a list of scripted interview questions, I probed around pertinent topics as I learned more about each teenager. When we met, our conversations revolved around these topics. To prepare for these in-depth conversations, I adapted interview techniques from work with chronically ill participants (Schulman-Green et al 2011). I also studied narrative work with young mothers and vulnerable women (Hanna, 2000; Hanna, 2001:458; Heilbrun, 1988; Kvale, 1996:5; McLeod 2001). I worked hard to create space for teenagers to open the doors on their personal relationships (Steinberg, 2013). Recognizing individual agency in this way helped me facilitate "participatory development" (Anyidoho, 2010; Spradley, 1980; Wenger, McDermott, & Snyder, 2002).

During conversations with pregnant teenagers and teenage mothers, I followed where teenagers led. They dictated the pace and depth of our discussions. Sometimes, our meetings were more formal: I would use my tape recorder, and ask questions from my notebook. More often, however, our meetings were informal. Interviews manifested as unstructured conversations in clinic waiting rooms, driving back from the hospital, at kitchen tables, in living rooms, or on backyard verandas. I usually spent time with teenagers in their homes, where they felt

comfortable and safe. This provided essential context for their stories. I saw how Maipato cared for her baby when I witnessed her bathing the child. Letsoba told me about the meaning of her name, and how she felt about her father, when we were seeking shelter in a lightning storm. It was during Bohlale's poetry recital that I learned about her relationship with her baby's father. Through the cracks of the mundane days, I began to understand what it was like to be young and pregnant in Botshabelo.

Importantly, I could not *only* rely on what teenagers disclosed about their experiences (Swartz, 2009:176). By observing, I could learn what stories were *not* told, which characters did *not* appear, and why. Sharlene Swartz (2009) explored morality with young people in Cape Town's Langa township. She suggests that observing what 'does not' happen is as important as observing what 'does' happen:

> …ethnographic methods of observation and conversation provide the opportunity to *observe* how young people live as well as what they *say* about how they live. (Swartz, 2009:173, emphasis in original)

I used in-depth interviews and participant observation, in conjunction, to fully understand teenagers' stories (Willis, 2000). As fieldwork progressed, I believe these methods helped me think more critically about - or even alter - my interactions and interpretations. Nieto (1994) emphasises the importance of observation alongside interview:

> …to accept [young people's] words as the sole guide … is to accept a romantic view of students that is just as partial and condescending as excluding them completely from the discussions. (Nieto, 1994:396)

Consistent with narrative inquiry and ethnographic practices, I used participant observation to get "close to those studied" and "understand what their experiences mean to them" (Clifford, 1983; Emerson, Fretz & Shaw, 1995; Mead, 1930:12). I acknowledge that there are many ways to practice participant observation (Bogdan & Biklen, 1982; Patton 1980; Spradley, 1980). As anticipated, I was a privileged observer and a limited observer depending on each situation (Wolcott, 1988). Observation was the "deep hanging out" I did with participants at my fieldsite (Geertz, 1998:69). Such interactions helped me represent each participant as an individual with agency, not someone or something to be observed (Fabian, 1983:151-152). Scholars note that observation can "reveal the details of how people think and act ethically" day to day (Haimes 2002:106).

Observing, and interacting with the people around each teenager – her neighbours and family members, for example - was important too. I met families whenever I was invited or allowed. Indeed, Margot Ely and colleagues suggest that "each individual is a field of their own" in the complexity of their words and deeds (Ely et al., 2003:24). Details – about the structures, institutions, and people at my fieldsite - built context for teenagers' stories.

Data construction and layering

This research prioritised data "construction" - instead of data "collection" (McLeod, 2001). Obtaining empirical data is not as easy as "picking apples from a tree" (Polkinghorne, 2005:141). Stories and meanings are awarded (McLeod, 2001:138).

Constructing stories *with* teenagers was an important part of fieldwork. Experiences shared in stories are often embedded in profound moments of a person's life (Lazarus, 1966). These moments, when spoken, are influenced by who is talking and who is listening:

> …*personal* narratives are deeply social. (Turk & Kerns, 1985:4, emphasis in original).

As the researcher and listener, I influenced what was shared during interviews, whether this was my intention or not. My presence, prejudice, and position added to the temporal, spatial, and contextual facts shaping stories. I believe this influence is the value, not the downfall, of narrative work. For this research, the presence of a storytelling participant and listening researcher facilitated collaborative or "cocreated" narrative (Ion et al., 2016:186; Polkinghorne, 2005:143; Riessman, 2014:6).

Employing data construction methods meant spending as much time with pregnant teenagers as they would allow. I listened more than I talked. Usually, I prompted teenagers only when I needed clarification. Creating a sense of mutual respect was often the key to learning more about teenagers' lives. I believe such mutuality can minimize spatial and temporal distance in

an effort to approach "coevalness" in research (Fabian, 1971; Fabian, 1983). Indeed, trust was crucial to gain access to, or "enter" teenagers' experiences (Ely et al., 2003).

Data construction also meant constantly processing and evaluating empirical evidence. It was through this iterative process that 'true' meaning and empathy emerged.

The data construction process is well-suited to narrative inquiry, which relies on stories that researcher and participant "co-produce" (Mishler, 1999; Charmaz, 1990; Charmaz, 1995). Empirical data was shaped in a collaborative process involving teenagers, interpreters, and myself. The construction process granted all of us "active" roles in the way stories were told (Riessman, 2014:3). This construction approach also meant that there was no one-size-fits-all interview method. Based on each situation and each teenager, I was prepared to ask the storyteller to elaborate, or wait in silence so "more could be said" (Riessman, 2014:3).

Constructing stories helped me meet teenagers where they were. That is, I was working with teenagers who were at different stages of their pregnancy or motherhood journeys. Some teenagers had just discovered pregnancy, while others were breastfeeding newborns. I therefore used layering and "triangulation" to make sense of overlapping experiences (Ely et al., 2003; Polkinghorne, 2005).

In my field notes and memos, I divided (HIV-positive and HIV-negative) teenagers into three different groups. The first group comprised teenagers who could think about pregnancy prospectively: these teenagers were at an early stage of pregnancy, imagining how pregnancy

would progress. The second group included teenagers having the experience: these teenagers were months into pregnancy. The third group comprised teenagers and young women who could reflect on and recall the pregnancy experience retrospectively. These individuals were mothers tasked with raising toddlers, instead of carrying unborn babies to term.

Layering and triangulation were important. This was a logical way to accommodate HIV- and pregnancy-related experiences that shift in unexpected and chaotic ways. Exploring layered stories shed light on the multifaceted, complex emotions wrapped into teenage pregnancy and teenage motherhood in Botshabelo. Triangulation did not "verify" an experience so much as decode the "meaning" of a story or experience (Polkinghorne, 2005:142). Other scholars have used triangulation in qualitative research exploring teenage pregnancy (Polkinghorne, 2005; Riessman, 2002; Vescovi, Pereira, & Levandowski, 2014).

My privilege and position

The 'data construction' method has been used in other work with young women in South Africa (Lesch & Kruger, 2004:466). This approach "compels the researcher to engage with his or her own locatedness and investments in the research process" (Lesch & Kruger, 2004:466). For me, this meant recognising my privilege and my position.

My privilege as an educated, middle-class outsider no doubt influenced the ways I experienced and observed this social world. My race and ethnicity – as an Indian South African – also influenced my social position. Some teenagers assumed I was a medical doctor. Teenagers and nurses were used to seeing medical students in the township's clinics. These teenagers asked

me questions about their prescription medications, blood tests, CD4 count, or other medical information. In these instances, I referred (and often accompanied) teenagers to nurses at the clinic. Many teenagers called me 'Dr Sasha' and still refer to me as such in our WhatsApp texts. I clarified and reiterated my status as a researcher and DPhil student – and not a medical doctor – throughout fieldwork.

At times, my race and ethnicity 'othered' me more than my privilege did. This was particularly obvious during the political election in May 2019, and the xenophobic violence in July and August 2019. I discuss these events later on. During these times, nurses and interpreters told me it was not safe for me to travel through the township, because I was not Black.

I was constantly negotiating my privilege during fieldwork. Some teenagers shared more with me because of my privilege. One young mother, Metsi, highlighted this. She is HIV-negative, and lives in Robong section. She is a community health worker.

> …my boyfriend says that they (teenagers) will tell you things, but they won't tell me. (Metsi 2018)

Working with nurses - authoritative healthcare providers - influenced my position of privilege. This association made me less relatable to some teenagers, and more caring to others. Changing meeting locations – from the clinic to teenagers' houses – shifted the nature of what stories were shared, and how teenagers felt about me. As fieldwork progressed, I was seen as a 'curious researcher' more than a 'healthcare provider'.

Moving around the township

Each morning, I drove from Bloemfontein to Botshabelo. I spent the day in the township, and returned to Bloemfontein by about 17:00 - depending on the weather and season. For safety reasons, I left the township before sunset.

Traveling was risky for me because I was a non-local woman. The nurses told me that they worried about my safety. Sister Sehlare highlights this. She calls me 'Sasha.'

> Sasha, but it's dangerous. You know last week there were two community health workers. They were going door-to-door for health TB testing. And one of them was raped in one of the houses. You must be careful. It's dangerous here. (Sister Sehlare 2018)

Sister Sehlare also worried about me, although she supported my presence and this research. What she highlights here is a sober part of working in this community. Between 2013 and 2014, the Free State province had approximately 175 sexual crimes per 100,000 people (Eyewitness News 2014). This was the highest rate across all provinces. Sexual abuse is an issue for the whole country. Between 2018 and 2019, more than 33,000 women and 3,500 men were victims of rape, nationally (Mlambo, 2019). Many scholars have explored rape and sexual violence as an issue in South Africa (Jewkes & Abrahams 2002; Jewkes & Morrell, 2002; Jewkes, Morrell, Christofides, 2009; Moffett, 2006).

To alleviate some worry, I phoned the antenatal nurses (like Sister Sehlare) when I entered and left the township every day. Additionally, I did not move around the township alone. My interpreters and I walked between the clinic and teenagers' houses. My interpreters knew the area's geography, and when to avoid areas known for gangsterism.

Nurses were also worried about theft. The nurses advised me not to drive around the township. It was not always safe to park the car outside teenagers' houses. Furthermore, the roads would likely damage or puncture my tyres. Only a few main roads are tarred in Botshabelo. Every day, I parked my hired car at the clinic, and moved around the township on foot.

Safety concerns not only limited my movements. Sometimes, safety concerns also limited participation. There were days when we could not meet teenagers because I needed to drive out of the township before sunset. On other days, we met fewer teenagers than I had planned, because it took too long to walk between teenagers' houses. Sometimes, we could not meet teenagers who lived in unsafe areas. They did not want to meet us at the clinic. It was too far for them to walk. After phone calls and Whatsapp conversation, they eventually withdrew from the research.

I learned how to circumvent some of these limitations over time. As I learned about the township's geography, I scheduled meetings with teenagers who lived close to each other. This minimised the walking time between teenagers' houses. During the warmer months, when the sun rose earlier, I scheduled more meetings in the morning so we could fit more interviews into each day.

Unrest and violence

During May 2019, in the middle of my fieldwork, there was a national political election. Leading up to this election, there were protests and political unrest in the township. Residents were usually protesting poor service delivery, or housing shortages. The protests influenced whether I could meet with teenagers or not, and whether I could access (drive into) the clinics from the main road. I could not drive into the township when protestors had blocked main roads with rubbish, boulders, or rocks (Figure 2).



Figure 2. Road block in Hlano section

(Source: Moodley, S. 2019)

Moreover, it was sometimes unsafe for teenagers to meet me. On one occasion, protesters ransacked homes. When police and guns became involved, residents remained inside their locked houses. Mammako explains one incident over WhatsApp (2019).

> Mammako: Good evening, Dr. It seems as if this week we are unfortunate. The community is protesting again. It's not safe, the police are shooting.
>
> Sasheenie: OK Mme…thanks for letting me know. Are you safe Mme?
>
> Mammako: People are running all over the streets. But yes, I'm safe, Dr, I'm inside the house. I will not go out. It has just started at 18h00pm. I'm behind my fridge, not in an open space. And I will sleep in Thapelo's (her son's) bedroom. It is not near the street.

Sometimes, protests made it unsafe for me to walk around the township. My interpreters told me that my race made me a target for "angry people". Mammako and Letsoba explained this to me on different occasions:

> …I don't think it's safe to do interviews tomorrow. For the ladies, it's not safe, but also for you doctor. The people are angry. They don't want to see anyone who is not from here. They don't want to see anyone who's not Black. It's not safe for you. (Mammako 2019)

> For me, there is no protest. For you, there is protest. (Letsoba 2019:36)

Like my supervisors, nurses and interpreters warned me to be cautious during election time. This was also necessary during the particularly violent xenophobic attacks that surged between July and September 2019 (BBC News 2019; Crush, 2008; Crush, 2001; Harris, 2002; Human Rights Watch, 2019a; Human Rights Watch, 2019b). These events emphasised my shaky status as an outsider.

During these periods of unrest and violence, I modified my fieldwork schedule accordingly. I assessed how feasible and safe it was to travel into Botshabelo on a daily basis. I discussed this with my supervisors, interpreters, and nurses. On days when it was not safe or possible to travel into the township, I devoted time to concurrent analysis. I talked to interpreters and teenagers over the phone, or on Whatsapp, about emerging themes.

Analysis

In the context of HIV

HIV was one - extremely important – factor influencing teenagers' experiences with pregnancy and motherhood. While HIV has the power to alter the experience of motherhood, I found that some HIV-positive and HIV-negative teenagers described similar experiences. In other instances, however, their experiences differed. Beyond HIV, there were other equally salient factors influencing these experiences. Throughout my empirical chapters, I reveal a speaker's HIV status when this information is pertinent to my argument. I do not explicitly attribute

stories or behaviours to having HIV or not. Instead, I situate teenage pregnancy and teenage motherhood in the context of HIV in an effort to prioritise teenagers' agency and autonomy (Allen, 2003; Arnfred, 2004; Lesch & Kruger, 2004:481, Shefer et al., 2000; Walker, 1998:336; Welles, 2005; Wood & Foster 1995). Moreover, I offer more than one explanation for my empirical data. As feminist discourse scholars encourage, I tried to provide a "constellation" of meanings (Barnes et al., 1997; Riessman, 2008:14). I hope that my analysis conveys the idea that each teenager is a dynamic individual who makes decisions based on her best judgement, her social world, and her networks.

Concurrent analysis

During fieldwork, data analysis was "ongoing" (Vale 2015:162) and iterative (Ely et al., 2003). I created detailed fieldwork "logs" (Ely et al., 2003). These included emotions, questions, observations, and interview transcripts. Using field notes helped me remember holistic details (Ely et al., 2003:69-82). Alongside my fieldnotes, I wrote regular one-page "analytical memos" (Charmaz, 2006:72). I shared these with my supervisors. The memos reflected on surprising or confusing empirical data. These memos were often the first places where I scribbled themes that became central to my dissertation. Furthermore, I dedicated weekly time to debriefing with my interpreters. During this time, we could "reflect upon, and analyse, emerging data" (Vale, 2015:162).

Such concurrent analysis proved to be an essential part of data construction in the context of storytelling (Riessman, 2014). Teenagers' experiences and perspectives were "layered" (Ely et al., 2003; Polkinghorne, 2005). I listened to reflections on pregnancy (from new mothers)

alongside assumptions about pregnancy (from teenagers in the first pregnancy trimester). Concurrent analysis helped me organise, and think critically about, these overlapping experiences. Furthermore, I could assess how fieldwork was progressing, what I had learned, and which themes teenagers captured in their stories. It was largely through understanding what empirical evidence I had that I could discover where to go next. It was important to analyse each participant's context, interview data, stories, and experiences in order to gauge what she was sharing with me and why.

Retrospective (post-fieldwork) analysis

It was necessary to combine three analysis methods in order to make sense of my narrative data: deconstructive discourse analysis (Macleod, 2003), grounded theory (Glaser & Strauss, 1967), and narrative analysis (Riessman, 2014). Using discourse analysis, I was able to analyse all interactions and discussions as "discursive events" (Macleod, 2003). Grounded theory helped with thematic analysis: I coded themes that arose from the data, instead of force-fitting preconceived themes into the data. I used narrative analysis to guide my structural analysis: I examined the structure and interaction of language in teenagers' stories. One analysis method alone seemed insufficient for this specific study. I worked with an extremely vulnerable group of participants (HIV-positive, pregnant teenagers) to explore a stigmatised topic (teenage pregnancy, HIV-positive motherhood). By combining all three analysis methods, I could highlight themes in the data, while recognising each teenager's agency, and respecting the trauma and power in her stories.

These three methods have been used in other research exploring pregnancy and motherhood, trauma, vulnerability, and stigma. Discourse analysis has been used in work examining teenage pregnancy in the South African context (Macleod, 2003:423, Macleod, 1999c; Macleod, 1999a). Scholars have used "grounded theory" to examine HIV-positive motherhood in the United States (Barnes et al., 1997; D'Auria et al., 2006; Ingram & Hutchinson, 2000). Grounded theory has also been used in South African research with pregnant teenagers and women, and HIV-positive children (Alfred, 2012; Harries et al., 2007; Lesch & Kruger 2004; Vale, 2015). Narrative analysis has been used in research with vulnerable or traumatised participants. This research explores violence in urban areas (Labov, 1982), chronic illness and the self (Riessman, 1990), breast cancer (Langellier, 1989), and childlessness and stigma (Riessman, 2000a; Riessman, 2000b).

For the purpose of this research, I found certain limitations in each of the three analysis methods. Macleod's (2003) discourse analysis treats all data as "one body" which does not create enough space for individual voices (2003:424-425). Grounded theory analysis risks a "premature commitment to a set of analytic categories" (Charmaz, 1990:1164; Emerson, 1983; Katz, 1983). This can prevent a researcher from fully exploring the meaning and value of the data. Narrative inquiry can be limited when stories are "translated" into another language, and then analysed (Riessman, 2000a). Using these three analysis methods in conjunction helped to avoid, or at least mitigate, some of these limitations.

For this research, data analysis was largely a "reflexive process" that started in October 2019 (Riessman, 2000a:134). This provided time to delve deeper into the data. This immersion revealed deep insights and rich meanings. Below, I outline my analysis process.

Step 1. Immersion and familiarisation.

Step 2. Identify themes and categories from the data (thematic analysis).

Step 3. Organise categories into temporal groups.

Step 4. Identify and compare language and meaning (structural analysis).

Step 1. Immersion and familiarisation

I categorised and analysed my data as "discursive events" according to Catriona Macleod's "deconstructive discourse analysis" method (Macleod, 2003:423; Macleod 2002). She borrows "event" from Fairclough (1992). Macleod identifies a "discursive event" as "a piece of text, an instance of discursive practice and an instance of social practice" (2003:423-424). Considering the data in such a holistic way provided context that is crucial for ethnographic work. I considered all my empirical evidence as discursive events. The discursive events in my work were 1) observations and discussions with nurses and family members, 2) audio recordings of interviews and conversations with teenagers, 3) transcribed recordings and WhatsApp transcripts, 4) the "discursive construction" contained in fieldwork logs and memos, and 5) "research practices engaged in to collect information" (Macleod, 2003:424). Social media platforms, such as WhatsApp and Facebook, can be valuable tools in ethnographic research (Baker, 2013; Postill & Pink, 2012). Contemplating and comparing these discursive events

helped me deconstruct stories about teenage pregnancy and teenage motherhood in a context of HIV.

I worked hard to immerse myself in, and become "familiar" with, all my data (Huberman & Miles, 2002). Reading, and re-reading, were important to gain contextual understanding. Immersion meant that I did not only rely on 'recollecting' my data. Rather, I examined all empirical evidence as "one body" (Macleod, 2003:424). This was useful because I could focus on 'what teenagers did' and how that influenced pregnancy and motherhood, instead of only 'who teenagers were'. Even though I considered all data holistically, it was important to recognize each teenager's agency and context. This is why I immersed myself in teenagers' stories. I found that their "human agency and imagination" were expressed therein (Riessman, 2014:7).

Step 2. Identify themes and categories from the data (thematic analysis)

Using grounded theory methods, I identified and coded themes from the data (Glaser & Strauss, 1967; Riessman, 2000a). I had flagged some themes in my fieldwork memos. Kathy Charmaz (1990) discusses this:

> …grounded theorists use their emerging theoretical categories to shape the *data collection* while in field as well as structure the analytic processes of coding, memo-making, integrating, and writing the developing theory. (Charmaz 1990:1162, emphasis in original).

I paid attention to teenagers' stories - topics they discussed and revisited, words and phrases they used to show meaning and value - in order to organise my data into themes. These themes were more than simply descriptive. They shed light on the intricacies and intimacies of teenage pregnancy, and the mother-child relationship. Throughout the analysis process, I compared themes to limit bias (Charmaz, 1995:35). Beth Vale (2015) describes the reflexivity required for this process: "What are the implications of this? Where is the evidence for that? What else could this mean? How exactly do these ideas relate?" (Vale, 2015:169). Vale suggests a researcher should ask "how do I know what I know" – and not only "what do I know" (Vale, 2015:169).

I coded themes, and then sorted these themes into larger categories (Riessman, 2000b:116). Table 3 shows this process. While themes came from the data, categories were 'groups' I created.

Table 3. Process for thematic analysis

Themes are organised into categories, which are organised into temporal groups.

Theme		Category		Temporal Group
Being unmarried Having HIV Being young	➔	Shame	➔	Beginning of pregnancy
Hiding 'Not allowed' at school	➔	Punishment	➔	During pregnancy
Returning to school Taking care of baby	➔	Familial care	➔	After pregnancy
Protecting baby Connecting with baby Motherly love	➔	Teenage mothering	➔	After pregnancy

Comparing themes helped me refine them, and recognise nuances between and within categories. For example, 'marriage' was a broad theme that had relevance before and during pregnancy. At the beginning of pregnancy, being unmarried seemed to be linked to the shame of discovering pregnancy. Yet during pregnancy, being unmarried seemed to be linked to punishment and admonishing.

Step 3. Organise categories into temporal groups

Grounded theory methods were useful as I "re-examined" themes and focused on "writing and rewriting" to develop analytic insights (Charmaz, 1990:1167,1170). As new themes emerged,

I reorganised my categories. Sometimes, more complex themes became categories. I constantly compared and contrasted themes and categories in order to gain analytical insights.

My analysis was an "iterative process" (Vale, 2015:169). That is, the analysis involved dynamic conversations with supervisors, examiners, peers, interpreters, and some teenagers in Botshabelo. These discussions helped me understand when and why some things (themes) were more poignant than others. For example, teenagers worried about food and baby clothes during pregnancy, because these were symbols of good mothering. Teenagers discussed houses and education after babies were born, because these were ways to secure the future.

Furthermore, these conversations helped me make analytical distinctions between categories according to 'when' things occurred during pregnancy. As a result, I organised categories chronologically. By this I mean that I grouped categories into three temporal groups: beginning of pregnancy, during pregnancy, and after pregnancy. Table 3 shows this grouping.

Organising categories into temporal groups showed me how themes – experiences and events in the data - were changing. What seemed important at the 'beginning' of pregnancy, was less central 'during' pregnancy. I began to see the way teenage pregnancy evolved over the course of nine months, and as motherhood began. I asked: which themes are prominent and recurring? Why is this the case? What changes during the nine months, if anything? What do themes tell me about teenage pregnancy and motherhood, if anything?

Temporality was an important part of analysis because my data was "layered" (Ely et al., 2003; Polkinghorne, 2005). During fieldwork, I spent time with teenagers at different stages of pregnancy and motherhood. Gathering themes and categories into temporal groups helped me compare teenagers' experiences even though they happened at different points in time.

Furthermore, temporal groups helped me see how multiple stigmas (including but not limited to HIV-related stigma) mutated through teenage pregnancy and into motherhood. These stigmas – and the way they shift and change - play a major role in shaping teenagers' experiences in this social world.

The empirical chapters in this dissertation are organised 'chronologically' to accommodate these temporal groups. The chapter on **Discovering and disclosing teenage pregnancy** focuses on themes that arose at the 'beginning of pregnancy.' The chapter on **Being a pregnant teenager** focuses on themes that arose 'during pregnancy.' The chapters on **Dimensions of teenage mothering** and **Familial care** focus on themes that came up 'after pregnancy.'

Step 4. Identify and compare language and meaning (structural analysis)

I adopted Catherine Riessman's methods for thematic and structural analysis (Mishler 1999; Riessman, 2000a; Riessman, 2008; Riessman 2014). I used Riessman's work to learn more about language and meaning. My structural analysis is based on three of her key attitudes:

> "…resist automatic readings of text…" (Riessman, 2014:4). Consider what the participant says, the presence of the researcher, how the story is told, what

position the characters occupy. See Mishler (1999) for "coproduction" of narrative and the value of "digressions."

"…language use can come into view…" (Riessman, 2014:4). Pay attention to the words participants use and how these words have been used before, what is missing in the narrative, and what is not said.

"…interrogate our positions as researchers and interviewers…" (Riessman, 2014:4). Be aware of any assumptions in questions or discussion, as well as privilege and power between the person telling the story and the person listening to the story.

Structural analysis pays attention to the "particular version" of a story that is shared, and how this version is shaped by context (Riessman, 2014:3). Broadly, the researcher "examines the way a story is told – how it is put together, the linguistic and cultural resources it draws on, and how its performance persuades a listener of authenticity" (Riessman, 2000a:130). Riessman (2000a) suggests that narrative analysis should consider "structural and interactional features" of stories: language, diction, structure, and meaning (Riessman, 2000a:132).

This analysis method not only sheds light on teenage pregnancy and motherhood experiences. Paying attention to the structure and interaction of language, in teenagers' stories, also highlights the context – the messy bits – around these experiences. This context may be influenced by a teenager's perspective, or my presence as a researcher. Her perspective may

influence how she speaks about the characters and relationships in her stories, or her knowledge about the socio-political and economic factors shaping her experience. My presence may have influenced the "digressions" in an interview (Riessman, 2014:6). Paying close attention to the messy bits around stories signaled what was happening beneath the surface of a story. Digging deeper was difficult at times. Yet this proved paramount as I worked to understand intimately personal experiences.

I worked hard to view teenagers' stories subjectively (as teenagers described them) and then objectively (as stories compared to each other). I reiterated and reread my writing to do this. I triangulated stories to compare their structure, and nuanced meanings. For example, some teenagers told me about their dreams of 'marriage'. Other teenagers talked about 'marriage' with disdain. As another example, some teenagers were 'hiding' out of fear for witches. Others were 'hiding' by choice, to avoid gossip.

After identifying and organising themes, categories, and temporal groups, I paid close attention to the way teenagers' stories were (co)constructed. It was necessary to revisit all "discursive events" to do this. I discussed the power of words, and their meanings, with my supervisors, as well as peers and mentors working across anthropology and public health. I considered 'how' teenagers spoke – and not just 'what' they said - about being pregnant. I adapted some of Riessman's questions to do this (2000a:133). When does a teenager tell stories in the context of our interview conversation? How are these stories performed in front of me and my interpreter? How can the stories be interpreted? What different readings of them are possible?

Broadly and thematically, what do the stories reveal about how a teenager experiences pregnancy and motherhood?

Representation

During analysis, and while writing the dissertation, I reflected on what empirical evidence to include, and how teenagers were being represented in their stories.

I was discerning when "choosing what to write" (Macleod 2003:425; Vale, 2015:167-168). I focused on multidimensional and not "one-dimensional" themes (Vale, 2015:167-168). At times, a teenager's story touched on multiple themes. It was important to put some "boundaries" around stories (Riessman, 2014:7). This was a complicated task because stories were rarely neat or concise. Some stories spanned days or weeks. Other stories started at "unexpected moments" (Riessman, 2014:15). Teenagers would refer back to things they had said much earlier. I identified gaps and continuities when I read and reread my empirical evidence.

Furthermore, I corrected verb tenses in some interview transcripts in order to represent the true meaning of teenagers' stories. Donald Polkinghorne (2005) reiterates this: "the evidence is the ideas and thoughts that have been expressed by a participant" (2005:138). My modifications helped to avoid the impression that teenagers are "unsophisticated" or "childish" (Swartz 2009:82; Coetzee 1988:127-128). Swartz (2009) suggests that correcting words and/or grammar can recognise the agency and authority with which young people speak.

The issue of representing teenagers 'properly' and 'fairly' has been explored in work with young people in South Africa (Perrow, 2004; Seekings, 1993; Seekings, 1996; Steinber, 2004:11; Swartz, 2009) and abroad (Dance 2002:16-32; Griffin, 1993; Griffin, 2001). Scholars using narrative methods are encouraged to "listen and represent storied interpretations of life experiences" among stigmatised individuals (Greene et al., 2016:164; Hendry 2007). Stories involving traumatic experiences – with pregnancy, motherhood, or HIV for example - are more complex (Riessman, 2000a, 2000b, 2005). These require careful thought about how 'best' to represent participants. Aiming for 'fair' representation and interpretation, I placed teenagers' voices – and their experiences - at the center of my analysis. I moved away from portraying teenagers as victims, 'sick' women, or 'irresponsible' youth. Instead, I strived to make "social sense" of teenagers' dynamic identities and social positions (Bray, Gooskens, Kahn, Moses, & Seekings, 2010; Jewkes & Morrell, 2012:1730; Swartz, 2009:11; Wetherell, 1996).

Ethical considerations

Obtaining approval

Before starting my ethical applications, I completed ethical trainings and reviewed pertinent ethical guidelines (Appendices C, D). Thereafter, I submitted an ethical application to CUREC at the University of Oxford to obtain permission to 'observe' in my fieldsite (CUREC 2 reference: R56936/RE001) (Appendix K). I also sought permission from the CEO of Botshabelo Hospital, and the Director of Botshabelo clinics (Appendices I, J). Fieldsite observation took place from May 2018 to July 2018 (Appendix B). While observing in the field, I continued my ethical applications for 'full research' through CUREC (CUREC 2 reference:

R57304/RE001) and HSREC (reference: UFS-HSD2018/0212/3107) at the University of Free State in South Africa (Appendices L, O). After receiving these university approvals, I submitted my application to the Free State Department of Health. Provincial ethical approval is required by the National Health and Research Database (NHRD) before any participant-focused research can begin in South Africa. After revisions and in-person meetings in South Africa, I received approvals from the Free State Department of Health (Appendices H). I formally began my fieldwork in October 2018. Despite receiving all required approvals, negotiating with gatekeepers was an ongoing, "active process" (Ely et al., 2003:23). Gaining access to different situations and conversations required continuous and diligent effort.

Consent and withdrawal

When I met with a teenager to discuss and obtain her informed consent, I began by situating myself and the research. I explained that I was not working for the clinic. I reiterated that I was not a doctor at the clinic. I emphasised that this was an independent research project. Declining or accepting participation would not affect antenatal care or clinic access. I reminded teenagers that I would not tell the nurses if they were participating in the research or not. This soothed some teenagers' concerns: they told me that they worried about approval from the nurses.

In most situations, an interpreter was present. Having an interpreter present likely influenced the power dynamic. Yet this was a necessary risk in case some teenagers needed to ask questions in Sesotho. Subsequently, I met with most teenagers when an interpreter was not present. I reiterated the consent process. This gave some teenagers the opportunity to decline

participation, or ask further clarifying questions. This is how I tried to prevent coercive participation and mitigate any social pressure to participate.

If a teenager or her guardian seemed uncomfortable reading any documents, I read these out loud in a private room with an interpreter present. In hindsight, all the teenagers I recruited were literate. When their legal guardians were not literate or could not understand English, an interpreter read the (Sesotho) forms out loud. This happened in a private room while I was present. All documents were provided in English and Sesotho.

After situating myself, I explained the research topic and methods (interview and observation). I used an information sheet and consent forms to explain the research to teenagers, and their guardians (Appendices E, M, N). I asked if interviews could be audio-recorded. I explained that each teenager would receive some compensation for participation to cover out-of-pocket (usually travel) expenses. I emphasised that she could refuse questions or decline participation at any time without penalty, and without affecting access to clinic services. I invited her to ask any questions about participation throughout the consent process, and throughout fieldwork. Consent forms were signed privately in a nurse's office, or a teenager's house.

Negotiating informed consent was an on-going process. Beyond signing consent forms, I repeatedly reminded teenagers that they could withdraw at any point for any reason. Moreover, I emphasised that research participation or withdrawal would not affect antenatal care or clinic access. I reiterated that I was not a doctor at the clinic.

The participant age range was 16 to 50 years old. All participants were asked to sign consent forms in front of me and a witness (usually an interpreter). Participants who were younger than 18 years old were asked to obtain written informed consent from a legal guardian. When relevant, I offered to discuss the research objectives, and consent forms, with guardians. After obtaining informed written consent, I communicated with participants individually to schedule meetings.

Part of obtaining consent was anonymising teenagers' identities. On consent forms, I asked participants to choose pseudonyms for themselves. Furthermore, I created pseudonyms for nurses, schools, and locations in the township. These strategies aimed to protect participant confidentiality and prevent recognition by association. All the names that appear in this dissertation have been anonymised accordingly. There are a few exceptions: some teenagers insisted that their true names remained linked to their stories (Riessman, 2005:475). Some teenagers did not want to be anonymous. In these instances, I have anonymised everything about a teenager – her township section, clinic, nurse, school, relatives - except her true name.

After recruiting teenagers, and gaining informed consent, the negotiation to 'find' teenagers continued. Although teenagers had committed to the research, they were sometimes evasive. Some teenagers did not confirm meetings, or did not answer the door when I visited their houses.

In some instances, I interpreted evasion as an effort to withdraw from the research. In these situations, I asked teenagers if we could use their interview information to date. If they refused,

I destroyed all relevant fieldwork documents. I did not use their information or stories. There was no penalty for withdrawing. Before parting, I assured teenagers that they could always contact me if they wanted to meet again. As with the other participants, I made sure that teenagers who withdrew had the contact information for clinic counselors, and local helplines.

In other instances, teenagers assured me – during our phone calls or in WhatsApp texts – that they wanted to continue the research even though they missed meetings. They offered explanations for absences or evasion. Some teenagers regularly visited family or partners in Bloemfontein. In other instances, some teenagers told me that they had anxieties about the language barrier. These teenagers worried that they could not speak English 'well enough.' Other teenagers had family members at the house, or neighbours across the street, which meant less privacy during our conversations. To mitigate these anxieties, I reiterated that interpreters would be present during all discussions for in-situ translation. Not being able to speak 'perfect' English was not a barrier of participation. Furthermore, when necessary, I met teenagers in different locations where they told me they felt safe and anonymous. For example, we met in antenatal clinic examination rooms, a nurse's office, or a counselor's office at the clinic.

Protecting teenagers

The risks of participating in this research included unintended HIV disclosure, unforeseen HIV disclosure, publicising teenage pregnancy, and breaching confidentiality.

To avoid unintended HIV disclosure and unforeseen HIV disclosure, I did not publicly associate this research – or myself - with HIV. Because I walked between teenagers' houses, community

members quickly learned who I was and what I was doing. I presented myself as a researcher interested in 'teenage pregnancy and motherhood' and not '*HIV-positive* teenage pregnancy and motherhood'. HIV was only discussed in private, after teenagers had disclosed their (positive or negative) statuses to me.

My link to 'teenage pregnancy' concerned some community members. In Botshabelo, teenage pregnancy has a powerful stigma. Even talking about teenage pregnancy could be construed as encouraging teenage pregnancy. This is what some community members thought I was doing. Working with interpreters, who personally knew people in various township sections, helped to mitigate some of this criticism. Furthermore, I met teenagers when and where they felt most comfortable. This was usually in teenagers' homes.

To avoid breaching confidentiality, all hard copy data were stored under lock and key at my accommodation in Bloemfontein. All soft copy data were protected with codes and password-encryption. Throughout this dissertation, as in my fieldwork documents, I have anonymised all names and demographic information.

Compensation and coercion

The following compensation was discussed with, and approved by, multiple groups including: a community advisory group in Botshabelo, the HSREC at the University of the Free State in South Africa, CUREC at the University of Oxford, and the Free State Department of Health.

Each participant received a 'baby hamper' every month, as a token of gratitude for their participation. Hampers included nappies, lotions, towels, soap, baby clothes, baby shoes, blankets, or toys. These items varied each month, although contents were always consistent for every participant. Participants also received R20.00 (£1.20) monthly airtime vouchers for mobile phones so they could call me. Vouchers could be used in a medical emergency, or to contact me with research concerns. The ethics committees agreed that airtime vouchers provided enough money to make phone calls, but not enough money to be coercive. Where relevant, I reimbursed teenagers for their travel on a case-by-case basis. At the end of fieldwork, each participant received a chocolate and certificate of participant as a token of appreciation (Appendices F, G). Chocolates were among the luxurious treats that teenagers told me they could not often afford (Figure 3).

During fieldwork, compensation was discussed with participants during the informed consent process, but not during recruitment. Furthermore, baby hampers and vouchers were not advertised to prospective participants or non-participants in order to prevent coercive participation and incentivizing participation. These guidelines were stipulated by all ethics bodies. Moreover, participants received baby hampers at different times of the month to mitigate any association between hampers and research participation. Most participants did not know each other, which meant that prospective participants or non-participants did not really have a sense that current participants were receiving hampers.



Figure 3. Kananelo and her baby receive a certificate/chocolate

(Source: Moodley, S. 2019)

Power dynamics

To reduce unequal power dynamics, between teenagers and myself, I constantly reiterated that participation or withdrawal would not affect a teenager's relationship with any healthcare providers or facilities. I worked hard to ensure mutual respect, and preserve privacy and dignity, in all interactions (ASA Ethics Guidelines 2018). Discussing consent forms, and helping teenagers understand their rights and my responsibilities, were incredibly helpful to this end.

To reduce unequal power dynamics, between interpreters and myself, we discussed and signed an informal agreement to ensure timely payment, accountability, and confidentiality. As part of this agreement, the interpreter would undergo relevant ethical training: reading and discussing some South African guidelines for ethical, qualitative research (Appendix D). Building awareness of "vicarious trauma" was key during this training (Appendix C). Weekly debriefing with interpreters, as part of concurrent analysis, was an important part of recognising vicarious trauma instead of internalising it. During fieldwork, I discussed interviews with interpreters, and constantly asked for their opinions and perspectives. These discussions not only provided important context for teenagers' stories. Our conversations grew a sense of mutual respect for knowledge sharing. This helped to mitigate some power dynamics.

My social position, privilege, and association with some antenatal nurses influenced power dynamics in the field. When my interpreters – Letsoba and Mammako – first met me, they seemed impressed that the nurses had agreed to work with me. My association with the nurses validated my research. This was also the case for some teenagers. I constantly reiterated my

status as a DPhil student – and not a medical doctor – working with nurses at the clinic. This reiteration eased some power dynamics, although these were always present.

Furthermore, I regularly consulted with a 'community advisory group' in field (Appendix B). This group comprised nurses and doctors at Botshabelo Hospital and at the Free State Department of Health. Working with this group made my research methods more community-specific and participant-specific, as the needs and experiences of both community and individual evolved over the fieldwork period. These discussions also prompted continuous reflection during fieldwork.

III. Literature review

In this chapter, I present some literature that relates to the four threads shaping my dissertation: how others perceive teenagers, how teenagers perceive themselves, how teenagers experience others, how teenagers perceive their babies. These literary debates provide a necessary backdrop for my empirical findings. I focus on scholarship in South Africa, my chosen fieldwork location. I compare and contrast this literature with some international research on teenage pregnancy, motherhood, and HIV.

Section 1. How others perceive teenagers

This thread explores the way others (community members, family members) perceive pregnant teenagers and teenage mothers in the literature. I would like to signal that the social positions of community or family members differ quite substantially. I explore these social positions in the empirical chapters that follow. In this chapter, however, these social actors are grouped together - as 'others' - in order to highlight the cumulative effect of their actions on pregnant teenagers and young mothers. This grouping does not imply that a monolithic cohort. On the contrary, the cohort of 'others' suggests that diverse actions have devastating effects on the lives of young women who are punished and attacked at every turn.

Some of the earlier scholarship on teenage pregnancy in South Africa highlighted premature deliveries and high mortality rates for teenage teenagers (Bledsoe & Cohen, 1993; Blumenthal et al., 1982; Coetzee, 1970; Nash, 1990). This was consistent with other international

quantitative socio-health research, including work in Mozambique (Bacci et al., 1993), Kenya (Ngoka & Mati, 1980), Peru (Frisancho et al., 1983), the United States (Elster, 1984; Furstenberg et al., 1987; Hogan & Kitagawa, 1985; Horon et al., 1983; Naeye, 1981; Russell, 1982; Zlatnik & Burmeister, 1977), and globally sampled data (Edstrom, 1981; Forbes, 1981; Scholl et al., 1994). Contrastingly, certain scholars found that teenagers were "biologically" ready for pregnancy and childbirth in many settings including the United States (Kaminetzky et al., 1973; Osofsky et al., 1971; Phipps-Yonas 1980; Weigley, 1975). These debates continued into the new millennium in many areas such as South Africa (Cunningham & Boult, 1996; Mushwana, Monareng, Richter, & Muller, 2015), the United Kingdom (Godding, 2008), and the United States (Moloney et al., 2011). "Traumatic" health outcomes were offered as reasons to condemn (or even discourage) teenage pregnancy in South Africa (Nash, 1990:147; Richter & Mlambo, 2005). Yet there were other explanations for the negative social attitudes linked to teenage pregnancy. For example, certain ethnographies examined these attitudes even though these works were not explicitly about teenage pregnancy. More specifically, scholars explored the meaning of pregnancy and witchcraft (Wilson, 1951), motherhood and traditional medicine (Ngubane, 1977), and premarital pregnancy (Longmore, 1959; Vilakazi, 1963) in South Africa and Tanzania. In South Africa specifically, other scholars found that neglectful teenage parenting explained why society condemned teenage pregnancy (Cunningham & Boult, 1996; Nash, 1990:147; Preston-Whyte & Zondi, 1989:60). These scholars described teenage mothers as immature or lacking coping skills. This agrees with psychology scholars like Erica Burman (1994) in the United Kingdom and David Shaffer and Katherine Kipp (2007) in the United States who found that teenage mothers are caught between identity seeking and role confusion. This research drew on classical psychoanalytic theories of child and identity development

(Erikson, 1968; Piaget, 1972). This developmental psychology literature was echoed in certain quantitative socio-health work in areas like South Africa (Mushwana et al., 2015), Canada (Stanhope et al., 2008), and the United States (DeVito, 2010). In Zimbabwe and Australia, for example, certain scholars observed that teenage pregnancy and motherhood aggravated a teenager's inner strife with her identity (Benza & Liamputtong, 2015; Liamputtong, 2006; Ngum Chi Watts et al., 2015).

Certain scholars have pushed back against the 'neglectful teenage mother' trope. Ann Phoenix (1991) was one of the earliest scholars to do this with her psychosocial work in the United Kingdom. Phoenix examined both negative *and positive* aspects of teenage motherhood, an unprecedented stance at the time. She focused on the circumstances shaping teenage pregnancy. Psychosocial scholars like Phoenix inspired qualitative socio-health research on the positive aspects of teenage pregnancy. In South Africa, for example, scholars found that teenage mothers tried to be good parents by returning to school (Jewkes et al., 2001:734, 743; Kaufman et al., 2001; Madhavan et al., 2005; Mkhwanazi, 2014c; Panday, Makiwane, Ranchod, & Letsoala, 2009:6). Teenagers did this despite the social stigma linked to teenage pregnancy, which made returning to school a nightmarish negotiation (Macleod, 2003:433).

The (positive) reality of teenage mothers returning to school referenced earlier socio-health literature on teenage pregnancy as a burden to the education system in South Africa (Boult & Cunningham, 1991; Bledsoe & Cohen, 1993; Craig & Richter-Strydom, 1983, Cunningham & Boult, 1996; Meekers, 1994; Mogotlane, 1993; Olaniyan, 1992; Thomas & Khumalo, 1989)

and Sub-Saharan Africa (Kulin, 1988). In 2009, South Africa's Minister for Basic Education noted:

> Teenage pregnancy undermines the Department's efforts to ensure that girl children remain in school, in order to contribute towards a quality life for all, free of poverty. (Motshekga 2009:3)

Debates around pregnant teenagers' positions in the education system segued into and reignited earlier debates about teenagers' social and cultural responsibilities. Some scholars found that teenage pregnancy was a sign that socio-cultural institutions were being "eroded" (Varga, 1998:16) or teenagers had "too many rights" (Hodes, 2017a). That is, teenage pregnancy undermined the moral order sewed into the "basic values and standards" of certain South African communities (Chohan & Langa, 2011; Motshekga 2009:3). This literature echoed earlier socio-health work in South Africa (Craig, 1980), Canada (Spencer 1970:3), the United Kingdom (Curtis et al., 1988), and the United States (Clarke, 1986; Height, 1986). These debates are rooted in discussions about teenagers' socio-political rights, sexual promiscuity, and teenage pregnancy in South Africa (Craig & Richter-Strydom, 1983; Dubb, 1974; Kies, 1987; Longmore, 1959; O'Mahony, 1987; Thomas & Khumalo, 1989; van der Vliet, 1974; Vilakazi, 1962) and other developing countries (Caldwell et al., 1989). Ethnographic work responded to this qualitative socio-health literature by focusing on teenage pregnancy, culture, and community. Scholars like Nolwazi Mkhwanazi (2014a) found that teenage pregnancy is "not the absence of values regarding childcare but, rather, the attempt to uphold them" (Mkhwanazi, 2014a:108).

In some ways, South Africa's HIV epidemic provided new perspective to these debates. That is, both quantitative and qualitative research found that sexual promiscuity and teenage pregnancy increased the risk of HIV transmission (Christofides et al., 2014; Harrison 2008). In response, some scholars observed that contracting HIV was simply a "new part of growing up" in South Africa (Leclerc-Madlala, 1997:369-370).

> Ever since they (young people) reached sexual maturity, the threat of AIDS was there. They had come of age sexually, politically, and legally in the era of AIDS. (Leclerc-Madlala, 1997:367)

Other scholars found that intimate partner violence, more than teenage pregnancy, contributed to the spread of HIV in South Africa (Angless, 1992; Heise et al., 1994; Longmore, 1959; Maforah, Wood & Jewkes, 1997; Varga, 1996; Varga & Makubalo, 1996; Wood & Jewkes, 1997a; Wood et al., 1998a; Wood et al., 1996). Some of this work blamed HIV on gender dynamics, age-disparate relationships, and structural poverty in South Africa (Harrison, 2008; Jewkes et al., 2001; Leclerc-Madlala, 1996; Leclerc-Madlala, 1999a; Mkhwanazi, 2014b; Preston-Whyte, 1993; Preston-Whyte, 1994; Preston-Whyte, Abdool Karim & Zondi, 1991; Preston-Whyte & Zondi, 1989; Preston-Whyte & Zondi, 1992; Preston-Whyte et al., 1990; Varga, 1997; Varga, 1999; Varga, 2003; Varga & Makubalo, 1996). This echoed literature in Tanzania (Nnko & Poole, 1997), Zambia (Nzovu & Lwanga, 1997), Kenya (Balmer et al., 1995), Zaire (Schoepf, 1992), Uganda (McGrath et al., 1993), Nigeria (Orubuloye et al., 1993), and the United States (Kaloff, 1995; Kline et al., 1992; Lear, 1995; Sobo, 1994; Worth, 1989).

Sexual and domestic violence were not new topics in the South African literature (Longmore, 1959:24; Schapera, 1939). Yet these took center stage as scholars tried to understand the AIDS pandemic (Jewkes et al., 2001; Kotze, 1993:76; Ramphele, 1993; Varga & Makubalo 1996; Wood & Jewkes, 1997; Wood et al., 1998).

HIV seemed to add to the "moral panic" associated with teenage pregnancy in South Africa (Panday et al., 2009:58-59). Social labels – irresponsible, immature, immoral, and negligent – contributed to a powerful stigma linked to teenage pregnancy. Other work pushed back against the idea of teenage pregnancy as immoral or rebellious. Scholars found that teenage pregnancy was not a "sign of moral degeneration" (Mkhwanazi 2012:74, 2014a, 2014b, 2014c; Ngabaza, 2013; Ngabaza & Shefer, 2013:111). These scholars observed that pregnant teenagers respect and follow the socio-cultural expectations of 'good mothering' in certain South African communities (Mkhwanazi, 2010:357; Preston-Whyte & Zondi, 1989; Preston-Whyte, Zondi, Mavundla, & Gumede, 1990; Preston-Whyte, 1994). For example, some teenagers work hard to learn mothering from their own mothers (Mkhwanazi, 2010:357). This might be because, as earlier work suggested, childbearing is said to be socio-culturally important and deeply valued in South African communities (Preston-Whyte, 1993:6), and communities in the United States (Gerson, 1985; Kline et al., 1995) among other places.

In South Africa, other scholars found that teenage pregnancy did not stem from the lack or presence of morality. Rather, as Sharlene Swartz (2009) writes, teenage pregnancy sometimes came from minimal opportunities to reflect on the "dissonance" (perhaps even contradiction) between moral "beliefs and behavior" (Swartz, 2009:236).

Some work responded to this morality debate by invoking the socio-cultural expectations linked to marriage, and the way teenage pregnancy threatens marriage. In certain South African communities, marriage is said to offer some social and financial security (Mturi, 2015). Marriage begins the process of "family formation" and secures emotional support before the difficult experience that is pregnancy (Mlotshwa et al., 2017). Other South African scholarship found that when young people marry, their union indirectly strengthens parental authority and signifies obedience (Zwang & Garenne, 2008). Teenage pregnancy before marriage takes away a family's power to negotiate a lucrative engagement. This effectively robs a teenager's family of the wealth linked to her marriage. The exchange of wealth (bridewealth, lobola) in the context of marriage is an important part of life in some South African communities (Bozzoli & Nkotsoe, 1991; Hunter, 2010; Mkhwanazi, 2012; Stadler, 1994). Adding to her family's disappointment and anguish is the fact that a pregnant teenager might never marry her baby's father or anyone else (Mkhwanazi, 2012, 2014a; Singh & Samara 1996; Zwang & Garenne, 2008:104). Other work responded to this debate by arguing that teenage pregnancy can actually increase marriage opportunities. Pregnancy proves that a teenager can bear children. This has been explored in South Africa and Zimbabwe among other places (Jones, 2009; Kaufman et al., 2001, Macleod 1999b:14; Preston-Whyte et al., 1991). Furthermore, some South African scholars found that the institution of marriage before childbearing was dissolving (Longmore, 1959:150-51; Meekers, 1994; Preston-Whyte et al., 1990:15; Preston-Whyte & Zondi, 1989:55; Preston-Whyte & Zondi, 1992; Varga, 1998:18). The number of both civil and customary marriages has declined since their peak in 2009 (Statistics South Africa, 2018d). In 2013, only one third of South Africans older than 20 were married nationally (Department of Health, 2007; Mlotshwa

et al., 2017; Schatz et al., 2011; Statistics South Africa, 2013). This literature suggests that pregnant teenagers are 'blamed' for the decline of an institution (marriage) that began eroding before they were born (Delius & Glaser, 2005; Hodes, 2017b).

Section 2. How teenagers perceive themselves

The scholarly debates around teenage pregnancy, stigma, and marriage emphasise the way others perceive teenagers. These debates also overlap with a second thread of my dissertation: the way teenagers perceive themselves. In this section, I describe scholarship exploring what teachers and families do in the face of teenage pregnancy. This literature could be read as work describing how these social actors perceive teenagers, and how these social actors respond to teenage pregnancy. Yet I include this literature here, instead of in the previous section on 'how others perceive teenagers.' During my fieldwork, I found that the actions of teachers and families usually affects what pregnant teenagers say about themselves. That is, teenagers' ideas about themselves seem to be affected by what these social actors say and do. For example, I observed that a teenager's perception of her pregnancy is greatly affected by what her teachers, nurses and relatives say. The following scholarship describes the actions of teachers and families in an effort to illustrate how this affects teenagers and, in turn, how this influences teenagers' perceptions of themselves.

Some of the South African literature suggests that unmarried pregnant teenagers are painfully aware of their precarious social positions. That is, pregnant teenagers "internalise discomfort and fears of humiliation" associated with their pregnancies (Ngabaza & Shefer, 2013:111).

Early literature highlights a similar sense of irresponsibility and shame linked to teenage pregnancy (Pauw, 1964). It seems that these themes have been reproduced over decades. Some scholars found that teenage pregnancy disappoints parents, thwarts schooling, and jeopardises marriage (Mkhwanazi, 2014a). Some scholars observed that teenage pregnancy is less about irresponsibility and more about a teenager wanting to elevate her social status. In Australia, for example, some researchers found that a teenager who is a mother has a "place" in her community, and is a "bearer of nationhood" (Abu Duhou, 2007; Ngum Chi Watts et al., 2015:8). I think this is meaningful for a teenager who is unemployed, uneducated, and impoverished with few other means to gain respect. This has been discussed in Australia, Ghana, and South Africa among other places (Clemmens, 2003; Gyesaw & Ankomah, 2013:779; Hanna, 2000; Hunter, 2010; Ngum Chi Watts et al., 2015). Becoming a mother can be a way to transition from girlhood to womanhood in South Africa (Berglund, 1976; Krige, 1936; Ngubane, 1977; Preston-Whyte & Zondi, 1989:59; Sundkler, 1961; Varga, 1997b:60). Catriona Macleod (2003) suggests that this transition can be tricky in certain South African communities as most teenagers occupy an "undecidable" space (Macleod, 2003:421).

> …as the adolescent is not an adult but neither a child (and yet simultaneously both), she or he acts as what Derrida calls an 'undecidable.' (Macleod, 2003:421)

Teenage pregnancy can aggravate the 'not adult yet not child' tension. Pregnant teenagers are children, yet not children, and adults, yet not adults (Macleod, 2003:426). Pregnancy signals adulthood, while schooling signals childhood.

Some scholars found that the way pregnant teenagers interact with the education system is an important part of how they perceive themselves, and others. Some scholars observed that shyness, embarrassment, and stigma are some reasons why teenage mothers do not return to school in South Africa (Coombe & Kelly, 2012; Jefferis, 2017; Zwang & Garenne, 2008:104). On the contrary, some scholars found that some teenage mothers do return to school (Jochim, Groves & Cluver, 2020; Marteleto et al., 2006; Marteleto et al., 2008). For example, Janina Jochim and colleagues (2020) worked with young mothers in the Eastern Cape and Durban. They observed that more than half (65%) of the 1,114 teenage mothers in their cohort returned to school after giving birth. In some instances, teenage mothers might consider or attend night school (Ngabaza & Shefer, 2013). Despite returning to school, these teenagers live in "secrecy, duplicity, and fear of disclosure and rejection" (Ngabaza & Shefer, 2013:111-112).

Certain scholars found that pregnant teenagers do not return to school because of local school policies, more than personal insecurities or stigma. In some South African communities, pregnant teenagers are 'not allowed' to attend school (Bray et al., 2010; Hodes, 2017a; Jonas et al., 2016; Macleod, 1999a). Based on their work in Khayelitsha, Sisa Ngabaza and Tamara Shefer (2013) found that some schools exclude pregnant learners (2013:109). This is echoed in other South African literature (Bray et al., 2010; Mkhwanazi, 2012; Mkhwanazi, 2014b; Zwang et al., 2008). One poignant example is what Katleho Mokoena and Ncedisa Dlutu experienced in 2010 in the Free State province (Mkhwanazi, 2014c:326-327; National Professional Teachers' Organisation of South Africa, 2018; Southern African Legal Information Institute, 2013; Unite for Reproductive Rights, 2013). Mokoena (17 years old) and Dlutu (16 years old)

could not attend their respective high schools because they were pregnant. After giving birth to their babies, Mokoena and Dlutu were not re-admitted to their schools. In order to continue at Harmony High School, Mokoena needed to prove that she did not have a baby. Dlutu needed to repeat her first year at Welkom High School. The Free State Department of Education became involved in both legal cases. The cases were presented to the Free State High Court, and the national Constitutional Court - the highest court in the country. The Constitutional Court ruled that the Free State Department of Education had incorrectly interfered with the respective school policies. Furthermore, the Court ruled that the schools' policies were unconstitutional and in need of immediate review.

Preventing any (pregnant) student from attending school contradicts the 1996 South African Schools Act, law 38 in the 2005 Children's Act, the Convention on the Right of the Child, and Section 9 in the South African Constitution (Mkhwanazi, 2014c:326-327). The South African Schools Act makes it "illegal for schools to exclude pregnant learners" (Mkhwanazi, 2012:78). Furthermore, South Africa's Constitution states that a learner can return to school after having her baby (Kaufman et al., 1998; Kaufman et al., 2001:147, McNeil et al 1980; Mkhwanazi 2012; Mkhwanazi 2014b). In theory, this legislation protects teenagers and their right to education. In practice, however, local school policies have forced teenagers to choose between mothering and schooling. In a 2007 report, South Africa's National Department of Education suggested that teenage mothers should prioritise childcare over schooling:

> … learners as parents should exercise full responsibility for parenting, and that a period of up to two years may be necessary for this purpose. No learner should

> be re-admitted in the same year they left school due to pregnancy. (Department of Education, 2007)

This South African literature highlights contradictions between local policies and national legislation, all ratified within ten years of each other. Returning to school can be difficult when teenage mothers are torn between education and childcare. To make matters worse, some teachers favour childcare over schooling in an effort to honour a baby's right to care (Bray et al., 2010; Choane, 2017; Panday et al., 2009:55; Southern African Legal Information Institute, 2013). Some scholars have observed that teachers are uncomfortable around, or do not know how to interact with, pregnant teenagers and teenage mothers (Bhana et al., 2008; Bhana et al., 2010). As a result, some teachers are unkind and "hostile" to teenage mothers (Malatji et al., 2019:9). For example, some South African scholars found that teenagers are wrongfully accused when things go awry in the classroom (Chohan & Langa, 2011; Malatji et al., 2019:9; Shefer et al., 2013). These are some of the challenges pregnant teenagers must overcome if they want to access an education (Jewkes et al., 2001:734, 743; Kaufman et al., 2001; Madhavan et al., 2005; Mkhwanazi, 2014c; Panday, Makiwane, Ranchod, & Letsoala, 2009:6). This South African literature seems to suggest that the education system is a burden to pregnant teenagers. This responds to earlier scholarship arguing that teenage pregnancy is a burden to the education system in South Africa (Boult & Cunningham, 1991; Bledsoe & Cohen, 1993; Craig & Richter-Strydom, 1983, Cunningham & Boult, 1996; Meekers, 1994; Mogotlane, 1993; Olaniyan, 1992; Thomas & Khumalo, 1989).

Section 3. How teenagers experience others

Interacting with the education system is not only an important part of how teenagers perceive themselves. Education is also part of how teenagers experience others, usually their families. This is a third thread of my dissertation.

Some scholars found that families can "remove the sting" (or stigma) linked to teenage pregnancy when they support their daughters (Preston-Whyte, 1991; Preston-Whyte, 1993:64; Varga, 1998:109). This is the case when families absorb teenagers' babies into the family unit. Naming babies is an important part of this process. These families accommodate three or even four generations (Dubb, 1974; Marwick, 1978; Pauw, 1963; Preston-Whyte et al., 1990:14). This literature spans many years, which suggests that this has been happening for decades in various South African communities. More recently, some South African scholars have examined the role families play when their teenage daughters return to school or try to access education (Chohan & Langa, 2011; Mkhwanazi 2010; Morrell et al., 2012a; Ngabaza 2011; Nkani 2012). When families take care of teenagers' babies, some teenagers can return to school. Otherwise, childcare is a barrier to returning to school (Bhana et al., 2010). So much so that when families cannot help with childcare, many teenagers drop out of school (Department of Education, 2004:4; Selesho, Twala & Modise, 2012:129). On the other hand, when families help with parenting and childcare, teenage mothers are more likely to attend school. This is because their families provide much-needed emotional and financial support (Macleod, 1999c; Morrell, Bhana & Shefer, 2012a; Nkani, 2012). These scholars found that teenagers' partners and partner's families might also offer support. Based on their work in the Western Cape, however, Bray and colleagues (2010) found that most teenagers rely on their mothers to take

care of new babies (2010:124). Contrastingly, Nthabiseng Motjelebe (2009) observed that most teenagers received support from family, friends, neighbours and the church - not only their mothers (Motjelebe, 2009:24-28). Motjelebe worked with teenage mothers in Botshabelo township. Similarly, James and colleagues (2012) observed that teenagers *and their families* may be "totally segregated" from - and stigmatised in - their Port Elizabeth communities (James et al., 2012:191).

Not all teenage mothers can rely on familial support. The South African literature shows that some families exclude or reject their pregnant daughters (Chohan & Langa, 2011; Cunningham & Boult, 1996:693; James et al., 2012:191; Mkhwanazi, 2012; Mkhwanazi, 2014c). These teenagers cannot "expect" protection from, or in, their communities (Ngabaza & Shefer, 2013:111). The qualitative socio-health literature shows that single mothers who cannot rely on their families for emotional and financial support turn to multigenerational "female- or women-centered households" (Mlotshwa et al., 2017; Preston-Whyte, 1978; Preston-Whyte, 1993:67). These mothers form 'care networks' when they are divorced, not yet married, or abandoned by their partners. These networks largely comprise adult (not teenage) mothers.

Beyond their families, pregnant teenagers must confront others (nurses, community members) when they interface with the healthcare system. In Botshabelo, I observed that most teenagers interact with nurses, not doctors. In the early stages of pregnancy, this happens when teenagers are trying to learn about abortions. The South African literature shows that many pregnant teenagers face discrimination at the clinic (Manzini, 2001; Mkhwanazi, 2014b; Peltzer et al., 2010). This can discourage access to legal and safe abortions (Panday et al., 2009:6). This

echoes other qualitative research in Sub-Saharan Africa and South-East Asia (Williamson et al., 2009). In South Africa, the Choice on Termination of Pregnancy Act No. 92 of 1996 allows a pregnant teenager or woman to terminate her pregnancy up to twelve weeks in her gestation (Mkhwanazi, 2014c:330). In certain circumstances, a pregnancy can be terminated at twenty weeks (Mkhwanazi, 2014c:330). This might be necessary in cases that involve rape, incest, or if pregnancy risks the life of mother or baby (Mkhwanazi, 2014c). The Choice on Termination of Pregnancy Act replaced the Abortion and Sterilisation Act (no. 2 of 1975, amended in 1982). The former made it easier for (Black) women and teenagers to have legal and free abortions (Cooper et al., 2004; Cooper et al., 2005). In practice, however, scholars found that many pregnant teenagers cannot freely choose abortions in South Africa. Teenagers are discouraged by clinic staff. Some scholars observe that this is because choosing an abortion has moral and religious implications (Cates et al., 1983; Cooper et al., 2004:75; Cunningham & Boult, 1996; Klugman & Hlatshwayo, 2001; Maforah, Wood, & Jewkes, 1997; Matiyela, 2018; Mkhwanazi, 2011:5; Nash, 1990; Varga, 2002).

Section 4. How teenagers perceive their babies

In addition to abortion-related discussions, the literature shows that nurses are an important part of antenatal care routines, and the beginning of the mother-child relationship. The fourth and final thread of my dissertation explores this relationship, and the way teenagers perceive their babies.

In France, Elizabeth Badinter's philosophical work (1981) on "good mothering" - and mothers' active efforts to achieve this trope - shifted earlier ideas about motherhood. Badinter described 'good mothering' as something women could work toward, not an innate or "natural" ability as presented in the psychosocial literature (Klaus & Kennell, 1977; Lamb, 1983). In South Africa, scholars found that some teenage mothers were doing what they could to be good mothers. For example, some teenagers cherished their babies as companions (Preston-Whyte & Zondi, 1989:60). For other teenagers, good mothering meant finding employment, and prioritising childcare and parenting (Cluver et al., 2011; Motjelebe, 2009; Toska, Cluver, Boyes, Pantelic & Kuo, 2015). There is some debate about teenage parenting in the literature. Some scholars observe that parenting responsibilities can be overwhelming for teenage mothers in certain South African communities (Craig & Richter-Strydom, 1983; Leclerc-Madlala, 1999; Moeno, 1977; Preston-Whyte, 1990:11). This agrees with research in other areas including the United States, Ghana, and Australia (Clemmens, 2003; Dlamini, 2002; Gyesaw & Ankomah, 2013; Hanna, 2001; Paterson, 2001:65; Ngum Chi Watts et al., 2015). Scholarship in South Africa and other African countries found that one sign of 'overwhelmed teenage mothers' is teenagers who do not diligently access antenatal care (Godding, 2008; Goldberg & Craig, 1983; Helleringer, 2017; Jones et al., 2013; Mushwana et al., 2015; Richter & Mlambo, 2005; Ronen et al., 2017; Varga, 1998; Woldesenbet et al., 2015). On the other hand, some scholars observe that teenagers avoid antenatal care in order to avoid discrimination at the clinic, not only because teenagers are overwhelmed (Burman, 1992; Varga & Brookes, 2008). Antenatal care is crucial as things can go wrong during teenage pregnancy. The South African literature shows that teenagers' babies might struggle with neural tube defects, mental challenges, and even mortality (Cunningham & Boult, 1996; Godding, 2008; Nash, 1990:147; Richter & Mlambo,

2005; Russell, 1982; Varga, 1998). This is consistent with research in the United States, Sweden, and Czechia (David, 1986; Forrsman & Thuwe, 1981; Hardy et al., 1987). These scholars found that teenagers' babies have more developmental challenges and lower IQ scores, compared to babies born to adult mothers. Beyond monitoring the risks related to pregnancy, antenatal care is also an avenue to teach pregnant teenagers mothers about childcare, and nutrition for themselves and their babies (Jochim et al., 2020).

When it comes to parenting and motherhood, there are interesting debates on good mothering in the context of HIV. It seems that being a 'good mother' can take on different meanings for women living with HIV. Carol Long (2009) and Stinson and Myer (2012) have worked with HIV-positive (adult) mothers. Long (2009) focused on good mothering and mothers' attempts to protect their babies in Johannesburg. Stinson and Myer (2012) focused on 'mothering work' among HIV-positive mothers in Cape Town. These scholars explored the "duality of the 'good' and 'bad' mother" (Long, 2009; Stinson & Myer, 2012:43). More recently, Adeagbo Josephine (2019) worked with HIV-positive (teenage) mothers in Johannesburg. She found that these mothers lacked emotional support and resources. As a result, many teenagers struggled to cope and could not be 'good' mothers in the ways they hoped to be (Josephine, 2019:6).

In the United States, certain scholars have explored what "mothering work" means for HIV-positive adult mothers (Sandelowski & Barroso, 2003b). This ideology combines two concepts. The sociological concept of "work" was established by Strauss and colleagues (1982, 1985), and Strauss and Corbin (1998). The concept of the "work object" was presented by Casper (1998). In the South African context, for example, some HIV-positive mothers do "safety work"

and "hope and worry work" in an effort to protect their babies (Giles et al., 2009; Stinson & Myer, 2012:43). In the United States, for example, some HIV-positive mothers do "surveillance and safety work" to prevent HIV and its stigma from infecting and affecting their babies (Hejoaka, 2009). Adhering to medical routines is another example of mothering work in the United States (Misener & Sowell, 1998; Siegel & Gorey, 1997; Siegel et al., 2001; Sowell & Misener, 1997:67). This work includes taking HIV medications: azidothymidine (AZT) or antiretroviral therapy (ART). In South Africa and the United States, scholars observed that some HIV-positive mothers do "worry work" when thinking about childcare after maternal death, postpartum HIV infant testing, or "role reversal" if children must care for sick mothers (Aspeling & van Wyk, 2008; Barnes et al., 1997; Sandelowski & Barroso, 2003a:474; Shannon & Lee, 2008). There are examples of HIV-positive mothers doing mothering "work" in many settings including Canada (Sanders, 2008) and the United Kingdom (McMahon, 1995).

Margarete Sandelowski and Julie Barroso (2003) found that some HIV-positive mothers do mothering work to "recreate" what it means to be a good mother, despite HIV-related stigma (2003a:473). They examined four landmark studies. In the United States, Deborah Ingram (1996) and Sally Hutchinson (1999a, 1999b, 2000) described "defensive motherhood" when HIV-positive mothers struggled to be seen as good mothers as they battled crippling illness. Shortly after this, Diana Barnes and colleagues (1997) explored "eternal motherhood." In this study, HIV-positive mothers immortalised their advice by recording videotapes. These tapes served to prepare their children for life without their mothers. Maria Valdez (1999, 2001) observed that certain HIV-positive Hispanic mothers made promises to God in return for the good health of their babies. Valdez termed this "protective motherhood." Ruth Anne Van Loon

(2000) similarly discussed HIV-positive mothers finding creative ways to bypass their physical limitations. She called this "redefined motherhood." Sandelowski and Barroso (2003a) titrated these four ideologies into a theory of "virtual motherhood." They argued that some HIV-positive mothers try to take care of their children emotionally, spiritually, and psychosocially especially when physical childcare is too taxing. Ultimately, these theories seemed to suggest that, by reworking the meaning of motherhood, HIV-positive mothers are at least one step closer to becoming "good mothers" or "good enough mothers" as discussed in France, the United States, the United Kingdom, and Brazil (Badinter, 1981; Hanna, 2001; Scheper-Hughes, 1993:361; Winnicott, 1965). Furthermore, these theories were critical in shifting the way some theorists and practitioners perceived HIV-positive mothers, and showcasing how some HIV-positive mothers perceived their babies. These theories also shed light on the way HIV-positive mothers perceive themselves.

Chapter summary: research implications

I have organised this literature review into four threads to show how others perceive teenagers, how teenagers perceive themselves, how teenagers experience others, and how teenagers perceive their babies. These threads weave a story about teenage pregnancy and teenage motherhood in the context of HIV. In this dissertation, I argue that these four threads intersect and overlap when it comes to stigma, marriage, education, parenting, and good mothering, among other themes. Although the scholarly debates in this chapter reflect these intersections, these debates also inspire new questions.

Most of this scholarship underscores a painful stigma and prejudice linked to teenage pregnancy. Yet we do not know how or when this stigma manifests or eases. What aggravates this stigma? Who is protected from this stigma, if anyone, and why? When it comes to education, we do not yet know enough about how pregnant teenagers make sense of school policies. How do their families and communities react? Moreover, we do not know enough about how families - and their teenage daughters – make sense of schooling during and after pregnancy. Who makes the decision to attend school or not? When are these decisions made? What factors influence them? Furthermore, we do not yet know enough about why some families support teenage daughters while others do not. How do pregnant teenagers behave around their families? How do teenagers' interactions change during pregnancy, if at all? There is a need to explore these questions - related to stigma, education, and family life - with HIV-negative and HIV-positive teenagers.

Most of the qualitative scholarship on HIV-positive motherhood focuses on adult mothers' experiences in South Africa and abroad (Long, 2009; McMahon, 1995; Sandelowski & Barroso, 2003a:473; Sanders 2008; Stinson & Meyer, 2012). Mothers' ages vary from 16 years old to more than 40 years old in most of the literature on HIV-positive motherhood. Such scholarship focuses on research in Kenya (Turan et al., 2008), Canada (Greene et al., 2016; Ion et al., 2016), England (Lingen-Stallard et al., 2016), and the United States (Andrews et al., 1993; D'Auria et al., 2006; Hackl et al., 1997; Hutchison & Kurth, 1991; Marcenko & Samost, 1999; Miles et al., 2001; Napravnik et al., 2000; Regan-Kubinski & Sharts-Hopko, 1995; Shannon & Lee, 2008; Siegel & Schrimshaw, 2001; Siegel et al., 2001; Sowell & Misener, 1997; Vescovi et al 2014, Wesley et al., 2000). Most of what we know about HIV-positive motherhood explores

HIV-positive teenagers' experiences incidentally (Preston-Whyte & Zondi, 1989; Preston-Whyte, Zondi, Mavundla, & Gumede, 1990; Preston-Whyte, 1994). Josephine's (2019) work with HIV-positive *teenage* mothers in South Africa is part of the emerging scholarship on HIV-positive teenage pregnancy and motherhood. This dissertation is intended to be an ethnographic exploration that will add to this emerging field.

In this dissertation, I explore what life is like for (HIV-positive and HIV-negative) teenagers and young women, during pregnancy and motherhood. What do these young women experience, during and after pregnancy? How do their communities and families behave? How do their interactions change at school, in the home, and with their partners? What must they endure, or enjoy? How does HIV influence pregnancy and motherhood, if at all?

IV. History and context

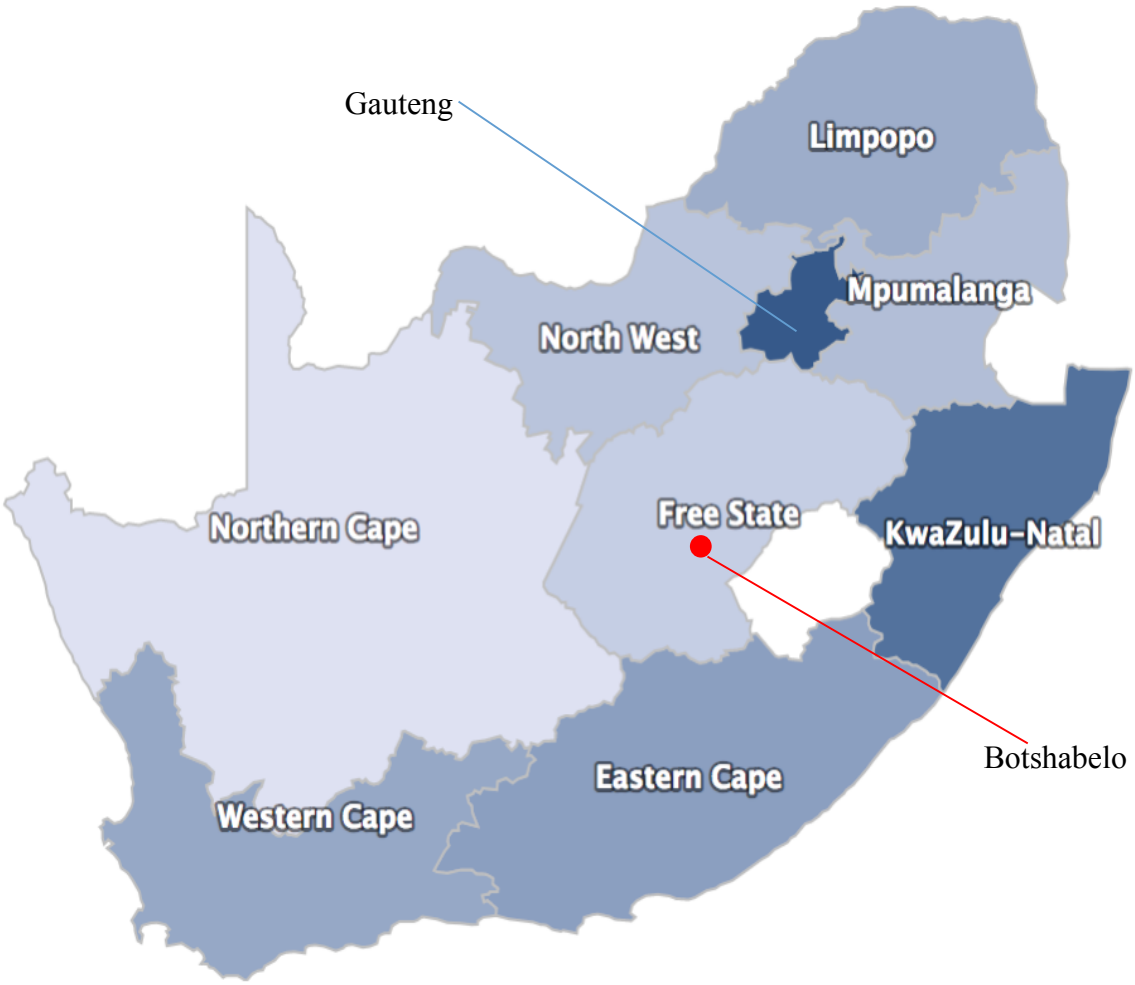

Figure 4. Map of South Africa showing Botshabelo

(Source: Statistics South Africa, 2020)

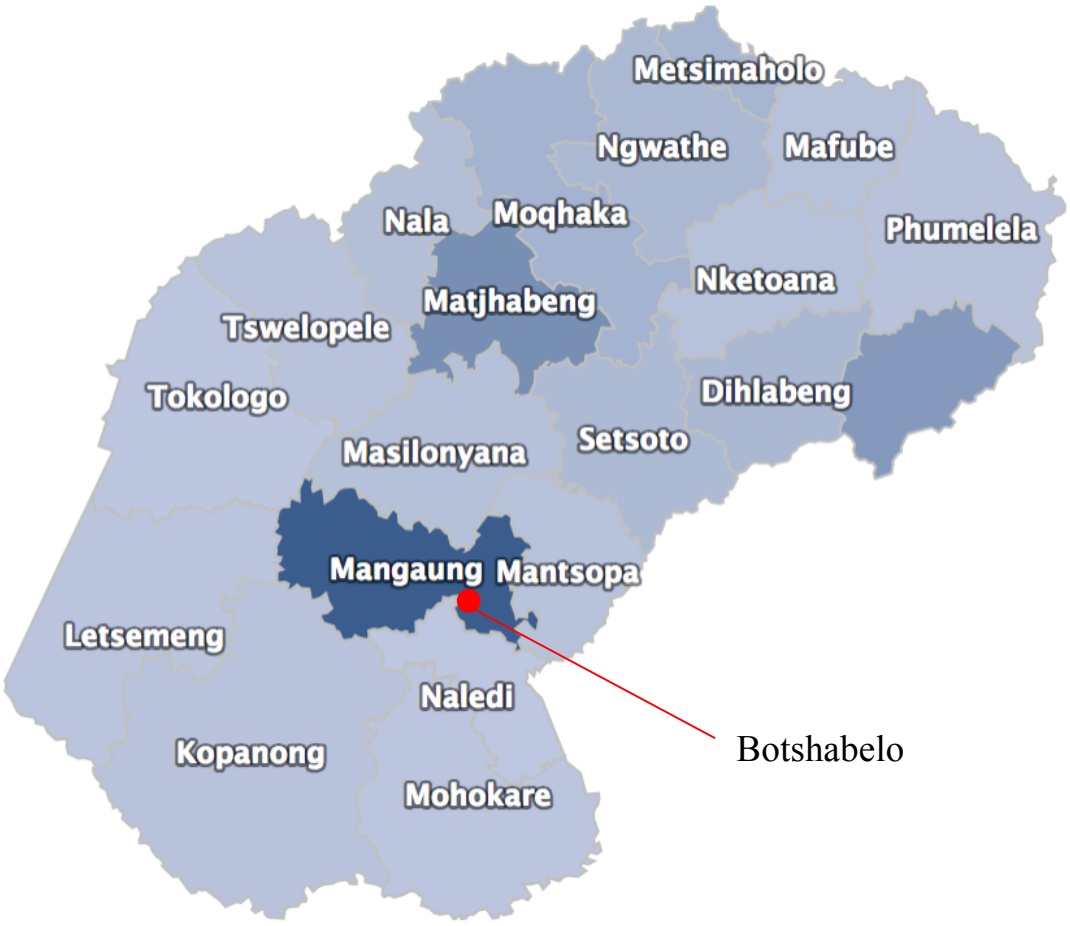

Figure 5. Map of Free State Province districts showing Botshabelo

(Source: Statistics South Africa, 2020)

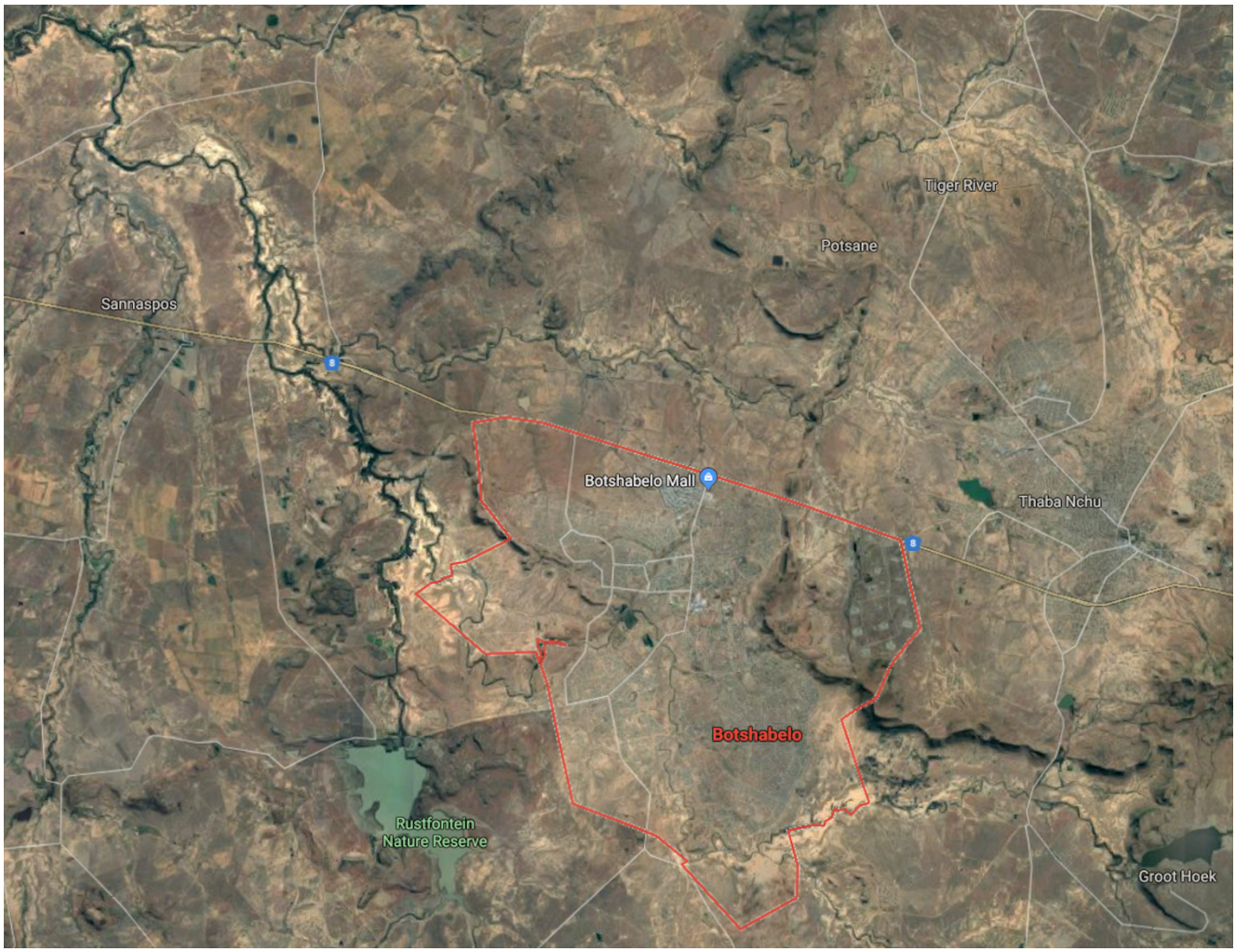

Figure *6. Map of Botshabelo and Thaba Nchu*

(Source: Microsoft Bing Maps, 2020)

After exploring some of the relevant literature, I would like to describe my fieldwork location. In this chapter on **History and context**, I explore how and why Botshabelo came to exist.

Botshabelo was initially established as a small Berlin Mission Society station in the nineteenth century (Murdock, 1959; Poewe et al., 1999; Smith, 1969; Waldmann, 1975:139). Today, Botshabelo is the largest township in the Free State province, and in the Mangaung district (Figures 4, 5). Approximately 181,000 people make up the township's population (Statistics South Africa 2020). Two government strategies were instrumental in shaping this township: forced removals, and industrial decentralisation. I discuss these in section one. The former strategy controlled Black urbanisation. As a result, 'Onverwacht' emerged as a new township. I discuss this in section two. This township would later be renamed 'Botshabelo.' The latter strategy – industrial decentralisation – limited black urbanisation by bringing industry to the edges of homelands. I discuss this in section three. Industries in or close to townships usually provided employment. In the 1980s, however, deindustrialisation and economic downturn changed this. Poverty and unemployment fuelled the spread of HIV and AIDS. I discuss this in section four. After 1994, even the newly-elected African National Congress (ANC) could not stop the tide of poverty, unemployment, and HIV/AIDS. Still, government welfare, housing, and education services tried to offset these challenges. I discuss this in section five.

Section 1. Black urbanisation

Pass laws

The pass laws exemplified legislation that controlled "urban residential segregation," Black labour, and Black urbanisation (Beinart & Dubow, 1995; Christopher, 1988; Christopher, 1990:421; Marks, 1975; Wells, 1983). At the beginning of the twentieth century, there were twice as many Black people compared to White people living in what is now called the Free State province (Wells, 1983:59). This differed from the national average where the ratio of Black to White people was four to one (Wells, 1983:59). Around 1910, the province's largest city, Bloemfontein, faced a labour shortage (Wells, 1983). Black people who ventured into Bloemfontein seeking work required "passes" or "dompasses." These were identity documents that proved a Black person's legitimacy in areas reserved for White people. The stringent pass laws drove Black people away from Bloemfontein. No other province controlled Black movement as strictly (Wells, 1983). Furthermore, around 1913, the Free State restricted trading rights for Black professionals and craftsmen (Wells, 1983). One result of this was that many Black people moved to other provinces to pursue "better prospects" (Wells, 1983:59).

Land acts

Outside the city, in agricultural areas, the Land Acts also influenced Black urbanisation. Resolution 159, ratified in 1855, prohibited Black people from owning land. As a result, most Black people worked on White farms, and 'shared' crops with White landowners (Murray, 1984:39; South African History Online, 2019a; South African History Online, 2019b). Because

of the urgent need for Black labour on White-owned farms, the government issued the Land Act of 1913 (Beinart & Dubow, 1995; Wells, 1983). This legislation outlawed 'share-cropping' contracts between Black people and White farm owners. Many Black people sold their crops at mediocre prices, left White farms, and sought employment in Bloemfontein's urban center (Plaatje, 1921; Suttner, 2012).

Forced removals

In the middle of the twentieth century, the government (under different leadership) began to restrict Black activities more forcefully. The Suppression of Communism Act, and the Group Areas Act were instrumental to this end. The former controlled Black political activity, and outlawed organisations that the government believed to be communist. Members of organisations like the South African Communist Party (SACP) and the African National Congress (ANC) were detained and the organisations banned. However, these organisations continued to exist illegally underground (Suttner, 2012:727). The latter, the Group Areas Act of 1950, controlled Black movement. This act prohibited ethnically- or racially-mixed neighbourhoods around the country. This legislation was intended to encourage each race to develop in their own areas.

Forced removals not only displaced Black people, but also moved Black people away from White city centers. A number of scholars offer compelling accounts of the political tensions, riots, and fierce violence during this time (Baines, 2007; Beinart, 2001; Marschall, 2008; Marschall, 2006; Smith & Alexander, 2013). Mixed-race families, friends, and communities were torn apart in extremely painful ways. Many people were displaced (Murray 1987,

Goldberg 1993, Maharaj 1994). The Surplus People Project – a compelling report compiled by Laurine Platzky and Cherryl Walker in 1983 – highlights that people were not merely resettled or 'removed'. They were "discarded" (Desmond, 1971; Surplus People Project, 1983a; Surplus People Project, 1983b). Many were thrown out of society without property or reason.

Scholars suggest that moving to Group Areas was "more of a carrot than a stick" for some people (Freund, 1984:58). New areas supposedly offered better housing and employment. Most scholars, however, describe this legislation as "morally indefensible" (Maharaj, 1994).

It is worth mentioning that forced removals affected all (non-White) racial groups: Black, Coloured, Indian, and other marginalised people. Yet, Black people were especially "dispossessed and denationalized" (Cobbett & Nakedi, 1987:32). In the Free State, for example, Black people had few basic rights, as well as poor housing, health, and education (Mammako 2018, Nurse Mohlare 2018). Segregation resulted in gross disparities.

Section 2. Onverwacht

In the 1950s, South Africa's homeland policy created Bantustans. This policy forcefully separated races, and deprived Black South Africans of citizenship (Beinart, 2001; Phillips, 2017). Furthermore, these laws gave way to forced removals and resettlements beginning in the 1950s, and scaled up in the 1970s. The Group Areas Act regulated urban residence around the country. In the Free State province, successive versions of the Land Act regulated rural residence. Many Black people were not allowed to live – or work - on White-owned farms. As

levels of agricultural employment began to fall, Black people began seeking employment elsewhere – especially in Bloemfontein (Cobbett & Nakedi, 1987:33). This predominantly White city had limited job opportunities. As a result, many Black people resettled in Thaba Nchu (Figure 6). Because Thaba Nchu's land was held in Trust, this was an attractive area for Black people who were "landless and jobless" (Cobbett & Nakedi, 1987:37, Murray, 1984).

As more and more Black laborers moved to Thaba Nchu - some 40,000 "illegal squatters" – the area emerged as a new home for different Black cultures (Cobbett & Nakedi, 1987:37; Murray, 1987:318). Most of the Black people relocating to Thaba Nchu were Sesotho. Yet current residents were Setswana (Cobbett & Nakedi, 1987:39; Murray, 1984; Murray, 1987). This led to fierce, and awful, conflict between new and existing residents. The government opportunistically used the violence in Thaba Nchu to further illustrate the need for ethnic segregation (Cobbett & Nakedi, 1987:39). Aiming to solve the tensions, the government created Onverwacht in April 1979. This was a new area, opposite Thaba Nchu, where Black (Sesotho) people could resettle.

Onverwacht means "unexpected" in Afrikaans (Cobbett & Nakedi, 1987:40). Yet the Orange Free State Administration Board claimed that they had carefully planned this township or "refugee" site (Cobbett & Nakedi, 1987:40). As the name suggests, the "new slum" surfaced unexpectedly as the government moved unemployed Black labourers out of Thaba Nchu, and away from Bloemfontein (Murray, 1984:33). Scholars have described Onverwacht as a "dumping" or "resettlement" site for Black people (Bradford, 1988; Centre for Development and Enterprise, 1998; Christopher, 1994; Cobbett & Nakedi, 1987:40, Marais et al., 2016;

Platzky & Walker, 1985). Yet people traveling on the main road, which is now the N8 highway, believed that Onverwacht was a community with "tarred roads, street lights, and pleasant houses" (Cobbett & Nakedi, 1987:40). This was the view from the main road. Black people called this view "The Curtain" - it veiled the reality of bucket system sewage, typhoid, overcrowding, and no potable water (Cobbett & Nakedi, 1987:41). Bureaucrats renamed 'Onverwacht' as 'Botshabelo' between 1979 and 1980. *Botshabelo* means "place of refuge" in Sesotho (Cobbett & Nakedi, 1987:41). The area's new name contributed to The Curtain's facade.

From its inception, living conditions in Botshabelo were horrendous. Colin Murray (1984) observed that this township had the "greatest local concentration of poverty and unemployment" in the country (1984:33). Each family who arrived in Botshabelo received one tent and three-days-worth of rations (Cobbett & Nakedi, 1987:40). It was expected that new residents would quickly build more permanent housing. Used tents were passed on to the 50 new families who arrived each day (Cobbett & Nakedi, 1987:40). The way the government treated these residents made it seem as though they were exiled refugees.

As the 1980s continued, many Black people worked in Bloemfontein and lived outside it, in Thaba Nchu. This did not continue for very long. Thaba Nchu leadership soon forced residents to choose between Thaba Nchu and South Africa. A political border separated Thaba Nchu from South Africa. The leaders in Thaba Nchu maintained that residents could not live in Thaba Nchu, yet work in Bloemfontein. The latter required South African citizenship. Many Black people were therefore forced to choose between a "place to live" and a place to work (Murray,

1987; Murray, 1995). Those who chose to live in Thaba Nchu adopted Bophuthatswana citizenship. They were effectively "foreigners in the country of their birth" – South Africa (Murray, 1987:329). Those who chose South African citizenship were forced to leave Thaba Nchu for Onverwacht.

Section 3. Industrial decentralisation

The Land Acts forced Black people to leave farms, and seek work in Bloemfontein. This was meant to alleviate the city's labour shortage at the beginning of the twentieth century. By the end of this century, however, there were too many Black people – and too much Black labour - in Bloemfontein. Black agricultural workers became "superfluous" as White-owned farms downsized. Black people flocked to Bloemfontein seeking employment (Cobbett & Nakedi, 1987:33). This resulted in "surplus labour" and too many unemployed Black people (Cobbett & Nakedi, 1987:34; Pickles & Wood, 1989:516). One attempt to move some Black people away from Bloemfontein was the government's incentivising industrial growth outside the city (Centre for Development and Enterprise, 1998). William Cobbett (1987) called Botshabelo, and other townships like it, "state-subsidised sites for the exploitation of workers, devoid of any meaningful protection" (1987:97). While forced removals pushed Black people into Botshabelo, the government's industrial investments ensured that Black people remained there. These investments began in the 1970s. Around 1982, a number of industries moved out of Bloemfontein's city center, and into Botshabelo. The township became an "industrial center" (Cobbett & Nakedi, 1987:40).

Industrial investment grew rapidly, especially in the textile sector. The government subsidised costs in, and around, the township. They agreed to pay 95 percent of wages: up to ZAR100 per worker per month for seven years (Cobbett & Nakedi, 1987:41, Pickles & Wood, 1989:517, 526). These wages were paid in cash, and not taxed. Companies claimed more from the government than they paid workers (Cobbett, 1987; Cobbett & Nakedi, 1987:41, Pickles & Wood, 1989:524). In 1987, monthly wages were between ZAR50 and ZAR80 in Botshabelo (Pickles & Wood, 1989:519). This was less than the ZAR100 government subsidy. Many companies pocketed the difference, and bulked up their profits. The government also offered incentives to move factories to Botshabelo. This township had "the cheapest electricity rate in the country, housing for 'key' personnel, and tender preferences" (Cobbett & Nakedi, 1987:41). Other subsidies included relocation costs, loans, training, and rail use (Cobbett & Nakedi, 1987:41).

Government incentives that moved industries to "peripheral regions" – like Botshabelo and other Bantustan areas - paralleled disincentives in "metropolitan areas" (Pickles & Wood, 1989:516). In cities like Bloemfontein, the government made land expensive, increased controls on construction, and limited the size of the workforce (Pickles & Wood ,1989:516). The government effectively shunted Black labour away from urban centers (Pickles & Wood, 1989:516). Such "internal restructuring" and "decentralisation" were the trademarks of the 1980s (Pickles & Wood, 1989:516).

Many White-owned companies moved their production to factories in Botshabelo. They could thus prevent unionization, and avoid health and safety mandates (Cobbett & Nakedi, 1987:41).

Moreover, global players – like Israel and Taiwan – took advantage of the low-cost labour available in Botshabelo. They poured money into Botshabelo's factories (Cobbett & Nakedi, 1987:41). Israel sold goods (manufactured in Botshabelo) in Europe. Taiwan fed the United States minerals and metals that were mined in the Free State (Pickles & Woods, 1989:510). Israel and Taiwan diverted goods through Mauritius and Zurich to avoid international sanctions during Apartheid (Cobbett & Nakedi, 1987:42; Crawford & Klotz, 1999; Mangaliso, 1999; Pickles & Woods, 1989). These sanctions intended to starve South Africa's government into democratic submission.

Approximately 50 factories were built in five years (Cobbett & Nakedi, 1987:41). Almost 5,000 Botshabelo residents were employed (Cobbett, 1987:96). Yet they earned deplorable wages, and were subjected to appalling working conditions.

Limited employment opportunities in Bloemfontein, combined with industrial decentralisation, confined many Black people to Botshabelo. This township became a place to "dump" surplus Black labour *and* source it. By the late 1980s, Botshabelo was South Africa's second largest Black township (Murray, 1987:312). The township population approached half a million people (Murray, 1987:312). Most of Botshabelo's industries were textile- and clothing-based. Most of these industries are still operational today, albeit on a lower scale.

Despite the industrial development, unemployment and poverty remained high. By the middle of the 1980s, only about 58,000 people - out of some 500,000 Botshabelo residents - were employed (Cobbett, 1987). That is, almost nine out of ten people were unemployed. Outside of

Botshabelo's factories, it was not easy to find employment. A person needed a "soekwerk stamp" - a permit 'to seek work' - just to look for work in Bloemfontein. These permits were usually difficult to obtain, and did not guarantee employment (Murray, 1987:319). Many Black people travelled to Goldfields – a gold mining company in the Free State – seeking employment. During the 1980s, almost 30,000 men were working in the Virginia and Welkom mines in the Free State (Murray, 1984:47; Murray, 1987:318; Cobbett & Nakedi, 1987:38). A good portion of Botshabelo's families became dislocated. Parents worked and lived away from children who were under the care of older relatives.

Section 4. Life after Apartheid

Poverty and unemployment

Since South Africa's first democratic election in 1994, the ANC has maintained hold of Botshabelo. Election data for Botshabelo has not been published. I therefore reference election data from the Free State province in Table 4 (IEC, 2019a; IEC, 2019b). In the most recent 2019 election, there was an obvious split between the ANC and the Democratic Alliance (DA) in the Free State. ANC support decreased from 80.79% in 1999 to 61.14% in 2019. My fieldwork in Botshabelo overlapped with the 2019 election. I observed that the Economic Freedom Front (EFF) galvanized considerable support. The DA, and the Women Forward party, were also popular. Nonetheless, the ANC won the majority vote in the Mangaung district, in which Botshabelo is the largest township (IEC, 2019b) (Figure 2).

Table 4. Election data for Free State province 1999-2019

Year	Valid votes cast (number)	*Voter turnout (%)	ANC votes (%)	Next most popular party (%)
1999	1 107 851	90.38	80.79	Democratic Party (5.33)
2004	1 027 401	77.76	81.78	Democratic Alliance (8.47)
2009	1 049 066	75.55	71.10	**COPE (11.61)
2014	1 029 297	71.01	69.85	Democratic Alliance (16.23)
2019	897 185	61.35	61.14	Democratic Alliance (17.58)

*Number of valid votes cast out of the total number of people registered to vote in the Free State province.
**COPE - Congress of the People.

While South Africa's political landscape was shifting, unemployment and poverty persisted through the 1990s and into the new millennium (Hart, 2004; Posel, 2004; Whiteford & van Seventer, 1999). This was especially true in townships like Botshabelo. By 1993, half of all Black South Africans were living in poverty (Carter & May, 2001:1987; Ozler, 2007). Deindustrialisation devastated many factories (Fine & Rustomjee, 1996:252; Hart, 2004). Labour markets in the mining sector shrank (Mohammed & Finnoff, 2005; Wilson, 2001). The price of gold and its profitability were unstable. These events coincided – and even slightly preceded – the transition to democracy. It seemed that the world freedom fighters and comrades had envisioned was caving in.

Table 5 shows that, by 1999, almost four in ten individuals were unemployed nationally. As a result, by 2000, more than three in ten individuals (34.4%) were living below the international poverty line: USD2 per day or ZAR174 per month (United Nations Development Programme, 2005).

Table 5. National unemployment in 1995 and 1999

	1995	1999
Narrow unemployment (%)	17	24
Broad unemployment (%)*	29	38

*Broad unemployment rate includes "discouraged workers" (Klasen & Woolard 2000). Source: Hoogeveen & Özler, 2006:60; Klasen & Woolard, 2000.

To offer some reprieve, the ANC offered increasing levels of government welfare including pension, child support, and disability grants. These subsidies increased in both size and coverage (Mokate, 2000:66-67). Still, many people were living below the poverty line (Table 6).

Table 6. Poverty headcount index in South Africa 2000-2006

Year	Percentage*
2000	50.8
2001	51.4
2002	49.0
2003	47.6
2004	46.9
2005	44.5
2006	43.2

*Poverty headcount index describes the percentage of the population living below the poverty line ZAR3000 per year or USD400 per year in the year 2000. Source: Pound Sterling Live, 2020; United Nations Development Programme, 2007.

By 2007, more than two in ten (26.4%) individuals were unemployed in the Free State (Jacobs et al., 2009:13). This agreed with the national unemployment rate (25%) at the time (Jacobs et al., 2009). Table 7 shows unemployment in the Free State in 2007, disaggregated by race

(Jacobs et al., 2009). Less than one in ten White people were unemployed nationally (7.5%) and in the Free State (8%). Contrastingly, more than four in ten Black people were unemployed nationally (44%) and in the Free State (42.5%). These data compare 'total' unemployment statistics for individuals 15-64 years old.

In less than a decade, by 2014, total unemployment in the Free State province had more than tripled: more than seven out of ten people (76%) were unemployed (Free State Department of Health, 2014:12). The unemployment rate in Botshabelo township was at least equal to the provincial rate. Township-specific data were not available. Provincial unemployment exceeded national unemployment. Less than four in ten people (34.6%) were unemployed nationally in the same year (Statistics South Africa, 2014). Table 8 shows national unemployment rates in 2014 and 2019, disaggregated by age (Statistics South Africa, 2014; Statistics South Africa, 2019). Table 9 shows national unemployment rates in 2014 and 2019, disaggregated by gender (Statistics South Africa, 2014; Statistics South Africa, 2019). Disaggregated statistics were not available for the Free State province. The data in Tables 8 and 9 provide some idea of unemployment facing my research group: pregnant teenagers and teenage mothers 15-20 years old. In 2014, almost five out of ten (48.8%) people in the 15-24 age group were unemployed nationally (Statistics South Africa, 2014). In 2019, almost seven out of ten people in this age group were unemployed nationally (Statistics South Africa, 2019). National unemployment was the highest for this age group. Moreover, these statistics show that more young women were unemployed compared to young men. Based on the data in Table 7, more Black individuals were unemployed compared to any other racial group. Not surprisingly, most of the young Black women in my research group were unemployed.

These data suggest that there is both disadvantage and declining opportunity in Botshabelo. Both impact life for pregnant teenagers, teenage mothers, and their families. As a result, there are few things more valuable than a steady income or anything that might lead to this. Today, unemployment remains a major issue in Botshabelo. Those who can secure employment usually have “piece jobs” in the township’s factories, or in Bloemfontein (Ngabaza & Shefer, 2013). Many families cultivate vegetables, and farm cows, sheep, or pigs. Animal pens are maintained on the outskirts of the township. Subsistence farming is an important source of food (Free State Department of Health, 2014; Statistics South Africa, 2003).

Table 7. Unemployment in Free State and South Africa by race in 2007

Racial group	South Africa unemployment rate* (%)	Free State unemployment rate* (%)
White	7.5	8
Indian/Asian	20	Data not available
Coloured	29	26
Black	44	42.5

*These percentages were approximated based on graphical data in the 2007 Labour Force Survey. Statistics South Africa conducts these quarterly surveys (Jacobs et al., 2009:14). This data describes "expanded" – and not "strict" - unemployment rates. Expanded rates describe individuals who are unemployed *and* have stopped looking for work (Altman, 2003).

Table 8. National unemployment rates by age in 2014 and 2019

Age group	Unemployment rate* (%) in 2014	Unemployment rate** (%) in 2019
15-24 years	48.8	69.1
25-34 years	29.6	44.0
35-44 years	19.0	29.5
45-54 years	12.3	24.2
55-64 years	7.10	17.5

*Expanded unemployment rates. Source: Statistics South Africa, 2014:6-7, 13-14.
**Expanded unemployment rates. Source: Statistics South Africa, 2019:41-42, 51.

Table 9. National unemployment rates by gender in 2014 and 2019

Gender*	Unemployment rate** (%) in 2014	Unemployment rate*** (%) in 2019
Men	31.3	34.9
Women	38.4	41.5

*These data refer to men and women in the 'working' population: 15-64 years old.
**Expanded unemployment rates. Source: Statistics South Africa, 2014:6-7, 13-14.
***Expanded unemployment rates. Source: Statistics South Africa, 2019:41-42, 51.

HIV and AIDS

It was against this backdrop of poverty and unemployment that HIV and AIDS exploded in South Africa.[3] Tables 10 and 11 show AIDS-related deaths and HIV prevalence (specific to my research group) in South Africa and globally. Early on, this epidemic impacted the nation's mining industry and exacerbated unemployment challenges (Moodley, 2001; Okyere, 2012; Pelser & Botes, 2005; Pelser & Redelinghuys, 2006,). Many Botshabelo families, who depended on mining jobs, were forced to rely on government welfare.

In 2003, the South African government implemented a national HIV treatment program. HIV medicines took the form of antiretroviral (ARV) drug cocktails and antiretroviral treatments (ART). Table 12 shows this. National treatment came after Doctors Without Borders or *Médecins Sans Frontières* offered ARV regimens in a few community clinics in the Eastern Cape and Western Cape (Levy et al., 2005). Jonny Steinberg (2009) writes about the incredibly complicated social dynamics embedded in this roll-out process, based on his work in the Eastern Cape. Steinberg (2017) suggests that ART was part of a "politics of hopeful expectation". Other scholars observed that ART strategies uncovered corruption. Didier Fassin (2007) suggests that AIDS exposed the ideological structure of South African society - national identity, race, and "conspiracy suspicion".

[3] For further discussion on the rise of HIV and AIDS in South Africa, please see Chigwedere et al., 2008; Farmer et al., 2006; Fassin, 2007; Fassin & Schneider, 2003; Godby, 2004; Grebe, 2011; Hunter, 2010; Karim, 2006; Robins, 2005, Schneider & Fassin, 2002; Wood et al., 2000.

Table 10. AIDS-related deaths among adults and children globally and in South Africa 1990-2018

	Globally	South Africa
1990	290,000	1,300
1995	810,000	20,000
2000	1,400,000	100,000
2005	1,700,000	210,000
2010	1,200,000	140,000
2015	880,000	75,000
2018	770,000	71,000
Source: UNAIDS, 2020.		

Table 11. HIV prevalence among women (15-24 years old) globally and in South Africa 1990-2018

	Globally		South Africa	
	Number	Proportion	Number	Proportion
1990	3 300 000	0.2	43 000	0.6
1995	7 700 000	0.5	590 000	6.4
2000	11 500 000	0.5	1 900 000	15.3
2005	13 200 000	0.5	2 800 000	16.2
2010	15 000 000	0.4	3 600 000	14.6
2015	17 400 000	0.4	4 300 000	12.6
2018	18 800 000	0.4	4 700 000	11.3
Source: UNAIDS, 2020				

This crisis of HIV and AIDS was as political and social as it was biomedical and financial (Farmer, 1994; Farmer, 1997). As medications were rolled out, there was debate about cost and access in South Africa and abroad (Grebe, 2011; Kim & Farmer, 2006; Zwi et al., 2000). In 2000, the first line of medicines cost USD568 per month or ZAR3411 per month in South Africa (Karim, 2006). By 2006, this cost had decreased to USD51 per month or ZAR307 per month (Karim, 2006). As of 2016, South Africa has offered free HIV treatment to any person living with HIV (UNAIDS, 2016c).

Table 12. ART coverage globally and in South Africa 2010-2018

	Globally		South Africa	
	Number	Proportion	Number	Proportion
2010	7 715 000	24	1 393 000	23
2012	11 224 000	34	2 384 000	36
2014	15 073 000	43	3 219 000	46
2016	19 132 000	53	3 929 000	53
2018	23 331 000	62	4 788 000	62

Source: UNAIDS 2020

Section 5. Pregnant teenagers today

One consequence of apartheid policies is that, today, some pregnant teenagers and teenage mothers live far from their relatives in Thaba Nchu or Lesotho. This was because Thaba Nchu leadership forced residents to choose between Thaba Nchu and South Africa in the 1980s. Teenagers told me that they rarely see family members in Lesotho, save for funerals or weddings. I learned that teenagers and family members rarely have the passports required to travel between Botshabelo and Lesotho – another country. Disjointed families decrease the amount of care and support pregnant teenagers receive. Furthermore, after the baby is born, there are fewer family members who can help a teenager with childcare.

Another consequence of apartheid was deindustrialisation in the 1980s and 1990s, and its subsequent economic challenges. This led to mass unemployment in Botshabelo. While township-specific data were not available, provincial data provides some idea of the unemployment challenges (Tables 7, 8, 9). As a result, many families told me that they try very hard to maintain employment, that is, keep their jobs. This seems especially important when a new baby is born. In the **Discussion** chapter, I will reiterate that some family members continue

work while new teenage mothers take care of babies at home. Unfortunately, the opportunity cost of this decision is usually a teenager's education.

Many families send their children to government-funded 'public' schools. One of the ANC's aims, when it was elected in 1994, was improving education access for families who could not afford 'private' schooling (Bray et al., 2010). This remains true in Botshabelo today. All the teenagers in my research group were enrolled in public schools. Their curriculum is taught in English (Panday et al., 2009). As discussed in my literature review, national education policies encourage learners to attend public school during pregnancy. Locally, however, not all Botshabelo schools abide by this legislation. Many teenagers are 'not allowed' to attend school while they are pregnant. Their school principals and teachers enforce this. Yet many teenagers and family members told me that education is the 'key' to a successful future. There is a deep emphasis on finishing high school as a means to secure one's future. I think that this might be because gaining an education is socially considered the best way to escape poverty, as is evident elsewhere (Soudien, 2001). Other scholars have found, however, that education cannot always guarantee employment (Bray et al., 2010).

Largely because of unemployment, many families rely on government welfare including (child support, disability, pension) grants and housing allowances. Government-funded houses are built through the Reconstruction and Development Programme (RDP). This program was part of the ANC's vision for national "transformation" (Donaldson & Marais, 2002; Fitchett, 2001; Moolla et al., 2011). In Botshabelo, families initially live in 'shelters' and may move many

times before settling in an RDP home. Letsoba explains this below. She highlights that housing often comes with uncertainty about price, location, and timing.

> You arrive in Botshabelo, and go to the municipality. You buy a piece of land from them or the home-owner. So, the prices can be different. Land for shelter can be like R50,000. Then you build your shelter. At the same time, you put your name on a register for an RDP house. Then the municipality makes its way down the list and builds RDP homes. (Letsoba, 2019)

Most of the families who live in RDP houses earn less than ZAR3500 per month (Charlton & Kihato, 2006:254; Mphambukeli, 2014:110). Using respective exchange rates, this converts to approximately USD303 per month or GBP195 per month.[4]

HIV and pregnancy

As with education and housing, many Botshabelo families rely on government-funded 'public' healthcare. Usually, each township section has at least one functional primary healthcare clinic (Zakhura, 2018). Nurses told me that most pregnant teenagers and teenage mothers access antenatal, postnatal, and HIV care at these clinics. Abortions are free and legal in clinics before the pregnancy has reached twenty weeks (Panday et al., 2009:24-25). The clinics feed Botshabelo Hospital, which serves the entire township (Torres, 2018). Nurses told me that most, if not all, teenagers deliver their babies at Botshabelo Hospital, a government-funded facility.

[4] Currency conversions were calculated using www.exchange-rates.org.

This is the only hospital in the township. Nurses told me that 'high-risk' or hypertensive teenagers access antenatal care at the hospital too (Sister Sehlare, 2018).

In 2017, the Free State province had the second highest number of teenage pregnancies in the country (Choane, 2017). In the same year, South Africa had one of the highest teenage pregnancy rates in the world. There were approximately 77 live births per 1000 teenagers, 15-20 years old, in South Africa (Statistics South Africa, 2017b). This compares to the birth rate for the same group in a 'developing' country like Ghana: 60 live births per 1000 teenagers (Ghana Statistical Service, 2011; Gyesaw & Ankomah, 2013). This is higher than the birth rate in a 'developed' country like the United States: 22 live births per 1000 teenagers (Hamilton, Martin, & Osterman, 2016).

In addition to teenage pregnancy, the Free State struggles with high rates of HIV. Table 13 compares national and provincial HIV prevalence. In 2002, national HIV prevalence was higher than the provincial prevalence. By 2003, HIV prevalence in the Free State had surpassed the national prevalence. Almost two in ten (17.7%) people were HIV-positive in the Free State. The HIV prevalence in Motheo municipality, which includes Botshabelo township, exceeded this provincial statistic. In Motheo, in 2003, more than three in ten (36.3%) people were HIV-positive (Pelser, 2006). In just four years, by 2007, AIDS incidence increased by more than 60% in the Free State province (Pelser, 2006; South African Institute of Race Relations, 2004). As a result, life expectancy in the Free State dropped from 56 years in 2000 to 39 years in 2010 (South African Institute of Race Relations, 2004:18).

Table 14 shows antenatal HIV prevalence - among pregnant teenagers *and* pregnant adults - in South Africa, the Free State province, and Motheo municipality. This data is not disaggregated by age. In 2000, almost three in ten pregnant women and teenagers were HIV-positive in the Free State (27.9%) and Motheo (29.6%) respectively. Nationally, a few more than two in ten pregnant women (24.5%) were HIV-positive. By 2004, antenatal HIV prevalence increased nationally yet remained consistently high in the Free State and Motheo. Comparing Tables 13 and 14 shows that HIV prevalence is higher among pregnant teenagers and women than in the greater community.

A decade later, in 2014, statistics show antenatal HIV prevalence in the Mangaung district, disaggregated by age. This district includes Botshabelo. More than one in ten (12.9%) pregnant teenagers 15-19 years old had HIV (Free State Department of Health, 2014:16; National Department of Health, 2009). Almost three in ten (28.1%) pregnant women 20-24 years old had HIV. These data show that more than double the number of teenagers were HIV-positive when they reached 20-24 years old compared to when they were younger. Antenatal HIV among teenagers is higher nationally than provincially. Approximately two in ten (20%) pregnant teenagers, 15-19 years old, were HIV-positive nationally (Jewkes et al., 2001).

Table 13. HIV prevalence (%) in South Africa and the Free State province 2002-2014

	South Africa	Free State
2002	14.7	2.9
2003	15.5	17.7
2007	17.7	17.7
2010	18.9	17.1
2014	20.1	12.6

References: Free State Department of Health, 2014; National Planning Commission of South Africa, 2013; Pelser, 2006; South African Institute of Race Relations, 2004; UNAIDS, 2020.

Table 14. Antenatal HIV prevalence (%) in South Africa, the Free State province, and Motheo municipality 1996-2004

	South Africa	Free State	Motheo
1996	14.2	17.5	Data not available
2000	24.5	27.9	29.6
2002	28	26	Data not available
2004	29.5	29.5	27.6

Reference: Free State Department of Health, 2014; Municipal Demarcation Board, 2019; National Department of Health, 2003; National Department of Health, 2005; Pelser, 2006:358; South African Institute of Race Relations, 2004; UNAIDS & WHO, 2003; UNAIDS & WHO, 2004.

Testing and treatment

By 2017, more than 600,000 people had been tested for HIV in the Free State (Free State Department of Health, 2018). One third (33.3%) of these individuals were on treatment. These statistics are lower than HIV testing and treatment nationally, for the same year. There were approximately 7 million people living with HIV in South Africa. Two thirds (65%) of these individuals were on treatment (AVERT, 2020a; AVERT, 2020b; AVERT, 2020c).

High rates of antenatal HIV, and maternal and infant deaths, have influenced interventions to reduce mother-to-child HIV infections in the Free State (Free State Department of Health, 2014:12,51; National Department of Health, 2014; National Department of Health, 2015a; National Department of Health, 2015b). HIV treatment for pregnant women - prevention of mother-to-child transmission or PMTCT - is essential in curbing newborn infections. In 2017, HIV prevalence in newborn infants was reduced to 1.3% in the Free State (Free State Department of Health, 2018:25). This is consistent with national data. In 2018, HIV prevalence in newborn infants was 0.9% nationally (Goga et al., 2018). South Africa's PMTCT coverage is improving each year, and higher than PMTCT coverage globally. Table 15 shows this. In the Free State, however, PMTCT remains a challenge. Less than seven in ten (65.8%) women start antenatal care before twenty weeks (Free State Department of Health, 2018:30). This statistic includes pregnant teenagers and pregnant adults.

Table 15. PMTCT coverage globally and in South Africa 2010-2018

	Globally		South Africa	
	Number	Proportion	Number	Proportion
2010	582 000	44	177 000	65
2012	891 000	66	237 000	82
2014	1 032 000	77	242 000	83
2016	1 070 000	81	251 000	85
2018	1 071 000	82	248 000	87

Source: UNAIDS 2020

Chapter summary

Of all the government strategies that controlled Black urbanisation, forced removals were particularly significant in Botshabelo. Many Black people were forced to resettle in Onverwacht, when they were effectively exiled from their country of birth. A second, equally

significant, government strategy was industrial decentralisation. Heavily subsidised factories in, and around, Botshabelo created a new labour market for thousands of unemployed Black people. These factories also contributed to urbanisation, keeping Black people away from the city of Bloemfontein. In the 1980s and 1990s, the political drama seemed to exacerbate the economic drama. Light industries – especially textiles - were decimated. Employment in mining shrunk. In some ways, the world for which freedom fighters fought began to cave in. In other ways, an old world gave way to a new world of freedom and opportunity despite its many disappointments. This coincided with a political transition to democracy, and a (subsequent) expansion of government welfare. In areas like Botshabelo, deindustrialisation forced many families to rely on welfare payments as a main source of income. This was especially pertinent as HIV/AIDS was introduced against a backdrop of poverty and unemployment.[5] Today, poverty remains an important part of life in Botshabelo. This is perhaps one reason why pregnant teenagers (and their families) depend on each other and government-funded services for education, housing, and healthcare.

[5] A complete discussion of the spread of HIV/AIDS in South Africa is beyond the scope of this study. Mark Hunter (2010) provides a thorough ethnographic exploration of inequality, poverty and unemployment as potential drivers of AIDS in KwaZulu Natal, South Africa. For further discussion please see Chigwedere et al., 2008; Farmer et al., 2006; Fassin, 2007; Fassin & Schneider, 2003; Godby, 2004; Grebe, 2011; Karim, 2006; Robins, 2005, Schneider & Fassin, 2002; Wood et al., 2000.

V. Discovering and disclosing teenage pregnancy

The first four chapters of this dissertation have described how, why, and where I carried out this research. These chapters set the stage for the empirical findings laid out in the rest of this dissertation. As discussed in the chapter on **Theory and methodology,** I have organised my empirical findings into three temporal groups: beginning of pregnancy, during pregnancy, and after pregnancy. This organisation showed me how themes – experiences and events in the data - were changing. What seemed important at the 'beginning' of pregnancy, was less central 'during' pregnancy. I began to see the way teenage pregnancy evolved over the course of nine months, and as motherhood began. To this end, the four subsequent empirical chapters are arranged chronologically as teenagers move from teenage pregnancy into teenage motherhood. There are many complicated, nuanced emotions involved in these experiences. I highlight a few salient ones in the following empirical chapters.

I begin with this chapter on **Discovering and disclosing teenage pregnancy**. Herein, I describe how teenage teenagers discover - and then tell other people about or disclose - their pregnancies. Pregnancy alters the body in a physical way. It is no wonder that many pregnant teenagers are worried about being visible in this social world. Most teenagers do not want others to know that they are pregnant. I argue that pregnancy is a mark of shame largely because teenagers are unmarried. Marriage, in the broadest sense, is a form of protection. Pregnant teenagers who are married experience less shame than their unmarried peers. Yet the latter comprise the majority. Concealing pregnancy - in an effort to conceal shame - becomes a priority. I argue that being less visible can curb the shame linked to teenage pregnancy. As an extreme response, some teenagers strive to be as invisible as possible. This is why many pregnant teenagers 'hide' in

their homes. Teenagers want to avoid shame, gossip, and jealous[6] witches. Moreover, teenagers hide to obey their mothers' pregnancy-related precautions.

In the first half of this chapter I explore what happens when teenagers find out they are pregnant. In section one, I describe pregnancy tests, and HIV tests. After teenagers discover pregnancies, most teenagers choose someone in whom they can confide this news. Trusted confidants are usually mothers or partners (section two). These confidants can offer teenagers much-needed support. I argue that disclosing these challenges to a trusted confidant is a way to share the burden of teenage pregnancy. Some teenagers demonstrate impressive agency based on how they confide their news. To guard against gossip, some teenagers falsify their identities in crowded clinics. This makes teenagers less visible. I explore this in section three. Most teenagers do not tell their confidants, or families, about HIV. Unlike pregnancy, HIV is less visible, hidden in the blood. I explore this in section four. I argue that teenage pregnancy – like HIV and AIDS - can unveil sexual activity.

In the latter half of this chapter, I explore how teenagers - and their mothers – make meaning of teenage pregnancy. Most teenagers heed their mothers' pregnancy-related precautions (section five) and avoid witches (section six). I argue that these are both means to the same end: keeping teenage daughters at home, and out of the public eye. I suggest that keeping a pregnant teenager hidden in the house protects her. Yet a teenager's hiding also curbs her mother's shame. There is some tension here. I explore this in section seven. As mentioned above, I argue that teenage pregnancy is shameful and scandalous (largely) because teenagers are unmarried.

[6] I explore envy and witches later on, in my **Discussion** chapter.

I argue that being married is an important - if not required - precursor to having a baby. There is tension here too: the very people who require marriage before pregnancy were not married when they first had children. I discuss this in section eight. Interestingly, some pregnant teenagers manage to recast their challenges – being unmarried, being a pregnant teenager - as possibilities. I explore this in section nine.

Section 1. Testing for pregnancy and HIV

In Botshabelo, pregnancy and HIV tests are usually done within thirty minutes of each other. South Africa's Department of Health mandates HIV tests alongside pregnancy tests (National Department of Health, 2015a:20). The nurses in my various fieldsite clinics confirmed this practice (Sister Leloba, 2018; Sister Sehlare, 2018). This means that teenagers – who are already anxious after receiving a positive pregnancy test – usually learn that they have HIV on the same day. Their shock is twofold. Teenagers handle this shock in different ways. Maipato and Baby-Boo explain this.

Maipato lives with her mother and step-father in Robedi section. Financially, the family is far from comfortable. They rely on government welfare and free healthcare at Robedi clinic. Maipato's mother works in Bloemfontein. She does not know the nurses at Robedi clinic. This is perhaps why Maipato opted to do her pregnancy test at this clinic. Maipato confesses that she discovered her pregnancy and HIV on the same day. She suggests that one of her initial reactions was anger. She says that her boyfriend infected her with HIV. This was an act of

betrayal. Maipato suspected that her boyfriend had contracted HIV from another girlfriend. Maipato vowed she would never see her boyfriend again.

> They also did the other tests for STDs and blood pressure and I saw I was (HIV) positive. … it was my boyfriend. He infected me. … I never want to see him again. I am still angry. He hurt me. He lost my trust. (Maipato, 2019)

Like Maipato, Baby-Boo was upset when she discovered her HIV positive status. Baby-Boo lives with her now-husband in Tshelela section. She knew she was pregnant before doing a test at the clinic. She is close to her mother, and older sister. They suspected her pregnancy.[7] Baby-Boo was excited to tell her husband about the pregnancy and he in turn was excited about their new baby. Yet, she says, he was also worried. He later told her that he was HIV-positive.

> I told my husband I was pregnant. I didn't need the pregnancy test (at the clinic). Then he told me, wow, he told me he had it - HIV. I was so scared. I thought it was a death sentence. And he never told me before this! I was very angry. I was crying, and crying and crying. He was also crying. … He said he was born with it. So how can I be angry? It wasn't his fault. So, I must forgive him. He wanted to tell me because it must not hurt the baby. He doesn't want our child to be infected. … I went to the clinic. They told me I was infected. Then I learned about HIV. My husband said it is not death. He said, 'Look at me. I am on my

[7] See work by Fiona Ross (2010:175-182) for further discussion on older women assessing "tell-tale" signs of pregnancy in younger women and pregnant women perceiving HIV as a death sentence.

> treatment and I am living a good life. We can do it.' He helps me a lot. He reminds me about my medication. He supports me a lot. (Baby-Boo, 2019)

Baby-Boo said that she felt "very angry" when her husband told her about his HIV status. She said that she felt "betrayed" because he did not disclose his HIV status before she married him (Baby-Boo, 2019). She said that he should have volunteered this information earlier. With time, however, she said that she forgave her husband because "he was born" with HIV. The fact that he had contracted HIV perinatally – and not sexually - meant that having HIV "was not his fault" (Baby-Boo, 2019). Her mother and sister did not blame her for her HIV because her husband was "infected at birth" (Baby-Boo, 2019). There seemed to be less shame linked to his HIV-positive status and (by association) her HIV status.

Section 2. Disclosing pregnancy

Many teenagers told me that they fear what others will say when they discover teenagers' pregnancies. This was the case for Bohlale. She says that a "gangster-truck-driver" infected her with HIV when she was in high school. Bohlale lives with her mother and younger brother in Robedi section. The neighbours on their street know each other well. Moreover, the nurses at Robedi clinic know Bohlale's mother. Bohlale says this is why people talk about her pregnancy and her HIV. Her pregnancy, and her HIV, provide enough gossip for her neighbourhood. In her anecdote below, Bohlale says that her mother is "in the church." As a pastor in the church, Bohlale's mother is a beacon in the community, someone who teaches right from wrong. Her mother's social position exacerbates the moral opprobrium associated with Bohlale's teenage

pregnancy. Bohlale should know better largely because she has heard her mother preach in the church and at home. In her anecdote, Bohlale iterates that the reality of her teenage pregnancy is a difficult pill to swallow in the shadow of her mother's rectitude.

> … It is hard sometimes. My mother is in the church. People talk. I don't like that. There must be a bravery. This is why I teach my brother. I tell him things. (Bohlale, 2019)

Most teenagers know all too well what community members say about pregnant teenagers. I argue that this is because teenagers would contribute to this gossip, before they themselves became pregnant. Kananelo explains this. Kananelo lives with her grandparents. Gossiping is one way she bonded with her grandfather. This bonding was important because Kananelo is an orphan. The pair would talk about pregnant teenagers in the neighbourhood. When Kananelo became pregnant, their daily gossiping rituals ceased. Kananelo did not want anyone to gossip about her, or her grandfather.

> Before I got pregnant, my grandfather and I would stand there, outside, at the gate. We would talk about all the people who were walking. I love my grandfather. He supports me, even now. But after I got pregnant, I didn't go outside. I knew what people would say. … They will say I am too young, and I am not married. They say why must a child have a child. My grandparents are in the church. It will embarrass them. (Kananelo, 2019)

Kananelo describes the way gossip attaches to pregnant teenagers if they are seen in public. This gossip is part of the punishing discourse linked to teenage pregnancy. Yet this gossip is also part of a process of repairing familial conviviality. In order to repent for the mistake that is teenage pregnancy, teenagers like Kananelo must remain in the house. This is repentance because this act prevents family members (like Kananelo's grandfather) from becoming the subject of community gossip.

In this context of gossip and social scrutiny, it is understandable that pregnant teenagers might seek support. I argue that disclosing these challenges to a trusted confidant is a way to share these burdens. Seipati explains this.

> I used to clean the house, and cook, and wash the clothes. I live with my mother, and my grandmother, and her (Seipati's mother's) grandmother. But, with the pregnancy, I cannot do those things. I can't clean. I can't cook. I can't wash. My mother must help me. … She talks to me, and she supports me. … I talk to my mother about my future. I want to be a soldier. She listens to me. … I love my mother so much. She is my hero. She understands my situation. (Seipati, 2019)

Seipati lives in a one-bedroom RDP home in Hlano section, a matriarchal household. Seipati tells me that she loves her mother dearly. The teenager calls her mother her "hero" (Seipati, 2019). Seipati's decision to tell her mother about her pregnancy was as necessary as it was rewarding. During her pregnancy, Seipati needed help with her domestic chores. Pregnancy limited which household chores she could, and could not, do. Additionally, Seipati needed

emotional support. Fortunately, she could lean on her mother. She talks to her mother about the joys and challenges of pregnancy, and her plans for the future.

In many cases, when teenagers disclose pregnancy, families do not receive this news well. Largely because of this, some teenagers worry about their families' reactions. Baby-Boo emphasises this: "*Kele ke tsooweele*" (2019). This means 'I was scared' in Sesotho. She feared her family's wrath and disappointment. When teenagers talked to me about their families' reactions, I found that they used powerful words: *scared, mistake, blame, shame, disappointment*. I feel that these words emphasised the toxic emotions some teenagers internalised. Furthermore, these words indicate what some teenagers think – or are told to think - about their pregnancies. If teenagers do not already feel ashamed, they are told that they carry shame, not a baby. If teenagers do not already feel guilt, they are told that they are to blame for the mistake that is teenage pregnancy. If teenagers do not already feel indecent, they are reminded of this.

The ways families first react to teenage pregnancy has been explored in other South African communities. A number of scholars suggest that families initially rebuff pregnant teenagers, and then gradually accept and support them (Chohan & Langa, 2011; Mkhwanazi, 2010; Mkhwanazi, 2014b; Morrell et al., 2012; Ngabaza 2011; Nkani, 2012; Preston-Whyte et al., 1990; Preston-Whyte, 1993:64; Varga 1998:109). This is not unique to South Africa. Some of the international literature emphasises similar familial reactions (Benson, 1996; Bunting & McAuley, 2004; Clemmens, 2003; Deans Lake, 1999; DeVito, 2010:32; Garret & Tidwell,

1999; Gyesaw & Ankomah, 2013; Mercedes, 1990; Mykietka, 1998; Ngum Chi Watts et al., 2015; Ray, 1997).

Despite their anxieties and worries, I observed that some teenagers still choose to tell their families about being pregnant. Metsi says that families "deserve" to know. Moreover, Metsi suggests that pregnant teenagers need help and support. Metsi is a community health worker, and counsellor, at Robong clinic. Metsi discovered her pregnancy during her first year at university. Here, she discusses what pregnant teenagers (including herself) consider before disclosing pregnancy.

> Those teenagers are thinking a lot. I see it, and I worry. Has she told them or not? Is she still scared? I'm telling you it might take a while to tell the families. Because she's thinking over and over - should I tell them? … but she must say something. They deserve to know. And she needs all the help she can get. Pregnancy is hard! … She is thinking, 'How am I going to be able to take care of this child?' (Metsi, 2018)

After discovering her pregnancy, Metsi chose to tell her mother. Most teenagers choose their first confidants very carefully. Some teenagers disclose pregnancies to older sisters or cousins. Other teenagers tell boyfriends or husbands. Most teenagers, however, tell their mothers. When Metsi told her mother, Metsi did not talk about her pregnancy directly. She used documents – cellphone texts and a clinic file - to avoid confrontation. Metsi texted her mother: "I am pregnant." Her mother did not respond to the cellphone text. Metsi told me that the family

dynamic seemed undisturbed, especially around mealtimes. This response tormented Metsi. So, five days later, she tried to tell her mother again. Metsi purposefully left her antenatal clinic file on the kitchen table. She wanted her mother to see proof of her pregnancy. After several days, her mother finally acknowledged the news. Her mother said she would support the pregnancy, and the new baby.

Like Metsi, Botho told her mother about her pregnancy indirectly. She lives with her mother in Robedi section. She was particularly worried about her mother's reaction. Instead of telling her mother that she was pregnant, Botho hinted at her pregnancy in the most obvious way she could. She let her mother see her morning sickness.

> I felt ashamed and scared to tell my family. I thought, 'How the hell am I going to tell my mother?' She would not forgive me. So, I didn't tell her. Well I did. … What I did is that I showed her. In the morning, I left the toilet door open. Then my mother could see my morning sickness. After some days, my mother came to me. She said I must do a pregnancy test at the clinic. (Botho, 2019)

Both Botho and Metsi used creative ways to disclose their pregnancies. This is consistent with Sisa Ngabaza's (2011) work in Khayelitsha where pregnant teenagers use "strategic ways" to disclose pregnancy. This highlights their "agency and thoughtfulness…even within the framework of a challenging situation" (Ngabaza, 2011:50). These methods of disclosure also suggest household practices of deference, discretion and euphemism. Moreover, in the

forthcoming chapters, I will argue that this kind of disclosure echoes teenagers' practice of hiding and a need to repair familial relationships.

Section 3. Secrecy

Apart from their families, most teenagers do not want anyone else to know about their pregnancies. I suggest that this is one reason why some teenagers keep their identities secret at the clinic. Mammako explains this. She was a pregnant teenager in the 1990s. Now, she is an HIV counselor at Hlano clinic. In the excerpt below, she is talking about pregnant teenagers. Mammako suggests that, by falsifying their personal details at the clinic, some pregnant teenagers manage to keep their real identities secret. As a result, most nurses do not know teenagers' real names, how to contact them, or where to find them. In some ways, this kind of secrecy helps teenagers be less visible – perhaps even a little invisible - in a public clinic.

> They change their names. They change and falsify their houses (home addresses). They say they have no phones. They go to different clinics all the time and pretend about who they are. … A girl might be (HIV) positive at Hlano clinic. Then she goes to Leshome clinic and says she is (HIV) negative. She says she knows nothing about HIV. (Mammako, 2019)

During fieldwork, I experienced first-hand the 'secrecy' Mammako describes here. One teenager enrolled in this research at two different clinics with different cellphone numbers and home addresses. Yet she used the same name. The secrecy and invisibility in the clinic sphere

intrigue me. Some scholars have explored the opposite - namely visibility. Beth Vale (2015) worked with a group of young HIV-positive people in the Eastern Cape. She explored the "ART surveillance system" (2015). This surveillance describes the way blood tests reveal whether a person has adhered to HIV treatments, or not:

> …the scheduled blood test served as a constant reminder that ART users were being watched and that their indiscretions would soon be unmasked. (Vale, 2015:283-284)

Vale observed that surveillance is usually linked to blood tests. These tests render HIV - and ARV adherence - visible. Among pregnant teenagers in Botshabelo, surveillance is linked to antenatal care. This medical routine renders pregnant teenagers visible, throughout the pregnancy period. It is while attending antenatal care appointments that most pregnant teenagers are monitored by community members. In theory, antenatal care makes a teenager more visible. Yet, in practice, some teenagers have found ways to become invisible and retain access to antenatal care. Teenagers travel between different clinics, carry different clinic files, and keep their identities secret. Secrecy is an extreme response to discovering pregnancy. I argue that this is how some pregnant teenagers evade and interrupt surveillance in Botshabelo.

Section 4. Hiding HIV

Although most teenagers discover HIV and pregnancy on the same day, few teenagers disclose HIV to their family members. This was the case for Lerato. She lives with her grandfather in

Hlano section. Her mother lives and works in Bloemfontein. Lerato told me that she did not want anyone to know about her HIV. She diligently took her ARVs to control and hide her HIV. When her sister threatened to expose her HIV status, Lerato told me that she was terrified.

> I wanted to tell my mother, and my grandfather about the pregnancy. My sister knew about it. She stole my clinic file, and she saw it in there. She knows about the baby. In that file, she also saw my HIV status, ja. … my sister doesn't like me. It's because my grandfather likes me. I am his favourite. So, when we were fighting, she wanted to tell everyone my (HIV) status. She was going to shout in the street. It was too scary for me. Nobody knows in my family. I take the treatment every day. I always take my medicine. (Lerato, 2019)

Like Lerato, other teenagers also conceal HIV from their families. Mahlony lives with her now fiancé in Tshelela section. Her mother lives in the house directly behind hers. Her elder sister lives nearby. This is a tight-knit family that seems to support each other. When Mahlony discovered her HIV status and pregnancy she was in high school. She says that she knew her pregnancy disappointed her family. She did not want to disappoint them further. She says that did not want to hurt them. Not telling them about her HIV was her way of protecting them. Like Mahlony, Maipato and Bohlale also concealed their HIV. Maipato contracted HIV from her ex-boyfriend, as discussed earlier. Talking about her HIV status would mean telling her mother about her boyfriend's infidelity. She was trying to avoid this. Bohlale did not want to disclose her HIV status because doing so would expose her sexual activity.

> It was very sad. … I thought HIV was a death sentence. … I didn't know how to tell my family. I love them too much. (Mahlony, 2019)

> My mother doesn't know about my (HIV) status. My boyfriend gave it to me. … We broke up. He lied to me. He really hurt me. (Maipato, 2019)

> I was too embarrassed. They will know that I had a boyfriend. (Bohlale, 2019)

These narratives are consistent with some of the literature in South Africa (Hardon & Posel, 2012:S4; Ngabaza, 2011:48; Ngabaza & Shefer, 2013). Furthermore, Bohlale's narrative echoes some of Jonny Steinberg's (2008a) work on HIV/AIDS and relationships in the Eastern Cape (Steinberg, 2008a:43; Steinberg, 2008b). Steinberg suggests that sex is not in and of itself problematic. Instead, the problem is that people *know* that people are having sex when HIV is transmitted. He suggests that HIV/AIDS overtly flags what should be covert and intimate. This "unveiling" fuels sexual shame: AIDS "both unmasks and enflames a sense of disgrace" (2008:43-44). Steinberg's work builds on previous scholarship on the subject (Posel, 2003; Posel, 2005).

I argue that teenage pregnancy – like HIV and AIDS - can unveil sexual activity. I am especially cautious here. I do not mean to imply that teenage pregnancy, HIV, and AIDS are comparable experiences. Instead, I believe that there is something similar about the way these experiences expose intimacy. Both HIV and teenage pregnancy publicly expose something that young people do in a private moment (Steinberg, 2013:505). Both alert a teenager's family to the

reality that their teenage daughter is sexually active. Yet HIV can be concealed more easily than pregnancy. I argue that this is why some teenagers disclose teenage pregnancy, and not HIV. Pregnancy is disclosed out of necessity, it seems, because pregnancy is more visible than HIV. Vero describes this. On one occasion, we were talking in Leshome clinic. I asked her about HIV in her community. Although Vero is HIV-negative, I include her response here because I think she provides an interesting perspective on HIV.

> If I must choose? Uh, I don't have HIV, and there is still stigma for those people. … I would rather have HIV than sugar (Type 2 diabetes). Because with sugar, you can lose your leg. (Vero, 2018)

Vero's choice comes down to visibility. That is, diabetes and its complications are more visible – harder to hide - than HIV. Type 2 diabetes is a major health challenge in South Africa. Approximately one in ten South Africans has this chronic disease (Bertram et al., 2013). Poorly-managed diabetes can lead to amputations. Leg amputations are the most common (Bertram et al., 2013; Oloyede, 2017). Diabetes alters the body in an extremely visible way. Vero suggests that HIV is less visible – and easier to hide - than diabetes. This is consistent with some of the South African literature. ARVs can "mask" or hide HIV in the blood (Vale, 2015:72). HIV can be made relatively "invisible" (Steinberg 2008a:16; Bray et al., 2010:285).

Other scholarship suggests that the difference between diabetes and HIV is about severity, more than visibility. Emily Mendenhall and Shane Norris (2015) explored experiences with Type 2 diabetes and HIV/AIDS as described by a small group of women in Soweto. Some of these

women noted that HIV/AIDS is more "easily manageable" (Mendenhall & Norris, 2015:457) compared to diabetes, because diabetes requires a strict diet and its medications cannot always prevent clinical symptoms. This is perhaps why some of these women consider diabetes to be as severe as, or more severe than, HIV/AIDS (Mendenhall & Norris, 2015:459).

Vero's comment - that HIV is easier to hide than diabetes – suggests that having HIV is better than having diabetes because diabetes has more severe consequences. This contrasts what Mendenhall and Norris found in Soweto, that is, having HIV is better than having diabetes because diabetes is more difficult to manage. Vero implies that the consequences linked to diabetes (limb amputations) are supposedly more severe because these consequences are more physically visible.

It is also true that diabetes can be invisible, and HIV can alter the body in a physical way. The latter is evident when it comes to Bohlale's experience with HIV, which I will describe in the forthcoming chapters. Usually, however, diabetes cannot be managed well in low-income and/or impoverished households in Botshabelo. These households necessarily depend on a carbohydrate-heavy (and thus sugar-heavy) diet. Yet HIV treatments are more easily accessible for any HIV-positive person given South Africa's national ARV rollout program (UNAIDS, 2016c). It is more likely that poorly-managed diabetes will become physically obvious while HIV remains hidden.

Furthermore, I argue that some teenagers do not disclose HIV because it is more urgent to disclose pregnancy. Rachel Bray and colleagues (2010) explored this with young learners in

the Western Cape. The scholars observed that some teenagers disclose pregnancy - and not HIV - because pregnancy is a more urgent threat. I think there is some tension here. On one hand, teenage pregnancy compromises "social integrity" (Bray et al., 2010:285-286). A teenager's reputation and relationship networks are affected. On the other hand, HIV compromises "physical integrity" (Bray et al., 2010:285-286). This disease has the potential to cripple a teenager's health and capability, as was the case for Bohlale despite her adherence to strict ARV regimens. I explore this in later chapters. For most individuals, HIV is easier to hide with ARVs. Yet teenage pregnancy grows more obvious each day. This is why, for some teenagers, "HIV is not a big issue" (Bray et al., 2010:285).

> The more immediate threat to social integrity that pregnancy poses appears to outweigh the more long-term threat of HIV/AIDS to physical integrity.…The 'problem' is about *hiding* from others one's sexual 'transgression'…rather than the physical implications of this 'transgression.' (Bray et al., 2010:285-286, emphasis in original)

I think it is important to note that teenage pregnancy and HIV affect both social and physical integrity. It is not true that HIV has no bearing on social integrity. What I found, however, is that teenage pregnancy has a greater bearing on social integrity (a teenager's social position). It is teenage pregnancy, and rarely if ever HIV, that warrants scolding, punishment and admonishing in her community.

I argue that the discourse on visibility and the discourse on urgency are closely linked. Something that is less visible is perceived to be less urgent. One example of this might be HIV. On the other hand, something that is more visible seems more urgent. Examples of this might be diabetes or teenage pregnancy. I do not mean that diabetes and teenage pregnancy are similar experiences. Instead, I mean that both diabetes and teenage pregnancy can visibly alter the body in a physical way. In Botshabelo, pregnancy will soon reveal itself, even if a pregnant teenager chooses not to disclose it. Contrastingly, HIV can remain hidden with routine ARV treatment. Pregnancy is a secret that everyone will discover; if not when they see a teenager, then when they see her baby.

I find it interesting that many teenagers continue to keep HIV secret even after their sexual transgression (teenage pregnancy) has come to light. As suggested in the anecdotes above, this secrecy might serve to protect teenagers' families from further hurt, and further disappointment. Additionally, in the forthcoming chapters, I will argue that teenagers try to keep HIV secret because of an additional stigma linked to HIV, that is, the stigma linked to HIV-positive motherhood. HIV-positive mothers are socially considered 'sick' mothers who are incapable of the physical demands of childcare. Moreover, HIV is associated with death. This has roots in the "duality of motherhood" as presented by Margarete Sandelowski and Julie Barroso (2003a:475). Scholars have found that these mothers are perceived to be 'not good' mothers (Ingram & Hutchinson, 1999a, 1999b, 2000). I will argue that many teenagers keep HIV hidden in an effort to avoid further punishment and scolding.

Section 5. Pregnancy-related precautions

As teenagers begin to make meaning of teenage pregnancy, some can rely on their confidants - their mothers. This is not the case for all teenagers (Bray et al., 2010, Mkhwanazi, 2012; Mkhwanazi 2014a). The mothers who do offer support usually encourage their daughters to follow certain 'pregnancy-related precautions.' Mothers tell their daughters that taking these precautions will prevent pain and complications during pregnancy and birth. That is, these precautions protect both teenager and baby. Seipati explains a few precautions here. She says that if a pregnant teenager braids her hair, then her delivery will be "painful". If she waits in a doorway, then "her baby will wait" in the birth canal. If she spends time staring out of any windows, then her baby "will stare out of the womb" without coming out. If she uses a knife to cut vegetables during her pregnancy, then her vagina will be "cut" during delivery. In other words, she will have a Cesarean – not a natural – delivery.

> A pregnant teenager must leave her hair loose (precaution 1). She must not loiter in a doorway (precaution 2). A pregnant teenager must not stare out of a window (precaution 3). And she must not use a knife (precaution 4). …My mother taught me these things. Now, I am teaching you. I listen to these things sometimes, but not always. I don't believe in them. But I don't want bad things to happen. I want to protect my baby. (Seipati, 2019)

At first glance, these pregnancy-related precautions are directly linked to a teenager's pain during her delivery (birthing) experience. The penalty for disregarding these precautions is a longer, more complicated, or more painful delivery. Looking closer, however, I argue that these

precautions serve another purpose. When a pregnant teenager follows these precautions, she remains 'hidden' in her home.

If a teenager leaves her hair loose – or does not braid her hair - then she will not need to visit a hairdresser (precaution 1). Hairdressers are usually neighbors with make-shift (informal) hair salons attached to their houses. Like the first precaution, the second precaution – avoid standing in doorways - aims to keep teenagers away from curious neighbors. When pregnant teenagers stand in doorways, passers-by can see their growing bellies (precaution 2). Curious neighbors may even quiz teenagers. This can fuel community gossip. Similarly, a teenager keeps away from prying eyes when she avoids windows (precaution 3). This is especially pertinent in Botshabelo. RDP houses and 'shacks' sit close to each other. Most neighbors can easily see into someone's home through a window or doorway. Finally, in the fourth precaution, being 'cut' refers to having a Cesarean procedure. Most pregnant teenagers expect to have natural births. Cesarean sections are greatly feared, because they are rumored to be "extremely painful" as Seipati says. Furthermore, some teenagers told me that cutting a baby out of the womb can risk the baby's health.

> There is a lot of bleeding when they cut you. It hurts, yoh! I am scared of it! And it is dangerous. I am scared of that. And I don't know what it will do for my baby. I will bleed, so I will be weak. What about my baby? (Seipati, 2019)

Seipati feared that a Cesarean delivery would weaken her. She would not be able to take care of her new baby. When the time came, Seipati needed to have a Cesarean delivery because she

was hypertensive. Her high blood pressure made a natural delivery more risky. Thankfully, she did not have any complications, or unnecessary bleeding. Other scholars have explored Cesarean deliveries among teenagers in South Africa, Brazil, Mozambique, and Turkey (Bacci et al., 1993; Hoque et al., 2008; Mphatswe et al., 2016; Santos et al., 2014; Zeteroglu et al., 2005). This literature suggests that Cesarean procedures do not significantly harm teenagers or their babies.

Section 6. Avoiding witches

Beyond these precautions, some mothers encourage their daughters to stay at home because of 'witches' in the neighbourhood. Witches, teenagers told me, are unknown community members who will intentionally harm a pregnant teenager or her unborn baby. I learned that most pregnant teenagers remain out of sight so that witches cannot hurt them. Metsi explains this below. Like most other teenagers, Metsi stayed at home unless she was attending antenatal appointments at the clinic.

> …we don't walk around (during pregnancy) with the (unborn) baby. Because the witches might curse the baby. We only leave the house for the clinic, or for an emergency, or if we really have to leave the house. … the witches can see the size of your tummy and then they will know when the baby is coming. They will stop the baby or hurt the baby. … One girl I know, her baby came too early. Another girl, her baby was stillborn. (Metsi, 2018)

Even though few (if any) pregnant teenagers have seen witches in action, most teenagers seem deeply afraid of them. In this case, seeing is not necessarily believing. Ironically, just like the pregnant teenagers on which they prey, witches themselves 'hide' in this social world. I argue that witches' actions live in the scary stories circulating in the clinic or at the kitchen table. Kananelo and Lerato explain this below.

Kananelo lives with her grandparents in Hlano section. Both her parents have passed away. She describes herself as "someone who loves fun" and socializing. Yet, during her pregnancy, she did not invite any friends or visitors to the house. This was partly because she was trying to avoid anyone who might be a witch in the community. Her grandmother warned her about "jealous witches" in the community (Kananelo, 2019).[8] Moreover, Kananelo did not want her friends to see her pregnant. She seemed shy, and embarrassed when she admitted this to me.

> …my friends they miss me. We used to like parties. We had a lot of fun. Some of them came to visit me at the start, during my pregnancy. But when the baby came, they don't come. I don't want them to come. They must not see me like this. … I mean, they have too much (studying) work. They are all in matric (Grade 12) this year. … I don't know who are the witches, so I don't want to see anyone. (Kananelo, 2019)

Like Kananelo, Lerato fears witches. She lives with her grandfather in Hlano section. Her mother lives and works in Bloemfontein. Despite living away from her daughter, Lerato's

[8] I revisit ideas around envy and witchcraft later on, in my **Discussion** chapter. Isak Niehaus (2002, 2012) provides important theoretical work on these topics in the South African context.

mother managed to restrict her daughter's movements during pregnancy. Lerato's mother taught her about witches. It was clear that the teenager greatly values her mother's advice. Moreover, Lerato has heard witch stories from her neighbour.

> I have never seen a witch. My family has never seen one. But my mother told me what happened to the neighbour's house. They saw a witch throwing herbs on the roof of another house. Then, the child in that house got sick. His leg was very painful. … my family says I must stay at home. If the witches see me, then they will hurt me too. Just because I cannot see it, it can still be there. … My mother says I am safe in the house. … My mother told me about witches. They are not good. … witches don't want you to have good things. Like education. They don't want you to do well, and provide for your families. … This is why I must stop school. My mother says the witches will see the pregnancy. (Lerato, 2019)

Moreover, Lerato confessed that she did not attend school during her pregnancy. She feared that witches would see and harm her. Her mother taught her this. Witches would hurt Lerato if she tried to get something "good" for herself, like an education.

Section 7. A mother's shame

Most pregnant teenagers learn about pregnancy-related precautions and witches from their mothers. Both precautions and witches evoke, and exploit fear. I argue that both are means to

the same end: keeping daughters at home, out of the public eye. In some ways, witches and pregnancy-related precautions might be "scapegoats" for social ills that teenagers' mothers fear (Wilson, 1951:313). I believe this serves two purposes.

First, this is how some mothers protect pregnant daughters from pernicious gossip. Some teenagers' mothers were once pregnant teenagers themselves. Seipati, Letsoba, and Bohlale told me this. They were born when their mothers were teenagers. Their mothers know how hurtful community members can be. A mother's good intention to protect her daughter may be so great that she keeps her daughter at home. When teenagers avoid witches they inadvertently avoid a host of social ills: gossip, ridicule, stigma. Some mothers may find it difficult to explain these social ills to already-anxious daughters. Additionally, these explanations may take time that a single, working mother does not have. For these mothers, it may be easier – or perhaps more effective – to teach pregnant teenagers to fear witches. I argue that, in some ways, witches personify certain social ills such as gossip, judgement, punishment, or even jealousy. My argument has roots in Monica Wilson's (1951) ethnographic work. Wilson worked in Tanganyika (now Tanzania) and South Africa. She observed that, in these communities, witches personify illicit and tempting desires (Wilson, 1951:307-309). Giving into these desires meant inviting witchcraft into one's life. This could jeopardise family, marriage, or prestige. I argue that something different is happening in Botshabelo. Witches symbolise a surveying power, a policing force, more than temptation. Teenagers talk about witches with fearful whispers, and only in private spaces. It seems to me that the fear of witches drives most pregnant teenagers to follow their mothers' instructions. This is why most teenagers stay indoors, out of the public eye, away from gossip during pregnancy.

A second reason why some mothers keep pregnant teenagers at home is linked to visibility and blame. I argue that some mothers invoke precautions and a witchcraft discourse to protect themselves as well as their pregnant daughters. When teenagers hide in the house, they are less visible in their communities. In turn, there is less fuel for gossip about the teenager and her mother. Nolwazi Mkhwanazi (2009, 2010) discusses this based on her work in Khayelitsha. She worked with young people to explore teenage pregnancy, and how this affects familial relationships. In Khayelitsha, Mkhwanazi (2014a) observed that some communities hold teenagers' mothers accountable when teenagers become pregnant. These mothers are blamed for not teaching their teenagers appropriate sexual behaviors. Part of this is how to avoid pregnancy. The blame Mkhwanazi describes can inspire an unforgiving sense of shame. To partly combat this, Mkhwanazi found that some pregnant teenagers adopt a "discourse of regret" in order to "suture" relationships with their mothers (Mkhwanazi 2014a:116). Being less visible in their communities is one way to show regret. Other scholars have explored this in the South African context (James et al., 2012:191; Kaufman et al., 2001:149; Preston-Whyte et al., 1990).

> When a pregnant teenage publicly conducted herself with humility and showed remorse, she removed the blame of bad parenting from her mother. (Mkhwanazi, 2014a:116-117)

In Botshabelo, teenagers' mothers face a similar kind of blame and shame. Instead of flaunting pregnancy to the outside world, their daughters show regret and remorse by hiding in the house.

This is consistent with Mkhwanazi's (2014a) observations. When teenagers are not seen in their neighbourhoods, they protect their mothers from scathing gossip. Seipati and Mammako elaborated on this blame and shame during a conversation in Hlano clinic (2019). We were discussing why pregnant teenagers stay at home during pregnancy. The pair confirmed that witches are a falsehood that teenagers' mothers circulate. Their narrative strengthens my argument that some teenagers' mothers use witches as an excuse to hide unmarried, shameful, pregnant daughters.

> Sasheenie: Some of the other teenagers are not allowed to leave the house.
>
> Seipati: No, I think their parents are ashamed. I travel a lot. I go everywhere. … I don't believe that witchcraft can harm me … My mom doesn't want me to stay at home. She says, 'Ha! You sleep all day!' No. She doesn't want that. They don't even get to exercise. … Those other mothers, they are ashamed of their daughters. … I go to the church on Thursdays. There are old ladies there who take care of us. Sometimes there are other pregnant teenagers too. They massage my ankles with oils and lotions. Then we all drink tea together. I feel special when they do this. That's why I go every week.
>
> Mammako: That is like an abuse to keep teenagers (pregnant teenagers) at home. They are abusing the teenagers. It's part of abuse, not going anywhere. Abuse! … I don't believe in those witches. Society is living with the myth. … When the mothers keep the daughters at home that is an abuse. It is not right. … I don't

> think the witches are real. But I like to see what other people think about them. … Some people think the witch is walking in the street at night. And she has a cat by her house. I have a cat by my house. So, they think I am a witch! It's funny! … I have lots of mice in my house. I don't like the mouse. It brings snakes, like the ones from the Bible. So, I ask my friend if I can borrow the cat. At night, I put the cat in the house. I close all the windows and doors. Then there are no more mice.

I find it meaningful that Seipati links shame and visibility. Seipati suggests that mothers who keep pregnant daughters inside the house are "ashamed" of their daughters. A mother who hides her pregnant daughter in the house is a mother who is trying to hide her own shame. Mammako suggests that it is abusive to confine teenagers to the house. Because Seipati's mother is not ashamed of her pregnant daughter, Seipati can freely navigate this social world. Moreover, Seipati does not believe in witches. Her mother and grandmother do not fear witches either. This might be another reason why Seipati is not restricted to her house.

Like Seipati, Mammako does not believe in witches. Mammako says that restricting pregnant teenagers to the house is a form of abuse. She goes on to address the community's suspicion that she is a witch. She explains that she borrowed a cat to chase away the mice pestering her house. Mice attract snakes. Mammako is deathly afraid of snakes, because of the power they yield. Mammako is a devout Christian. Her faith has seen her through a separation from her husband, unemployment, and a precarious struggle with HIV. Shunning the prodigal snake – and its religious symbolism – is deeply important to Mammako. For Mammako, the suspicion

that she is a witch simply confirms that witches are a "myth," a fallacy. What others think is real, Mammako knows is not real.

Section 8. Being unmarried

Teenage pregnancy in and of itself is not terribly scandalous. The reality that some teenagers are pregnant *and unmarried* is what makes teenage pregnancy such a calamity. I argue that a pregnant teenager tries to be less visible so she can hide her pregnancy, her shame. I suggest that being unmarried aggravates, if not fuels, this shame.

Teenagers used marriage to describe many kinds of arrangements. Often, I could not distinguish between plans or hopes. Sometimes, marriage meant that a teenage girl wore an engagement ring. Other times, marriage meant that she was planning a wedding. This could be a cultural Sesotho ceremony, or a church wedding, or both. There were still other times when marriage meant that she was waiting for her boyfriend to pay *lobola* or bridewealth. Often, bridewealth negotiations were on-going. The South African literature explores bridewealth, and how this can delay or hasten marriage, for pregnant teenagers (Hunter, 2010; Kaufman et al., 2001:152; Mkhwanazi 2012:76, Mkhwanazi, 2014a; Preston-Whyte & Zondi, 1992). In this section, I use the term 'marriage' in its broadest sense.

Marriage came up whenever I asked teenagers why teenage pregnancy was a bad thing:

> They want to see their child being married before they make kids. (Bohlale, 2019)

> They don't like when you are pregnant, especially when you are unmarried … They want you to be married because you are pregnant. They don't care how old you are. (Kananelo, 2019)

> The community would say: 'How could you make a child while you are not married?' The community believes you must be married then have a child. (Seipati, 2019)

> The baby is a mistake. I will tell him when he is older. I am unmarried. (Lerato, 2019)

> …you always ask yourself questions – how am I going to be able to take care of this child? (Metsi, 2018)

Below, I share Monica's narrative. She reiterates the connections between visibility, shame, and marriage that some of the other teenagers explain above.

> My father is a pastor in our church. This is why my pregnancy is so bad. He teaches everyone else about marriage. But now I am pregnant. … My parents were very angry with me. Now, they have made peace. They have accepted it

> and they support me. … They say I cannot go to school because my tummy is starting to show. I must not show my shame to everyone. … My father always said how he wanted to see me in a white dress, like a princess. Now he does not say this. They are very disappointed in me still. (Monica, 2018)

Monica lives with her parents in Leshome section. Monica's parents told her that her pregnancy was an embarrassment. They did not allow her to attend school during her pregnancy. They did not want "everyone" to see her baby bump, she tells me, because they did not want their daughter to "show" her shame in the community. Her pregnancy was shameful largely because she was unmarried. Her father is a pastor. He preaches chastity before marriage, and pregnancy after marriage. Additionally, he dreamed of his daughter's wedding. He wanted to give her away "in a white dress, like a princess." Her teenage pregnancy was a slap in his face. Monica's experience highlights that it is not only school leadership that prevents pregnant teenagers from gaining an education. Sometimes, parents also play a role in schooling decisions.

I argue that being married is an important - if not required - precursor to having a baby. A teenager's pregnancy is problematic and shameful, because she is young and unmarried. Pregnancy and motherhood are important parts of "womanhood," but only at the right time and under the right circumstances (Macleod, 1999a; Macleod, 1999c; Mkhwanazi, 2010). A teenager should be older, married, and educated before she has a baby. Mahlony's experiences confirm this. Largely because she was married, Mahlony said she was "happy" – not ashamed – when she learned she was pregnant (Mahlony, 2019). Teenage pregnancy undermines the social rhythm of life in a very obvious, visible way.

What I witnessed in Botshabelo agrees with some of the South African scholarship. Harriet Ngubane (1977) explores the power of medicine, body and mind in KwaZulu-Natal. Ngubane suggests that an *unmarried* pregnant woman is more polluting, and more dangerous, than a *married* pregnant woman. Some unmarried women must quarantine in an effort to protect others. This is perhaps one reason why pregnant teenagers hide during pregnancy.

> Pregnancy is supposed to happen within the context of marriage, and even then it is polluting, but if it happens before marriage its pollution takes on a new dimension. (Ngubane, 1977:80)

Ngubane describes ideas about pollution, which relates to other research. Mary Douglas (1966) worked in the now Democratic Republic of Congo. She found that dirt is "matter out of place" (Douglas, 1966:35).

> Shoes are not dirty in themselves, but it is dirty to place them on the dining table; food is not dirty in itself, but it is dirty to leave cooking utensils in the bedroom, … out-door things in-doors; upstairs things downstairs; under-clothing appearing where over-clothing should be … (Douglas, 1966:35-36)

What Douglas explains here is more than just classifying dirt. Doulgas emphasises the "acts of ordering that [dirt] engenders" (Zaloom, 2020:416). Dirt must be organised, and excluded from an ordered system. Things that are from the outdoors should not appear indoors. Things that are

used to cook should not appear in a place for sleep. Such organisation can prevent disorder. This can be applied to teenage pregnancy in so far as 'teenage pregnancy' should be excluded from an ordered system or (in Botshabelo) a prevailing moral order. In this context, pregnancy in a teenager's womb is considered to be 'matter out of place.' I also found that pregnancy is considered to be 'out of place' if it happens before marriage. Teenagers who are pregnant *and* unmarried seem to disorder the 'moral way of life' (the ordered system) that their communities espouse.

Teenage pregnancy as 'matter out of place' contributes to a sense of disorder, a lack of moral order. This disorganisation is "destructive to existing patterns" (Douglas, 1966:94). In Botshabelo, teenage pregnancy threatens key sources of moral value: marriage, education, employment. This is perhaps why family members (especially teenagers' mothers) teach pregnant teenagers to separate their pregnant and unmarried bodies (their 'polluting bodies') from society. Their pregnancy is 'pollution' that can 'contaminate' others. That is, pregnant teenagers who are visible in their neighbourhoods have the power to condone (if not encourage) teenage pregnancy among their non-pregnant peers. I revisit these ideas in the next chapter, on **Being a pregnant teenager.**

The fact that teenagers are pregnant and unmarried causes tension in families and communities alike. In 2017, Former President Jacob Zuma publicly blamed teenage pregnancy for eroding culture and tradition in South Africa (Hodes, 2017b). This agrees with some scholarship in various African communities (Bledsoe & Cohen, 1993; Feyistan & Pebley, 1989; Ncayiyana & Ter Haar, 1989; Van der Vliet, 1974; Van der Vliet, 1991; Vilakazi, 1962). Interestingly, other

South African scholarship shows that the institution of marriage has been declining for several generations (Hunter, 2010). Christine Varga (1998) conducted ethnographic work in KwaZulu-Natal. Two decades after Ngubane's research, Varga observed that marriage and childbearing were slowly becoming "decoupled" (Varga, 1998:14). Similarly, in KwaZulu-Natal, Eleanor Preston-Whyte and Maria Zondi (1990) observed that having a baby out of wedlock, and while at school, was not always catastrophic. They found that pregnancy outside marriage did not "constitute the end of the world" (Preston-Whyte & Zondi, 1990:11). Other South African literature agrees with these findings (Meekers, 1994; Preston-Whyte, 1989; Preston-Whyte, 1993; Preston-Whyte & Zondi, 1989:55; Preston-Whyte & Zondi, 1992). This literature suggests that pregnant teenagers and teenage mothers are blamed for the decline of an institution (marriage) even though it began eroding long before them (Delius & Glaser, 2005). Moreover, pregnant teenagers are reputationally and socially punished by their communities for childbearing out of wedlock, even though this is not that far from the social norm. In 2013, only one third of South Africans older than 20 were married (Department of Health, 2007; Mlotshwa et al., 2017; Schatz et al., 2011; Statistics South Africa, 2013). National data show decreasing marriage rates in South Africa, as seen in Table 16 (Statistics South Africa, 2018d). The number of both civil and customary marriages has declined since their peak in 2009.

Table 16. Registered marriages in South Africa 2009-2018

	No. of civil marriages	No. of customary marriages
2009	171,989	13,506
2010	170,826	9,996
2011	167,264	5,084
2012	161,112	4,555
2013	158,642	3,498
2014	150,852	3,062
2015	138,627	3,467
2016	139,512	3,978
2017	135,458	2,588
2018	131,240	3,160

Civil marriages are legislated by the Marriage Act of 1961 (Act No. 25 of 1961). Customary marriages are legislated by the Recognition of Customary Marriages Act, 1998 (Act No. 120 of 1998). South Africa also recognises same-sex marriages through the Civil Union Act of 2006. These data were not included as no participants disclosed same-sex relationships. Reference: Statistics South Africa, 2018:21, 28.

In Botshabelo, I learned about marriage-related contradictions. Letsoba, for example, uses race and wealth to push back against this marriage discourse. The reality that teenage pregnancy is catastrophic if a teenager is poor and Black might be grounded in the promise of new liberation. This promise is juxtaposed with the fragility of Black success in a context of intergenerational poverty, as is the case for most families in Botshabelo (Dass-Brailsford, 2005; Madhavan & Crowell, 2014).

> They think it is a sin when you made a child at that young age. … Some of them, they make a child when they are 18 or 20, but they do not say it's a good idea to make a child at that age. I don't know why … They think you must make a child in a marriage. But when you are in a marriage and you didn't make a child, they are still talking about you, they still talking…. If you are married and you are

> 18, it is not ok. They say: 'You get married at the young age! And you don't work, you don't go to school or at university!' They still complaining. That's how our community is. It's old and young people – all – it is our community. It is like that. And they did the very same thing! … They think, because we are Black, Black people like to make a child. They like to compare us with White ones. Because they said: 'The White ones, it's brilliant, look! They don't make a child!' But when you look in America, right now, Justin Bieber made a child at the young age. But they don't say anything. That is not a sin for them. … he was 16. And Selena Gomez, she made a child when she was 15. It was when they were dating. And it's ok because they are rich. (Letsoba, 2019)

Letsoba lives with her older brother's family in two-bedroom RDP home in Robedi section. I think Letsoba's words are extremely insightful. Her words expose a complicated hypocrisy in this social world. Above, she says: "…but when you are in a marriage and you didn't make a child, they are still talking about you." When teenagers are pregnant, yet unmarried, others complain. When teenagers are married, yet not pregnant, others complain. When teenagers are pregnant *and* married, others still complain. These complaints sting more if they come from community members who were (at one time) pregnant teenagers themselves. This is what Letsoba means when she says: "they did the very same thing". In the latter half of her anecdote, Letsoba attributes this hypocrisy to wealth and race. Letsoba keeps up with social media and the tabloids. She compares her teenage pregnancy to a celebrity's teenage pregnancy. Letsoba says that the (White) celebrity singer Selena Gomez was pregnant when she was dating another (White) celebrity singer, Justin Bieber. Gomez was not punished for being pregnant. On the

contrary, her pregnancy was “ok because they were rich.” Letsoba suggests that teenage pregnancy is not shameful or catastrophic if a teenager is White, wealthy, or both.

Section 9. Adversity as possibility

The process of discovering and disclosing teenage pregnancy reveals a few tensions. Mammako, Baby-Boo, and Lerato highlight these below. Their narratives suggest that a baby is good, something that must be protected. This is why teenagers must take special precautions, and avoid witches. Yet teenage pregnancy is bad, scandalous, something that must be hidden. This is largely because a teenager is pregnant and unmarried.

There is also tension between pregnancy and HIV. Pregnancy is life-giving, some teenagers told me, while HIV is associated with death. This is what teenagers said despite their knowledge of HIV treatments in the clinic. This tension has been explored among HIV-positive adult mothers in the United States (Sandelowski & Barroso, 2003a; Sandelowski & Barroso, 2003b). I suggest that the association between HIV and death is one reason why teenagers keep HIV secret even after their sexual indiscretions are revealed by pregnancy. I learned that many teenagers have lost loved ones who contracted HIV in a time before ARV care. Teenagers necessarily watched over, or even cared for, family members in their last moments. I understand the link between HIV and death to be an additional layer of stigma that HIV carries, a dire fear that pervades despite accessible ARV care.

> Teenage pregnancy is not so good. But the baby is a blessing, and the teenagers say this too. (Mammako, 2019)

> Teenage pregnancy is bad, but a baby is a good thing. (Lerato, 2019)

> … I was so scared. I thought it (HIV) was a death sentence. … The people don't like it. They say, "You can't eat from the same food because you have HIV." They think you will infect them like that. It's very hard. … But a baby is a blessing. (Baby-Boo, 2019)

In order to make meaning of these tensions, I observed that some teenagers reframe them. Maipato explains this. She lives with her mother and step-father in Robedi section. Both parents work in Bloemfontein. Maipato spent most of her time alone during her pregnancy. She did not socialise too often for fear of witches. She says that she did not want her friends to see her pregnant. It seems this solitude gave Maipato time to think about her next steps.

> … And also, the school. They don't like teenage pregnancy. … For my friends, I am always happy. I say jokes, and they laugh. Ja. They miss me. They came to see the baby. Then they will see me on 2nd April. They are excited. Going back to school stresses me. …but I must come back to school because I'm going to do my Grade 12. Having HIV doesn't make me less. My life is full of possibilities. Ja. … After that, hei! I don't know, but I want to be a nurse or a paramedic maybe. … So, after Grade 12, I will go to university. … It's not easy

> to be a mother. And going to school, it's a big decision. I love my baby. I will miss her. … But education, it's the key of success. Success means a good life, a good house, the things I want to give my child. Like love, protection, support. [They say] money is not that important? No, it is important. I need it if she's sick or for her school or for a car to drive her when the weather is bad. I want like that Chevrolet in blue, like light blue. … I want to be a good and loving mother. (Maipato, 2019)

How did Maipato make meaning of pregnancy? She kept her pregnancy a secret so she could continue going to school. She attended class during the first two trimesters of her pregnancy. In her third trimester, however, her baby bump became too obvious to hide. Her mother and teachers insisted that she stopped going to school. It seemed that Maipato had kept her pregnancy a secret from everyone, until this point in time.

How did Maipato make meaning of HIV? The teenager aspires to be a nurse, or paramedic. When I asked why she worked so hard to attend school - despite the challenges of pregnancy - she said: "Having HIV doesn't make me less. My life is full of possibilities." I think that what Maipato reveals is far more powerful than just a determined work ethic. She sees adversity as opportunity. Maipato's dreams are juxtaposed against many challenges: having HIV, being unmarried, being a pregnant teenager, being uneducated. Yet these challenges do not restrain her dreams. On the contrary, they seem to catalyse them. She says that having a "good life" - making money, supporting her child, owning a house and car – is extremely important. Her education is one way to obtain this kind of life. What dream can be out of reach for a teenager

who only sees possibility? In some ways, her adversities are empowering. They provide perspective, "resilience," a tenacity to overcome (Nkani, 2012). Maipato's response suggests that she is not defined by her circumstance, or the life into which she was born. Instead, she is defined by her actions. I argue that, although her response is impressive, it is also pragmatic. She chooses to move forward so she can be a "good and loving mother" with a stable (lucrative) profession. She is simply making the best of her situation.

Chapter summary

It seems that, for most teenagers, discovering pregnancy is a painful and confusing experience. Discovering HIV, at the same time as pregnancy, is a double blow. Some teenagers cope by being less visible in this social world. They falsify their identities at the clinic. They keep their pregnancies secret, outside of confiding in mothers who can offer support.

In this chapter, I have argued that pregnancy is shameful (largely) because teenagers are unmarried. There is tension here. Teenagers are blamed for the decline of an institution (marriage) even though it began eroding generations before them. In the following chapters, I will argue that this shame also comes from exacerbating pressures on the family economy, affirming an intergenerational sense of disappointment, and disobeying the 'linear life trajectory' that society prescribes. That is, teenage pregnancy threatens the moral order to which this society clings.

I suggest that this shame is linked to, and feeds, the growing stigma surrounding teenage pregnancy. Most teenagers make meaning of this shame and stigma by following pregnancy-related precautions and avoiding witches. Both seem to be veneers for various social ills. Teenagers' mothers encourage daughters to hide inside the house where it is safe. Hiding is a way for teenagers' mothers to protect teenagers from these social ills. Hiding can also curb shame and blame for these mothers. Beyond this hiding, some teenagers make meaning of pregnancy (and HIV, respectively) by recasting adversity as possibility.

VI. Being a pregnant teenager

After discovering pregnancy, it seems that most teenagers have little space or time to consider its many implications. This introspection usually comes later, if at all. Instead, most teenagers talk about the uncertain path ahead. Pregnancy changes the present and future in ways most teenagers do not foresee.

I begin with the question: what meaning does this social world give teenage pregnancy? Although there are many, nuanced meanings of teenage pregnancy, I highlight a few poignant ones here. Teenage pregnancy carries social sanction. As a result, I argue that some pregnant teenagers are made to feel that they deserve social punishment from their communities. This is because they are not following a 'linear' life course (section one), and have jeopardised their educations (section two). There is tension here. Other people scold (and reputationally punish) pregnant teenagers because they cannot finish school. Yet not finishing school is closer to the social norm than most people would admit. I discussed a similar contradiction in the chapter on **Discovering and disclosing teenage pregnancy.** That is, other people scold pregnant teenagers for being pregnant and unmarried even though this seems to be closer to the social norm than others admit. Also in section two, I argue that a punishing discourse manifests when others continuously admonish pregnant teenagers. This is part of the social sanction surrounding teenage pregnancy. I argue that this punishment influences the way many teenagers make meaning of pregnancy. In addition to this, many teenagers are 'not allowed' to have abortions. In section three, I observe that this social world can make a pregnant teenager feel shame, guilt, and anxiety for even considering an abortion. In section four, I discuss an intergenerational sense of disappointment. Many teenagers are told that teenage pregnancy is a great

disappointment to their families. Furthermore, some teenagers' mothers seem to transfer the disappointment they felt during their own pregnancies onto their teenage daughters. That is, teenagers' mothers were once unmarried pregnant teenagers too.

In the next part of this chapter, I consider how some pregnant teenagers negotiate pregnancy. I suggest that some community members (re)produce and perpetuate the punishing discourse linked to teenage pregnancy. I ask: how do teenagers make meaning of being pregnant in a context where pregnancy is the source of crippling punishment? This punishing discourse creates a need for repair through acts of deference and discretion. To this end, I argue that many teenagers perform 'rituals of repair.' In section five, I show how teenagers 'hide' at home to show remorse for teenage pregnancy, and demonstrate that they have imbibed the shame and disappointment linked to this experience. Despite this 'hiding' ritual of repair, some teenagers take great care to protect themselves, and unborn babies, with medical routines outside the home (section six). I argue that some teenagers follow medical routines – antenatal care and HIV treatment regimens – because they aim to take care of unborn babies, please their partners, and make amends with their families. In section seven, I discuss the way some teenagers reframe, and respond to, the punishing discourse. They recast teenage pregnancy as a divine test, or a 'shake' from God. I argue that, in doing so, some teenagers frame their babies as objects to be loved, not rejected.

These are some of, although not all, the ways pregnant teenagers make meaning of the punishing discourse surrounding teenage pregnancy. These are not the beginning or end of

teenagers' responses, but rather a few aspects of the messy, convoluted experience that is teenage pregnancy.

Section 1. Marriage

In the preceding chapter - **Discovering and disclosing teenage pregnancy** - I argued that being unmarried is a source of shame for pregnant teenagers. In this chapter, I argue that this shame in turn influences the punishing discourse teenagers must endure during pregnancy.

A pregnant teenager is reprimanded because she is pregnant yet unmarried. She is told that teenage pregnancy outside marriage is shameful, a disappointment. Teenage pregnancy fractures society's expectations for her ideally 'linear' life where education precedes employment, which precedes marriage, which precedes childbearing. Some of the South African literature confirms this. Scholars suggest that, if a pregnant teenager is married, then her social world sees her as having "positive sexual values" (Macleod, 1999c; Zwang & Garenne, 2008). Because she is pregnant and unmarried, society does not credit her with these 'positive' values. As a result, her social world punishes her by gossiping about and scolding her. Bohlale explains this: "I disappointed my parents because I made a baby without getting married" (2019). She is HIV-positive. During the same conversation, Bohlale gave me a list of all the "bad things" (Bohlale, 2019) in her life including: being sick (and unable to take care of herself), being HIV-positive, burying family members (like her father), having a child before marriage, and not working hard enough at school. What struck me about our discussion was that she talked about having HIV, and having a baby before marriage, as equal 'wrongs.' It

seemed to me that Bohlale has had to endure HIV's acutest health impacts. Her pregnancy was particularly challenging, she told me, because it exacerbated her HIV. While she was pregnant, and after giving birth, she had multiple throat infections. These seriously impacted her digestion and breathing. She was admitted to the hospital almost monthly during her pregnancy. When she was at home, she was too ill to leave her bed. The weight of Bohlale's words is therefore highly significant. For Bohlale, having a baby before marriage is comparable to having HIV. I suggest that, because Bohlale is admonished in her social world, she talks about these as equally severe challenges in her life.

Being married, on the other hand, can reduce the punishing discourse surrounding teenage pregnancy. Letsoba explains this:

> When you get pregnant at your home, and you do not get married, they think you like sex at a young age. But when you get married, and then make a child, they say you are a good woman. (Letsoba, 2019)

Letsoba is dating her baby's father. His parents are advising the couple on marriage, and a new house. Letsoba is an orphan. Her brother recently moved to KwaZulu-Natal, and gives her minimal financial support. Although Letsoba is making plans for marriage, she is also supporting her fiancé financially. Letsoba told me that she is constantly frustrated when he spends what little he earns as a clinic pharmacist on alcohol. Still, Letsoba is determined (and excited) that they will soon be married. She is working hard to attain 'marriage' status in her community, despite a lack of support from her fiancé. According to Letsoba, "getting married"

can make a pregnant teenager a "good woman." Without marriage, a pregnant teenager is the opposite of this. She could be described as a 'bad girl.' I think both terms – 'bad' and 'girl' – are deeply meaningful.

Letsoba is 'bad,' because she is pregnant and unmarried. In the South African context, scholars have described the historical, socio-cultural value of marriage (Bledsoe & Cohen, 1993; Kaufman et al., 2001; Preston-Whyte & Zondi, 1992; Varga, 1998:18). My work agrees with this literature: marriage certainly has an important role to play in Botshabelo. To add this scholarship, I suggest that a married teenager can share the responsibilities of teenage pregnancy with her husband instead of carrying the weight herself. Additionally, two families (united by marriage) might share the burden of a teenage pregnancy better than one family can. Being married has the power to convert a pregnant teenager into a 'good' woman. Marriage can elevate a pregnant teenager's social status from 'teenager with a baby' to 'wife with a baby.' The latter is a protected social position in her social world.

Letsoba is a 'girl,' because she has not yet grown up (Macleod, 2003). Many scholars have explored this in the South African context (Berglund, 1976; Krige, 1936; Mkhwanazi, 2010; Ngubane, 1977; Preston-Whyte & Zondi, 1989; Varga, 1997a; Varga, 1997b:59). These scholars emphasise the significance of the coming-of-age experience that is motherhood. My work echoes this literature. I observe that being a mother has the power to make a 'girl' into a 'woman.' Becoming a mother can positively shift a teenager's social position.

Importantly, becoming a mother – without becoming a wife - is not powerful enough to elevate a pregnant teenager's social status (Richter & Mlambo, 2005). Her social world prefers marriage before pregnancy. Yet this is not the reality in Botshabelo where more than six out of ten (66%) people have never been married (Statistics South Africa, 2019b). I could not access official marriage rates, disaggregated by gender or age, for Botshabelo. Instead, I offer national disaggregated statistics. These resemble the marriage rates in Botshabelo.

Based on nationally representative household surveys, Rudwick and Posel (2013) found that few Black women, who are 20 to 30 years old, have ever been or are married. In 1995, these surveys show that two in ten Black women were married. By 2010, one in ten Black women was married. Other literature agrees with this trend (Budlender, Chobokoane, & Simelane, 2004; Hosegood, McGrath, & Moultrie, 2009; Hunter, 2010; Hunter, 2006; Margherio, 2015; Mohlabane, Gumede, Mokomane, 2019; Posel, Rudwick, & Casale, 2011; Posel & Casale, 2013; Yarbrough, 2013). Without being married, it is difficult for many pregnant teenagers to shift from 'bad girl' to 'good woman.' In some instances, a pregnant teenager will leave Botshabelo until she can be married. Dineo explains this. In 2019, she was pregnant with her third child. I met her at Robedi clinic when she was collecting her ARVs. She is HIV-positive and has two HIV-negative children. Dineo did not want to live in Botshabelo during her pregnancies. She could not stomach the social stigma of being unmarried, and pregnant. Therefore, she moved to Welkom - two hundred kilometers away - with her fiancé. He works as a security guard in a factory.

While Dineo lives in Welkom, her children live with her mother in Botshabelo. Dineo misses her children terribly. She sees them monthly when she visits Robedi clinic to collect her ARVs. Only after she is married, in 2020, will she return to Botshabelo. Dineo plans to live with her children. Her husband will continue working in Welkom. Dineo would rather be married, and live away from her husband, than live unmarried in Botshabelo. Like Letsoba, Dineo suggests marriage can make someone a 'good woman.' Marriage can protect Dineo from – or at least help her evade - some of the punishing discourse surrounding teenage pregnancy.

Despite its protection, marriage can also place a teenager under additional social pressure. I suggest that marriage can help *and* hurt a teenager. Maki explains this. She is a petite teenager. She sits quietly in most of our discussions. Her eyes are cast down. She only answers the questions we ask. She does not joke with, or gossip about, anyone else in the clinic. She speaks only when spoken to. Maki married her boyfriend after they discovered her pregnancy. His family live in Lesotho, so the couple married "in the traditional way," Maki said (2018). I assumed that living with in-laws in a new place had likely contributed to the way Maki behaved in the public clinic. Her demure and reserved nature perhaps mirrored the way she was with her in-laws. In return for his family's protection – through marriage – Maki would give them a healthy grandchild. I met her at Leshome clinic. She was worried, she said, because she was bleeding. She told me that she did not want to lose the baby. Maki said that a miscarriage would increase the tension in her marriage and pressure from her in-laws.

Section 2. Schooling

I would like to highlight two glaring contradictions facing pregnant teenagers in the school sphere.

Firstly, most families blame 'teenage pregnancy' when their daughters do not finish high school. Yet the reality is that most people do not finish school, regardless of teenage pregnancy. In the Mangaung district, in which Botshabelo is the largest township, less than one in ten (5%) students complete primary school (Free State Department of Health, 2014:12; Statistics South Africa, 2019a; Statistics South Africa, 2019b). Less than two in ten (16%) students complete high school. Less than one in ten (5%) people attend university.

Secondly, a pregnant teenager is punished by her social world for becoming pregnant (and not being able to finish school) by being excluded from school. There is tension here: she is deprived of the very thing that society expects from her - an education. Barring pregnant teenagers from school contradicts a number of national laws namely the South African Schools Act (SASA) of 1996, law 38 in the 2005 Children's Act, the Convention on the Right of the Child, and Section 9 in the South African Constitution (Mkhwanazi, 2014c:326-327). These 'formal' policies strongly advocate – if not dictate - that pregnant teenagers should continue schooling, during pregnancy. Yet this is not the reality in Botshabelo. Most teenagers expect that they cannot attend school during pregnancy. Most pregnant teenagers are temporarily 'expelled' because of 'local' (informal) school policies implemented by school principals and teachers. I discuss four such policies here, as teenagers and nurses explained them to me:

> There are no nurses at the school. What if something happens to the teenagers? It is not safe. So, it is better if the teenagers don't go to school, right? (Sister Mohlare, 2018)

> I think the teachers are angry. They are disappointed in teenage pregnancy. But they get angry because they care. (Mahlony, 2019)

> And if they are pregnant and in the classroom then other children will think it's ok to do this thing? No, it's not right. I think they must not send the message that teenage pregnancy is okay. (Sister Mookodi, 2018)

> …They say (this) only to teenagers, not boys. They think we, us, we go to the boys and trick them. That's how it is. Even at school, they must tell both of us that we must stay at home because it's our child. But they don't tell the boys. The boys can go to school. That's not fair. … (Letsoba, 2019)

The first local policy is that teenagers cannot attend school, during pregnancy, because there are no nurses on the school's staff. This is not a new issue in South Africa (Mda, 1997; Schoeman, 1990; Shongwe & Varga, 1997; Varga, 1998). Sister Mohlare explains this above. She has worked as a primary care nurse at Leshome clinic for more than thirteen years. During my fieldwork period, however, she was working at a male circumcision clinic. Sister Mohlare is an integral member of the community in Leshome section. She is active in both church and clinic spheres. She is a jovial mother of two grown-up children, and has made many friends

over the years. I learned that many people respect, and listen to Sister Mohlare's opinion. She suggests that it is safer for a pregnant teenager not to attend school. If a pregnant teenager has a medical emergency at school, then there is no one (no school nurse) to take care of her. Furthermore, school principals and teachers are hesitant to take (medical and legal) responsibility for a pregnant learner.

Second, some teenagers are 'not allowed' to attend school during pregnancy because their teachers are "angry." Mahlony explains this above. She discovered her pregnancy when she was in her final year of high school. She told me she was devastated. She said that her teachers were "angry because they care". Mahlony said that her teachers were "disappointed," because they had high hopes for her. Indeed, she had high hopes for herself. She planned to be the first person in her family to finish high school. Her older sister was unmarried and had two children. She had not finished high school, but wanted Mahlony to do so. The two teenagers found a way around the local school policy. They learned that the school would allow Mahlony to attend school during her pregnancy if she was accompanied by a relative. Mahlony's sister walked Mahlony to school every day. Her sister sat on a bench outside her classroom until the pair could walk home together. Mahlony successfully passed Grade 12, and had her baby shortly after. With support from her sister, Mahlony was able to circumvent angry teachers (one aspect of the punishing discourse) that tried to exclude her from the classroom.

The third local policy hints at issues of visibility and awareness. Sister Mookodi explains this above. She suggests that pregnant teenagers are temporarily 'expelled' because including them could condone teenage pregnancy. This relates to ideas about teenage pregnancy as "matter out

of place" (Douglas, 1966:35) with the power to 'pollute' an ordered way of life and 'contaminate' others. Sister Mookodi is a nurse in Leshome section, and the clinic's manager. Sister Mookodi is a stately woman. When she speaks, everyone seems to listen. Her poise and authority extend beyond the clinic, and into her own home. She has a beautiful daughter who is pursuing a Bachelor of Arts in Sociology at the University of the Free State. She drives the 80 kilometers from Botshabelo to her university in Bloemfontein in a car her mother financed. Unlike most other students in Botshabelo, she has access to convenient technology - Wi-Fi and a printer – in her home. It is partly because of her good behaviour (not being a pregnant teenager) that Sister Mookodi's daughter is bestowed these privileges. Whereas being excluded from school is a necessary punishment for pregnant teenagers, material goods are a reward for teenagers who side-step pregnancy. I did not have the opportunity to confirm this observation with Sister Mookodi's daughter. I could only rely on my discussions with Sister Mookodi. She told me that teenage pregnancy is "not right" and not "okay". She has perhaps repeated this mantra to her high-achieving daughter. I observed that even teenagers who are not pregnant teenagers are acutely aware of the punishing discourse linked to teenage pregnancy.

Finally, the fourth reason why pregnant teenagers are 'not allowed' to attend school is because these soon-to-be mothers face more severe moral opprobrium than their partners. This echoes Vero's earlier anecdote about teenage pregnancy and visibility. Fathers have plausible deniability, whereas a woman's sexual life and its consequences (pregnancy) are made visible on her body. In this anecdote, Letsoba explains that she discovered her pregnancy during her penultimate year of high school. Although she stayed at home during her pregnancy, Letsoba was preparing to return to school after she had her baby. She, and her brother, met with the

school principal. Her principal agreed, and gave her a scholarship for her textbooks. Yet this financial support did not materialise. Letsoba could not resume high school. She could not afford the textbooks. Letsoba says, if she had been a boy, things would have turned out differently. She explains that she would not have missed school in the first place. Beyond this, she would not have had a problem returning to school. She intimates that boys walk with an air of agency that is rarely afforded to their female peers. Letsoba signals a gendered school environment where pregnant teenagers – not their male partners and/or peers - must avoid school during pregnancy. This is an important topic in the South African literature (Bhana et al., 2010; Nkani, 2012; Panday et al.,2009). My work agrees with this literature. It seems that some teachers unfairly blame teenagers for teenage pregnancy, and not boys. There are at most whispers that a boy might also be (partially) responsible for a teenage pregnancy. After she gave birth, Letsoba enrolled herself in a new matric (Grade 12) program. She successfully completed this program two years later.

Mahlony's statement – that teachers are angry with pregnant teenagers because they care - and Letsoba's comment on gender discrepancies hint at the processes of care and repair. These processes are closely linked to teenage pregnancy and young motherhood. That is, care and repair are important aspects of social reproduction, the labour of which typically falls to women in the household. I explore these ideas later on in the chapter on **Familial care** and in my **Discussion** chapter.

Despite their varied motivations, these (informal) school policies achieve a common goal: they prevent pregnant teenagers from attending school. I argue that this is part of the punishing

discourse associated with teenage pregnancy. It seems to me that this discourse comes from the community itself. Neighbours, friends, teachers, and nurses constantly surveil pregnant teenagers. Teenagers are spotlighted as if they are in an amphitheater. Their mistakes – their pregnancies - take center stage. It seems to me that the individuals who live among pregnant teenagers produce and perpetuate the discourse portraying teenage pregnancy as a sinful mistake. I think there are interesting power dynamics at play here. Those with power (community members, often community elders) effectively exclude those without power (pregnant teenagers). Those without power also stigmatise each other. As a result, the powerless are forced into hiding.

I believe the state plays a complex role in this surveillance. At the local level, state representatives such as school principals decide whether pregnant teenagers can attend school or not. At the national level, however, state actors discourage this punishing discourse. That is, national education policies and the national Constitution mandate that pregnant learners attend school (Mkhwanazi, 2014c:326-327). These policies specifically address the importance of retaining pregnant learners in the education system. Moreover, national health policies have made abortions legal until twenty weeks in the gestation period (Maforah et al., 1997). These procedures are free, and guardian permission is not required. Despite the state's best efforts, this punishing discourse abounds. By this I mean that the state (legislation and policy) goes against this punishment discourse. Yet state actors (local authorities in the school and clinic spheres) and community members enforce this punishment. In fact, this discourse is reiterated through gossip and across generations. Most teenagers cannot avoid harsh remarks, because

they cannot conceal pregnancy. On the contrary, pregnancy is uncomfortably visible, and grows more obvious each day.

Other scholars have explored temporary 'expulsion' among pregnant students in the South African context. Based on her work in KwaZulu-Natal, Christine Varga (1998) found that some pregnant teenagers are excluded from school for similar reasons (1998:14). This agrees with other work. Absolom Vilakazi worked on socio-cultural change in Zulu communities. He found that school staff believed pregnant learners could "contaminate" their non-pregnant peers (Nkani, 2012; Vilakazi, 1962:55). To avoid this, communities prefer that pregnant teenagers stay away from school. Vilakazi's observations are based on work that took place more than fifty years ago. What happened then, and what is happening now, flags long continuities in the way schools and communities address teenage pregnancy.

Bhana and colleagues (2010) worked across eight schools in Durban and Cape Town. These scholars found that teachers are "uncomfortable" about interacting with, or accommodating, pregnant learners in the classroom. Most school staff are not 'trained' to take care of pregnant learners. Bhana and colleagues argue that training should be framed around support: understanding what life is like for a pregnant student, and empathising with students' "poor backgrounds" (2010:879). Such training could help teachers guide pregnant learners through school, or even pregnancy in some cases. What teachers are doing in classrooms should be combined with "formal school-based support" (Bhana et al., 2010:871). Furthermore, some teachers said that pregnant learners "disrupt" the learning environment when they sleep, or are bullied, in class (Bhana et al., 2010:874-875). This seems problematic to me. Instead of

supporting tired or harassed pregnant teenagers, some teachers reject them. Surely, this discourages teenagers from returning to school after pregnancy, or trying to learn remotely during pregnancy. Finally, some teachers suggest that pregnant teenagers are 'safer' at home (Bhana et al., 2010:876). There is a sense that pregnant learners may 'exert' themselves unnecessarily, while at school. The researchers found that some teachers posit that pregnant teenagers have a social and moral responsibility to take care of – and prepare for – their babies (Bhana et al., 2010:876). By being forced to stay away from school, a pregnant teenager need not precariously balance education and motherhood.

On the other hand, some pregnant teenagers would choose to leave school, even if school principals and teachers did not enforce this. Seipati and Kananelo explain this:

> I don't want people to see me. I am choosing to stay at home. I want to take care of my baby. After some time, maybe two years, I will go back. (Seipati, 2019)

> The people see pregnant teenagers and they talk, like a lot. I don't like that - so I stay at home. (Kananelo, 2019)

> I don't want (to go out) because the people see me, and they gossiping like: 'Aye, why did you make a child at your age!' (Maipato, 2019)

It seems to me that, in a space as public as the school sphere, showcasing pregnancy can invite more scrutiny and shame. Both Seipati and Kananelo did not attend school during pregnancy.

Seipati is a bold and boisterous young woman. She will readily communicate her opinion. She loves her family above all else. She lives in her mother's house. By staying out of the public eye during her pregnancy, Seipati aimed to save herself and her mother from gossip, another element of the punishing discourse. I found it noteworthy that Seipati quelled her vibrant, out-going nature in order to avoid this discourse. Kananelo lives with her grandparents. She is an orphan. She says that disappointing her grandparents (by becoming pregnant) caused enough pain. She does not want her grandparents to face any more heartache, gossip, or scrutiny. In some ways, the punishing discourse extends beyond Kananelo to her grandparents. I realised that, for both Seipati and Kananelo, staying away from school was easier than being pregnant at school. Maipato confirms this. When she stays in her house, she avoids gossip and harassment. Maipato lives with her mother and step-father. Both her parents work during the day. Unlike Seipati and Kananelo, Maipato does not talk about avoiding gossip for her guardians' benefit. She seems to be protecting only herself. This is why she stayed away from school while she was pregnant. She did not want her neighbours, teachers, or friends to see her.

When pregnant teenagers are temporarily 'expelled' from school, during pregnancy, there is a greater chance that they will not finish school (Panday et al., 2009). This is a sobering reality in Botshabelo. This was the case for Baby-Boo and Dineo. Both are now adult women, although their first pregnancies were in their teenage years. Baby-Boo stayed at home during her pregnancy. She did not finish high school. Now, she lives on her husband's income. Like Baby-Boo, Dineo depends on her partner's income. She did not finish high school.

In the Free State province, where more than seven out of ten people (76%) are unemployed, many pregnant teenagers dream of a better future (Free State Department of Health, 2014:12). Importantly, education cannot always guarantee employment (Bray et al., 2010). Yet this does not discourage pregnant teenagers from wanting and trying to finish school (Craig & Richter-Stardom, 1983; Mwaba, 2000; Richter, 1996). Based on her work with young people in the Eastern Cape, Rebecca Hodes (2017b) writes:

> While motherhood was both a value and aspiration among the teenage teenagers and young women in this research, the value of motherhood was balanced against more immediate aspirations regarding education, professional advancement and financial stability. (Hodes, 2017b:15)

Other scholars agree (Vale, 2015). Hodes confirms what many teenagers in Botshabelo told me: getting an education is "the best means of pursuing a lucrative career" (2017b:15).

Some teenagers proactively plan how, and when, they can resume their schooling. This is one way that teenagers respond to this punishment from their community. These plans consume daily thoughts. This was the case for Sibongile. She plans to attend medical school after Grade 12. She, and her mother, met with her school's principal during the last trimester of her pregnancy. She arranged to return to school for the new term, after she gave birth to her baby. I revisit Sibongile's experiences more thoroughly in the chapter on **Familial care**. Sometimes, these proactive plans do not – or cannot - materialise. This was the case for Letsoba, as explained above. Still, many pregnant teenagers place considerable value on education.

Bohlale, for example, told me that "education is the key to success" (2019). Similarly, most community members say that education can help a young person secure a future. Sister Mohlare explained this when she told me that education is a "weapon," and pregnant teenagers must "go back to school" (2018).

Although education is valuable, not all pregnant teenagers make immediate plans to return to school. In Botshabelo, some teenagers' post-pregnancy plans include only taking care of their babies. Some teenage mothers may choose motherhood (taking care of babies at home) over school. This has been explored in South Africa (Bhana et al., 2010; Preston-Whyte & Zondi, 1989,), Ghana (Gyesaw & Ankomah, 2013), and the United States (Barnet, Arroyo, Devoe, & Duggan, 2004; Bunting & McAuley, 2004; Phipps-Yonas, 1980; Unger & Cooley, 1992; Vescovi et al., 2014; Warrick, Christianson, & Walruff, 1993). Some teenagers told me that they were too ashamed or embarrassed to go back to school. It seemed to me that they had internalised the punishing discourse to the extent that this discourse was crippling. Some teenagers seemed to even believe that they deserved their lack of education. Schooling, and employment, are reserved for teenagers who have 'earned' it – teenagers who have not made the mistake that is teenage pregnancy. This is what many people tell pregnant teenagers, and what pregnant teenagers (in turn) told me.

Section 3. Abortion

Some nurses punish pregnant teenagers by delaying abortion appointments indefinitely. Mmami explains this. Other pregnant teenagers – Nyefolo at Leshome clinic and Sphola at

Robedi clinic – share Mmami's experience. Mmami is the daughter of a prominent pastor, a religious man who is well-known in the Leshome neighbourhood. This was one reason why Mmami said she initially considered an abortion. She did not want her parents to know about her indiscretion. She said that she did not want to disappoint them. Her father told her he would one-day walk her down the aisle in a white dress: "and now it can't happen," Mmami tells me softly. Mmami says that when she scheduled an abortion at Leshome clinic, the nurses were "supportive" (2019). Yet she never had an abortion because the nurses continuously "cancelled" her appointments. She eventually passed her twenty weeks of gestation. Many pregnant teenagers are effectively prevented from having abortions at the clinic in a similar way. This is perhaps one of their most severe punishments, a particularly painful contradiction associated with teenage pregnancy. That is, denying abortions contradicts national legislation.

In South Africa, the Choice on Termination of Pregnancy Act of 1997 legalised abortions. The law states that women and teenagers – even those younger than eighteen - do not need parental consent to have abortions. Importantly, abortions are only legal up to twenty weeks in pregnancy. Beyond twenty weeks, a pregnant woman cannot have a legal abortion in a public (government-funded) clinic. Pregnant teenagers who are more than twenty weeks pregnant often become desperate. Sometimes, they resort to dangerous, illegal, and sometimes fatal "backstreet" abortions (Maforah et al., 1997; Varga, 2002).

When Mmami discovered that she was more than twenty weeks pregnant, she did not seek an alternative means of abortion. Still, she says she felt forced to "accept" her pregnancy (Mmami, 2018). With time, however, she began to "bond with the unborn child" (Mmami, 2018).

A number of scholars have explored abortion in the South African context (Cates, Schulz, & Grimes, 1983; Cooper et al., 2004:75; Cunningham & Boult, 1996; Klugman & Hlatshwayo, 2001; Matiyela, 2018; Mkhwanazi, 2011:5; Mkhwanazi, 2014c:330; Nash, 1990; Panday et al., 2009:58). These scholars emphasise a formidable social stigma linked to this medical procedure. I observed a similar stigma – and reluctance to even consider abortions - in Botshabelo. Scholars have also observed the ways some nurses mistreat pregnant teenagers who seek abortions (Eaton, Flisher, & Aaro, 2003; Harries, Orner, Gabriel, & Mitchell, 2007; MacPhail & Campbell, 2001; Maforah et al., 1997; Panday et al., 2009; Ratlabala, Mafokane, & Jali, 2007; Walker, 1996; Wood & Jewkes, 2006). In Botshabelo, pregnant teenagers are not mistreated so much as 'coerced' or 'tricked' into avoiding abortions. Not being allowed to have an abortion - being forced to continue pregnancy - is another form of punishment.

Even the unborn baby's life is discussed as a way to punish pregnant teenagers. This social world talks about 'protecting' a neonate's life. A pregnant teenager must protect the unborn baby at all costs. Harming the baby would be committing another 'crime' in addition to the tragic mistake that is teenage pregnancy. Pregnant teenagers are told that having an abortion would be 'murdering' an unborn baby. Community members, especially nurses, tell teenagers that having an abortion is wrong based on "moral and religious grounds" (Patel & Kooverjee, 2009; Varga, 2002; Varkey, 2000). This admonishing is at least partly rooted in the resilient Christian discourse in this social world. Christianity is deeply embedded in this township's rich tapestry. As early as the 1850s, Botshabelo was a home for "converts and missionaries" associated with the Berlin Mission Society (Poewe & Van der Heyden, 1999; Smith, 1969:239).

More recently, during the anti-Apartheid movements in the late twentieth century, the "Christian message" profoundly impacted the country's socio-political landscape (Balcomb, 2008; Coplan, 2009; Garner, 2000). Evangelical Christianity was espoused in townships across the country (Lund, 1989:62, Walshe, 1991). Broadly speaking, these religious influences "condemned" abortion (Balcomb, 2004:6). This remains true in Botshabelo today - whether a pregnant teenager is married or not.

In Botshabelo, teenage pregnancy is a sin, an act of immorality, a 'crime' against the religion. This has been observed in other South African communities (De Villiers & Kekesi, 2004; Macleod, 1999a; Macleod, Ida & Tracey, 2010; Mkhwanazi, 2006; Mwaba, 2000). Abortion is an additional crime, even more severe than the first. An abortion is viewed as 'killing' an unborn baby, and thus unthinkable. Society punishes teenagers for one 'wrong' (becoming pregnant), and effectively forbids them from even considering a second 'wrong' (murder in the form of abortion). In hindsight, it seems that nurses' actions to prevent these abortions might be considered a form of protection instead of only punishment. Mmami's earlier anecdote suggests that nurses offered more 'support' than judgement when the teenager discovered her pregnancy. It is possible that the teenager was undecided about and uncomfortable with an abortion so much so that the nurses created time for the teenager to make her decision.

A teenager's abortion-related decisions are publicly scrutinised in bustling community clinics. This only increases the anxiety related to this major decision. To be so young, and so unsure about one's resources and education, likely exacerbates these anxieties.

Over time, some teenagers internalise this punishing narrative. What some pregnant teenagers told me about abortions echoed, if not exactly reiterated, what nurses or teenagers' mothers told me. This is how most (if not all) pregnant teenagers talked about abortions:

> Abortion is a "separation of the unborn baby, the separation between a child and mother." (Letsoba, 2019)

> Abortion is a "sin." (Lebo, 2019)

> "To have an abortion is to kill a baby and that is a sin." (Seipati, 2019)

> Abortion is the "killing of an unborn baby." (Bohlale, 2019)

I think the diction in these narratives provides convincing evidence of the stigma linked to abortion. This social stigma, I believe, persuades – even manipulates, in extreme cases – many pregnant teenagers. This persuasion is possible because many mothers and nurses seem to work hand in hand. When teenagers come into the clinic seeking abortions, nurses tell teenagers to "go home" and talk to their mothers. Only then should teenagers return to the clinic to schedule abortion appointments. Reciprocally, teenagers' mothers tell their daughters to discuss abortions with nurses at the clinic. What I observed is echoed in some of the literature on South Africa. Scholars describe similar ways that family, especially mothers or grandmothers, can influence abortion decisions (Suffla, 1997; Varga, 2002).

Section 4. Disappointment

A pregnant teenager is repeatedly admonished for disappointing her family by becoming pregnant.

> Ja, we are afraid of disappointing our parents. The disappointment face…Yoh! It hurts more than a hiding! (Metsi, 2018)

> I fell pregnant at a young age. I felt embarrassed. It felt like I had let my Mom down for the rest of her life. (Barbie, 2018)

Metsi explains how this disappointment can feel. She suggests that the pain from being physically hit (getting a "hiding") is less severe than the pain of seeing a parent's disappointed face. Metsi is the oldest of four daughters. She leads her family. To this end, she was the first in her family to finish high school, and attend university. In 2020, she graduated from the University of the Free State with a Bachelor's degree in Criminology. Her daughter was four years old at her graduation ceremony. She takes her role as the eldest in her family very seriously. This is one reason why she tries not to disappoint her mother. She tells me that her teenage pregnancy was a great disappointment, but her family eventually accepted her. Now, they love her daughter as their own.

In the anecdote above, Barbie explains how she felt about her pregnancy, and how this influenced her familial relationships. She and her mother live alone. She carries all her mother's hopes and dreams for a better life, a better future. Her mother dreams of Barbie's career,

financial success, and prosperity. Given their close bond, I find her narrative to be quite powerful. She says that she let her mother down "for the rest of her life." The teenager emphasises the seemingly long-lasting impact of the punishing discourse that surrounds teenage pregnancy. She intimates that her pregnancy is so deeply disappointing that this disappointment will endure for a very long time.

It seems to me that another aspect of this disappointment is the fact that teenagers' parents (especially their mothers) hoped that their daughters would live a different reality than they did. Seipati, Letsoba, Bohlale, and Baby-Boo told me that their mothers had their first babies when they were unmarried and in their adolescence. For teenagers' mothers who were pregnant teenagers themselves, their daughters' pregnancies are painful reminders of their own punishment. More than this is the fact that these mothers cannot protect their daughters from this punishment. In some ways, a teenager's mother transfers the disappointment she felt during her own teenage pregnancy onto her daughter. This seems to give way to 'intergenerational' disappointment. Some teenagers hinted at this. They said they would one day support their pregnant daughters. Others refused that their daughters would become pregnant teenagers. They said teenage pregnancy is too challenging. Naledi and Zanele explain this:

> No one is perfect. So, I think I would support my daughter. (Naledi, 2018)

> I don't like it because she's too young. No, she's too young. She mustn't do that. She will get that abortion. She is too young. (Zanele, 2018)

Beyond their disappointment, most families can (and do) provide pregnant teenagers with support. The South African literature highlights the ways parents initially rebuff or reject pregnant daughters (Bhana et al., 2010; Chigona & Chetty, 2007; Lesch & Kruger, 2005; Mkhwanazi, 2010; Ngabaza, 2011). Over time, however, these scholars suggest that some parents accept and support their daughters. My work echoes this literature. Many teenagers told me that, when they disclose pregnancy, their families rebuff and reject them. After these initial reactions, some teenagers said, their families accept the situation. They support their pregnant daughters to their best of their abilities.

Section 5. Hiding pregnancy

Thus far, I have argued that there is a punishing discourse linked to teenage pregnancy. I suggest that this discourse creates a sense that teenage pregnancy is a calamity. Being young and pregnant is a catastrophe in eyes of this social world. It seems that, for many teenagers in Botshabelo, teenage pregnancy is a dark and lonely experience. Community members and kin relentlessly admonish pregnant teenagers. Community members and kin scold these teenagers because they are not married, have not finished school, and have disappointed their families. Many teenagers are 'not allowed' to attend school or have abortions, even if they want to. I argue that these happenings are all aspects of the punishing discourse associated with teenage pregnancy in this social world. As a result of this discourse, many pregnant teenagers retreat. That is, they seclude themselves, and hide their pregnancy from others. This is one way that they make meaning of pregnancy. Other meanings come from the ways teenagers follow

medical routines, and reframe teenage pregnancy as a 'divine' test. I will explore these themes in the subsequent sections of this chapter.

As mentioned earlier in this chapter, Kananelo stayed away from school during her pregnancy. She did not want people to see her growing belly. I argue that hiding protected her, and her grandparents, from scathing gossip and curious eyes. Moreover, I suggest that hiding was an act of deference, a way to avoid flaunting her transgression. The only time Kananelo would leave the house was to see her boyfriend, her baby's father. He used to live on her street. Now, he lives and works in Johannesburg. He periodically visits his family and Kananelo in Botshabelo.

> During pregnancy, I didn't want to go outside, because I didn't want people to see me like this (pregnant). I was allowed to go everywhere, but I didn't *want* to go. I went to the shops one day. I heard the old people gossiping about me saying, 'oh she is pregnant, oh look at her.' (Kananelo, 2019, emphasis in original narrative).

By 'hiding' in the house, Kananelo avoided the scolding and harassment from her social world. Additionally, when she was out of the public eye, her social world scarcely had opportunities to question her. Hiding in the house prevented others from seeing her pregnancy progress. Her social world did not receive regular updates on her pregnancy. It seems to me that the adage 'out of sight, out of mind' may apply to some pregnant teenagers. A teenager who is out of sight has a better chance of being out of her society's mind. I think her community desires her hiding

because her presence is an uncomfortable signal of her disobedience. That is, her pregnancy is a blatant sign that she has defied society's expectations, their rules. By hiding, she shows that she wants to conceal, and not flaunt, her transgression. I found that many families support, and even encourage, teenagers' hiding. Like many other teenagers, Kananelo was able to hide in her house because her family prepared her food, completed her chores, and bought her groceries. This might be how some families show that they have 'accepted' a teenager's pregnancy.

Hiding in the house is an extreme, although understandable, response to the social scrutiny that many pregnant teenagers experience. Yet, during pregnancy, a teenager must leave her house at least monthly for her antenatal appointments.

Outside the house, she hides her growing belly (her pregnancy) by covering her belly with a blanket. Pregnancy is a painfully obvious symbol of a teenager's shame, and her sexual promiscuity (Varga, 1998:117). Paballo explains this. I met Paballo during my fieldsite-observation period, before my fieldwork formally started. I was therefore unable to gather too many personal details about her life. During our short weeks together, however, she mentioned using a blanket during pregnancy. Paballo said that she wears a blanket, because she "does not want people to see" her pregnancy (Paballo, 2018). I learned that a pregnant teenager attempts to disguise her growing belly by wrapping a large, thick blanket around her chest, waist and legs. Her face is uncovered. The blanket forms a tent-like covering below her chest, and down to the ground. Using a blanket in this way helps her blend into the crowd. Many women

similarly drape blankets around their bodies to guard against the frosty clinic and uncomfortable chairs.

I think the use of blankets is interesting because these objects seem to have contradictory purposes. On one hand, many pregnant teenagers told me that wearing a blanket could conceal teenage pregnancy, even if only partly or just for a short period. On the other hand, I find it curious that something as cumbersome as a blanket is intended to offer discretion. In the hotter months, a blanket may flag teenage pregnancy more than obscure it. Using a blanket to cover one's growing pregnant belly might have something to do with humbling oneself, as well as striving for anonymity or safety.

Importantly, blankets are used when pregnant teenagers leave the house and venture into the public sphere. This is usually only done when a teenager visits the clinic. That is, attending antenatal appointments to monitor the baby's health, is more important than 'hiding' in her house. When a pregnant teenager leaves the house in a blanket, she puts her baby's comfort (and needs) before her own. I think that this is a powerful form of care, a selfless kind of protection.

In the previous chapter on **Discovering and disclosing teenage pregnancy**, I argued that some pregnant teenagers hide from witches. People say that witches have the ability to (sometimes fatally) harm pregnant teenagers or unborn babies, and prolong birth pain. Here, I share another way that teenagers protect themselves from witches. Many teenagers use blankets to hide their bodies - and their unborn babies - when they are in public.

Blankets can conceal pregnancy, and thus conceal shame. That is, blankets can hide a teenager's baby bump and sometimes even disguise a teenager's identity. Although blankets help to hide teenage pregnancy, I suggest that blankets are also a way for teenagers to show the appropriate deference and shame in public. It seems to me that wearing a blanket is a ritual of repair that pregnant teenagers undertake to make amends for the scandal that is teenage pregnancy. Metsi explains this. She tells me that pregnant teenagers use blankets because "they feel shame." Some teenagers say that they are "still too young" to have a baby (Metsi, 2018). Although Metsi experienced teenage pregnancy, she was a twenty-three-year-old mother at the time of this research. She was able to reflect on her pregnancy retrospectively. Metsi, like many other teenagers, used a blanket during her pregnancy when she left the house.

Section 6. Medical routines and repair

Some teenagers make meaning of the punishing discourse associated with teenage pregnancy by following medical routines: teenagers attend antenatal appointments and take ARVs. These are important rituals of repair in so far as these acts help teenagers protect unborn babies despite and show their mothers deference.

Nurses told me that most pregnant teenagers are diligent about antenatal care. Sister Mookodi explains this. She is the antenatal nurse at Leshome clinic. Sister Mookodi told me that pregnant teenagers "don't know what's happening or going to happen during labour. They are scared so they know it's important for them to come to the clinic to get info" (Mookodi, 2018). Pregnant

teenagers having their second or third babies (multiparas) do not attend antenatal appointments as diligently as primiparas do. Multiparas do not need antenatal "information" from the clinic, Sister Mookodi told me, because they can rely on previous pregnancy experiences (2018). Many of the teenagers confirmed this:

> I visit the clinic every week - four times a month. I want to check my health, and also to check my unborn baby. (Mmomo, 2018)

> I go there (to the clinic) once a month to check my health, and to know the problems that I have for my unborn baby. (Lebo, 2018)

> The nurses help me there (at the clinic) and give me support. It is important to go there so I can see my baby. (Mahlony, 2019)

All three teenagers – Mmomo, Lebo, Mahlony – are primiparas. They are talking about their first pregnancies. The teenagers share the reasons why they prioritise antenatal care. Chief among these is monitoring the unborn baby, and gaining support from the clinic. During antenatal appointments, nurses use ultrasound scans so teenagers can "see" the baby in the womb. This is what Mahlony describes. Mahlony said that she wanted to do everything possible to ensure her baby's good health. Her baby's father had died while she was pregnant. She says that he was murdered by gangsters. In some ways, her baby was all she had left of him. Her mother and sister helped her through her mourning and (simultaneously) her antenatal care.

Taking ARVs was a crucial part of her pregnancy because she is HIV-positive. Mahlony tells me that she was diligent about taking her ARVs.

In the South African context, scholars found that some pregnant teenagers prioritise antenatal care (Boult & Cunningham, 1992:306). This is consistent with my work. In other, more recent, literature scholars found that pregnant teenagers delay antenatal care, or attend appointments irregularly. This is the case in South Africa as well as other African countries (Godding, 2008; Goldberg & Craig, 1983; Helleringer, 2017; Jones et al., 2013; Mushwana et al., 2015; Richter & Mlambo, 2005; Ronen et al., 2017; Varga, 1998; Woldesenbet et al., 2015). Researchers found that some teenagers avoid antenatal care, because of social stigma in clinics (Burman, 1992; Varga & Brookes, 2008). I did not observe this in Botshabelo. Most teenagers told me that they routinely accessed antenatal care. This is why I was able to recruit teenagers at the clinic. Most pregnant teenagers are diligent about antenatal care and ARV regimens. While I could not access official antenatal statistics for Botshabelo, many nurses told me that "almost all" pregnant teenagers attend their antenatal appointments, and take their ARVs, throughout pregnancy. There are a few exceptions. Some teenagers start antenatal care late, or visit different clinics each month in order to maintain anonymity. Broadly speaking, however, many nurses told me that pregnant teenagers "prioritise" antenatal care. This anecdotal information suggests that many pregnant teenagers work hard to protect unborn babies.

This is not to say that there is no social stigma in the clinic. On the contrary, stigma is a painful part of the punishing discourse surrounding teenage pregnancy. Teenagers try to avoid stigma by hiding in the house, or concealing their pregnancies with blankets (as discussed above). Yet

stigma does not prevent teenagers from accessing antenatal care. I suggest that this is because teenagers' mothers *insist* that their daughters visit the clinic. In some ways, antenatal care is not a choice. I argue that it is a form of penance, a way to make up for the mistake that is teenage pregnancy.

Most HIV-positive pregnant teenagers seem especially determined to protect their unborn babies from HIV. Baby-Boo explains this. She was a teenager when she had her first baby. During my fieldwork, she was twenty-six years old and pregnant with her second baby. In the narrative below, Baby-Boo is retrospectively reflecting on her first pregnancy. Baby-Boo is HIV-positive, and lives in Tshelela section. She conveys that she was desperate to avoid infecting her (first) baby with HIV. Like Baby-Boo, most of the other HIV-positive teenagers – Dineo, Mahlony, Lerato, Bohlale – aimed to protect their unborn babies from HIV. Baby-Boo recalls that she was overjoyed when her baby tested HIV-negative. Her baby's father (now her husband) supported her through her pregnancy. He reminded her to take her ARVs on time. She tells me that her sister and mother were extremely supportive as well. They monitored her diet. Unlike most other teenagers, Baby-Boo had disclosed her pregnancy *and* her HIV-positive status to her family.

> I was so scared when he (the baby) was born…His father told me he was born with it (HIV). So, I was thinking, 'Ooh! My child will be born with it.' …I went to the clinic (classes). Then I was praying. When I got the result, I found out my child is normal. He is negative. I was so happy. (Baby-Boo, 2019)

In Baby-Boo's anecdote, she uses the word "normal" to talk about an HIV-negative status. To be 'normal' is to 'not have HIV.' To be 'not normal' is to 'have HIV.' HIV implies a state of abnormality. HIV is a state of sickness, stigma, and challenge.

When pregnant teenagers identify risks to unborn babies, such as HIV, most of them are extremely diligent about following medical routines. They do work to protect unborn babies. Baby-Boo, for example, attended weekly clinic classes during her pregnancy. She endeavored to learn about HIV, and mother-to-child transmission. Taking ARVs is another part of this work.

Margarete Sandelowski and Julie Barroso (2003a, 2003b) found that some HIV-positive mothers do "mothering work" to protect their babies from HIV, and its stigma (Giles, Hellard, Lewin, & O'Brien, 2009; Shannon & Lee, 2008:161). They worked with mothers in the United States. Scholars have also observed HIV-positive mothers doing this 'work' in Australia (Giles et al., 2009). In the South African context, scholars observed that HIV-positive mothers do "worry work" and "surveillance work" to protect their babies (Aspeling & van Wyk, 2008; Long, 2009; Mofenson, 2003; Stinson & Myer, 2012).

Baby-Boo wanted her baby to have a 'normal' life. She was therefore diligent about attending clinic classes. Her diligence was not only an act of repair, but also an act of care for her unborn baby. At the risk of exposing her HIV status and pregnancy to her social world, she learned about HIV in order to protect her child. Baby-Boo placed her baby's needs above her own. Pumza demonstrates something similar.

Pumza is HIV-positive, and lives in Hlano section. I met her during my initial fieldsite-observation period. I did not yet have ethical approval to formally collect personal or demographic information. Instead, I share a memorable anecdote to illustrate how some HIV-positive teenagers (like Pumza) make sacrifices for their unborn babies. Pumza told me that she was single, and living at her family's house. She had travelled to Hlano clinic to ask about some medications. The antenatal nurse gave her "pregnancy tablets," because her blood "was weak." These were FeSO4 vitamins, or "fee-zo-for" tablets as Pumza described them (2018). The iron (Fe) in this vitamin bolsters the blood's oxygen-carrying capacity (Hallberg, 1988; Nojilana et al., 2007; Zimmermann & Hurrell, 2007:513). This oxygen is essential for an HIV-positive pregnant teenager, and her unborn baby. The tablets made Pumza nauseous. She could not eat any other food. Yet she continued to take all her doses. She knew the tablets would help her unborn baby. Her own comfort came secondary to what she believed was good for her unborn baby.

Even when pregnancy aggravates HIV, some teenagers are diligent about antenatal care, because this protects their babies. Bohlale explains this. She is HIV-positive, and lives in Robedi section. In the earlier sections, I discuss the painful ways HIV aggravated Bohlale's pregnancy. Despite her many challenges with HIV, however, Bohlale told me that she attended all her antenatal appointments even when she "felt weak" (Bohlale, 2019). Her mother often accompanied her, helping Bohlale walk the two kilometers to Robedi clinic. When Bohlale was too sick to go to the clinic, her mother rescheduled the appointments. Bohlale suggests that,

even when HIV was physically debilitating, HIV did not thwart her antenatal care. Such was her determination to monitor her unborn baby.

I found that many teenagers (HIV-positive and HIV-negative) are diligent about antenatal care as they try to take care of their babies, in earnest.

> I don't stress, because stress is dangerous for the unborn child. (Cortez, 2018) (Cortez is HIV-negative)

> I love my child (baby boy) more than other people. It's only him who shows me how strong I am in the world. When I look at him, I see the light - I mean, the bright future ahead. It's only him who can put me on top of the world. I love my first born. I think it's the same for the second baby. (Roni, 2018) (Roni is HIV-negative)

> …As a mother, I love being close to my baby girl and every moment means a lot to me. I'm afraid to lose my family and my baby's father because those people are very close to my heart. I thank God for my lil' baby girl. (Mmase, 2018) (Mmase is HIV-negative)

Ensuring that a baby is healthy, during pregnancy and after birth, is a priority for mothers like Cortez. In the anecdote above, Cortez is talking about her first pregnancy. She lives with both of her parents. She describes them as her "heroes" because they "pay attention to her needs"

(Cortez, 2019). Her baby's father was also supportive during her pregnancy. These three individuals helped Cortez prioritise her health, for the sake of the baby, during her pregnancy. I suggest that protecting the unborn baby – by reducing her stress - is part of a ritual of repair.

Monitoring a baby's health (through diligent antenatal care) is an important ritual of repair, and a way to show love. Moreover, antenatal care is a way for teenagers to take care of babies who (in turn) provide teenagers with joy. This is incredibly meaningful in the context of punishment and shame linked to teenage pregnancy. Roni describes this. She met her baby's father at church. They sang together in the church choir. While her teenage pregnancy was a shock, she tells me that she really wanted "to be a mother" (Roni, 2019). During her pregnancy, Roni says: "everyone treated me special and they wanted to see me happy" (2019). This kind of emotional support created space for Roni to think about, prioritise, and love her baby. This support helped combat some of the punishing discourse linked to teenage pregnancy. During my fieldwork, Roni was pregnant with her second baby. Here, she is talking about her first born, her son. He gives her a reason to demonstrate her strength, and plan for a "bright future" (Roni, 2019). Her baby brings her hope and happiness: "It's only him who can put me on top of the world" (Roni, 2019). Roni describes the intrinsic joy mothers receive from their babies. Mmase echoes this. During my fieldwork, Mmase was twenty years old. She was pregnant with her first child. Mmase tells me that she "loves being close" to her baby (Mmase, 2018). Spending time with her baby brings her joy and comfort. Earlier in our conversation, Mmase says: "I love people and I love being happy all the time" (Mmase, 2018). In a context of punishment and scolding, it is important that young mothers like Mmase can find solace in the joy they gain from their babies.

There are many reasons why (HIV-negative and HIV-positive) teenagers invest so much energy in medical routines. Thus far, I have argued that these routines are a way for teenagers to take care of and protect their babies. Most teenagers do this because their mothers insist on it. Furthermore, some teenagers commit to these routines because they want to please their partners (boyfriends or husbands) and elders. I suggest that these medical routines are a way for teenagers to show their mothers deference. Medical routines are crucial to the process of repair between teenagers and their families. There is some tension here. On one hand, teenagers adhere to medical routines because they must follow what elders tell them to do. Listening to elders is a ritual of repair. On the other hand, teenagers adhere to medical routines to please their partners. I illustrate this tension in the anecdotes below. Most of the teenagers are talking about antenatal care retrospectively. That is, they are making these comments after they have given birth to their babies.

> I didn't consider abortion, because I wanted to have a baby and make my partner proud. The clinic helps me. (Nthabiseng, 2018) (Nthabiseng is HIV-positive)

> My boyfriend supports me during pregnancy. …he makes sure I am okay with the unborn baby. He makes sure I eat healthy food. ... He respects me as his wife. He gives me good and enough support. He is open. He tells me everything. (Popi, 2018) (Popi is HIV-negative)

For Nthabiseng, having a healthy baby will please her boyfriend and make him "proud". This is why she attends the clinic for antenatal care. This is also the reason she did not have an abortion. Nthabiseng had her boyfriend's support throughout her pregnancy. Later on, she says that she did not want an abortion because she was "prepared to have a child with him" (Nthabiseng, 2019). She also says that he "encourages" her to visit the clinic and take her ARVs (Nthabiseng, 2019). Antenatal care is a way to ensure that the unborn baby is healthy. It seems that protecting the baby is important because this suggests that Nthabiseng cares for the unborn child. This act of care is a ritual of repair. Yet protecting the baby is also a way for Nthabiseng to love her boyfriend, and recognise his concerns during the pregnancy period.

For Popi, taking care of her unborn baby – by respecting antenatal care routines – is a way to 'repay' her husband's support. He takes care of her by monitoring her comfort and diet. In turn, she cares for 'his' baby in the womb. In a subsequent discussion, Popi says that her husband "respects" her because she is his wife (Popi, 2018). This discussion took place the day after Popi's baby was born. Yet all Popi could talk about was her husband. She hardly talked about the baby, her pain, experiencing breastfeeding, or the birth. One reason for this is that Popi had only seen her husband intermittently during pregnancy.

> The first pregnancy was very hard because in our culture your husband must stay far away from you so that our elders can teach me how to be a mother, and what I am supposed to do. So, I didn't get enough support from my husband. (Popi, 2018)

After the baby was born, however, Popi was allowed to see her husband. Taking care of her unborn baby, and following the advice of community elders and in-laws, was a way for Popi to show that she could "be a mother" (Popi, 2018). This, in turn, justified her marriage and ensured that she would be reunited with her husband.

I think that pleasing partners, by providing them with healthy babies, is deeply significant. This can justify marriage (as was the case for Popi) or secure marriage. Roni describes the latter.

> My boyfriend, I love him and I hope one day he is going to be my husband. He will marry me because when he is with me, he likes to say: 'you are a girl of my dreams, my baby's mother, that is why I love you.' These words make me be proud of him. (Roni, 2018)

Roni is nineteen years old. She lives with her mother and four other siblings. She has not finished high school, and does not plan to. During my fieldwork, Roni was pregnant with her second child. Marriage, for Roni, is one of the few viable paths to financial security. In return, she aims to be a good mother and a good wife. Antenatal care is a way to achieve both: she can monitor her baby and please her boyfriend. Moreover, marriage can repair her reputation – as a pregnant teenager and teenage mother - if only a little. She can become a 'married mother' instead of just a 'teenage mother.'

I suggest that some teenagers are diligent about antenatal care because this is a crucial ritual of repair. Teenagers who prioritise antenatal care are one step closer to reconciling with their families. This is especially true when teenagers want to make amends with their mothers.

> My family told me: 'Don't go play with boys!' I would come home from school and drop my bag, then go out till 6 o'clock. I wanted to see what this (sex and pregnancy) felt like. What would happen if I did what they told me not to do. Then this happened [s*he points at her stomach*] and now I have him. [*She sighs while looking at her baby bo*y.] So, I take care of him. (Kananelo, 2018)

> …I worked hard and I passed my matric with good results. That was the best thing I ever did. My family were so proud. I decided to take a gap year. That was the stupidest thing I ever did. A lot happened throughout the year. I even fall pregnant, and that was the last thing I ever wanted at this age of mine. But my mom said: 'What's done is done.' Now I am willing to do what's best for my mother, and my baby. (Lavas, 2018)

Kananelo uses antenatal care (and childcare) to reconcile with her family. Kananelo lives with her grandparents and two younger siblings. She lost her parents when she was younger. Even today, she still grieves for her father. They were especially close. Kananelo is playful and enjoys pushing the boundaries in most situations. For example, she and her grandfather play tricks on others in the household. She likes pranking her grandmother, a serious woman who is an elder in the church. Kananelo tells me that she loves to laugh. In this anecdote, she admits that she

likes to "play" – date and socialise. She describes how she did not listen to her family when they talked about boys and relationships. The consequence of her rebelliousness was her baby boy. Kananelo's diligent antenatal care is a way to repent for her mistakes, clean the slate, and rebuild relationships with her grandmother. Lavas describes this. She is twenty years old. Her pregnancy was the "stupidest thing" she ever did (Lavas, 2018). She makes up for this by doing "what's best" for her mother and her baby (Lavas, 2018). This included finishing high school, and prioritising antenatal care. With her mother's help, Lavas is learning what it means to be a mother. She says: "when you are a mother you must be responsible and be protective of your child" (Lavas, 2018).

Amidst repairing familial relationships, I think that making amends with mothers is especially important. Most teenagers are very close to their mothers, as Popi suggests:

> My mother is the best person in the world because she is honest. I have trust in her. She has taught me well since I was young. She treats me like a queen. I want to teach my child like my mother did for me. She taught me how I must act when I get married. Now, my husband is very proud to have a good wife like me. I love my mother and I am very proud to have a mother like her." (Popi, 2018)

Popi takes care of her baby in the same way that her mother cared for her. Antenatal care is an important part of this mirroring. Going to the clinic, during and after pregnancy, is how Popi can follow her mother's example, show deference and enact repair. She trusts that her mother

will not lead her astray. She justifies this by referencing marriage. Her mother groomed her for marriage, and now she is a "good wife" (Popi, 2018).

Section 7. A shake

Amidst the punishing discourse and need for repair, some teenagers manage to eke out positive meanings of teenage pregnancy. Letsoba explains this using a "*Mageu*" carton (see Figure 1). This is a popular brand of *maas* or sour-milk in Botshabelo, and South Africa. During my fieldwork period, Letsoba was twenty-two years old. Her daughter was four years old.

> You know Mague. Now, it says: 'shake before use.' That is what I think God does to us. For example, let's say there is a girl and her father dies before her matric exam. That is a shake. If the girl gets through that, then her life will be better. Then God can use her for the right purpose. Her life will be easier. So, we must keep praying and know we are in a shake. We must have faith in God. (Letsoba, 2019)

Letsoba's father was a mineworker. He became seriously ill when Letsoba was in primary school. He soon died from tuberculosis. During high school, Letsoba nursed her sick mother who subsequently died from TB. When her mother passed away, Letsoba became the primary guardian for her seven-year-old brother. She lived with her older brother (and his family) in an RDP home in Robedi section. Letsoba was in her penultimate year of high school when she discovered her teenage pregnancy.

In this anecdote, Letsoba suggests that each challenge in her life is a test – a "shake" - from God (Letsoba, 2019). The challenge she talks about is her father passing away. This happened when Letsoba was a little girl. Yet the result of this 'shake' was that she failed her Grade 12 (matric) exam, almost a decade after her father had died. Letsoba suggests that a shake is a trial that can test her capability, faith, and tenacity. If she can prove herself to God, then her life will improve.

On another occasion, Letsoba told me that her teenage pregnancy was a shake. As was the case when her father passed away, she aimed to get through her pregnancy so her "life would be better" (Letsoba, 2019). She thus needed to take this 'shake' in her stride. She talked about teenage pregnancy as a 'divine' test, instead of a catastrophe.

I think Letsoba's anecdotes are immensely powerful, because she reframes teenage pregnancy in a positive light. This is a sophisticated response to the punishing discourse in her social world. She suggests that teenage pregnancy is divine endorsement, instead of divine opprobrium. As a pregnant teenager, she is neither forsaken nor punishable. Her pregnancy is not 'wrong'. Having a baby is not a moral or religious 'crime,' but rather a providential test. God is simply testing her. Furthermore, because teenage pregnancy is a providential test, the unborn baby is divinely endorsed. The baby is an object to be loved, not rejected. By attributing teenage pregnancy to God's will, Letsoba partly absolves herself of blame. In front of a nurse, Letsoba could confidently defend her morality and sexuality. She need only say that her pregnancy is God's test. This is a profound response in a community governed by the Christian faith. Letsoba

implies a particular view of God as merciful. Whereas nurses talk about teenage pregnancy as a “mistake” or “wobble,” Letsoba suggests that teenage pregnancy is providence, that God is offering her a challenge to overcome.

Chapter summary

In this chapter, I have described teenage pregnancy as a complex, and multifaceted, experience. Most teenagers succumb to many feelings simultaneously. This can be confusing, and frustrating. As if this confusion is not punishment enough, pregnant teenagers are relentlessly admonished. I argue that this social sanction inspires a punishing discourse linked to teenage pregnancy. Other people reprimand these teenagers because they are unmarried, not matriculated, and too young. Others scold these teenagers for even considering abortions. All this admonishing creates dramatic and endless anxieties for many teenagers. I argue that individuals who live among pregnant teenagers (re)produce and perpetuate this discourse. As a result, teenage pregnancy seems to be a painful and dark experience. Many, if not all, teenagers internalise the hurtful scolding hurled at them by other people.

The fractured relationships associated with teenage pregnancy create a need for repair. Many teenagers ‘hide’ (their pregnancies) at home to show their families deference and discretion. Hiding is a ritual of repair. Teenagers also show discretion when visit the clinic swathed in blankets. In addition to this hiding, some teenagers make meaning of repair by following medical routines such as antenatal care, and ARV regimens. I argue that some teenagers follow medical routines in an effort to take care of unborn babies, please their partners, and repair

familial relationships. Protecting babies can involve self-sacrifice when teenagers place babies' needs before their own. A particularly salient meaning of teenage pregnancy is the notion that (for teenagers like Letsoba) pregnancy is a divine test. This response not only positively reframes teenage pregnancy, but also talks back to the punishing discourse surrounding it and frames babies as objects to be loved, not rejected.

The themes I describe in this chapter – hiding, using blankets, showing deference, adhering to medical routines, reframing teenage pregnancy as a shake – all have in common ideas about moral salvage. It seems to me that different phases of moral salvage are at play as teenage pregnancy progresses and then once a teenager becomes a mother.

VII. Moving on: familial care

After the nine months of pregnancy, most teenagers must consider what life will look like after their babies are born. In this chapter, I describe life as it is lived in the first few months after the birth. This period of teenage motherhood seems complicated and chaotic for most teenage mothers, and their families. In this chapter, I ask: how do families adapt to the presence of a baby in the house? Teenagers' rituals of repair give way to a sense of reconciliation in many households. I suggest that this is why some families help with childcare responsibilities. The economy of a household – who works, how much income is earned, who goes to school, who stays at home – shifts when a new baby arrives. Families balance a need for income with childcare responsibilities and a teenager's education. I found that most families respond to the presence of new babies in many nuanced ways. What I describe in this chapter is not the beginning or end of familial care in Botshabelo. Rather, I draw attention to a few salient ways that teenagers and their families adapt to teenage motherhood.

Rituals of repair seem to restore the authority and caring role of the teenager's mother. Some teenagers return to school while their mothers take care of new babies at home. Usually, a teenager's mother must forsake employment to do this. In section one, I argue that some teenagers are *only* able to return to school with support and help from their families. Moreover, I argue that the ability to provide familial care is closely linked to the household's economy. Not all households can sacrifice employment, even if they want to. Some families must work instead of caring for new babies. In section two, I discuss education. Some teenagers told me that having an education could help them provide for their families and their babies. I argue that this is what motivates some teenagers to return to and finish school. Yet not all teenagers can

return to school. Some teenagers take care of their babies at home. Their families cannot help with childcare (section three). Furthermore, some teenagers are not capable of attending school. In some cases, childbirth aggravates HIV too severely. Teenagers are confined to bed after the baby is born. In section four, I show how some families take care of HIV-positive teenagers *as well as* their new babies. Families play a crucial role in supporting new teenage mothers and caring for newborns. I argue that, when families help new teenage mothers, families share the burden of a multifaceted stigma linked to HIV, teenage pregnancy, and teenage motherhood (section five).

Section 1. Familial care

Some teenagers can rely on their mothers to take care of new babies. This intergenerational care is observed in other parts of South Africa (Bray et al., 2010:124; Chohan & Langa, 2011; Dubb, 1974; Jewkes et al., 2009; Josephine, 2019; Marwick, 1978; Nkani, 2012; Pauw, 1963; Preston-Whyte et al., 1990:14; Varga, 1998:11; Zabin, 1993) and other parts of the world (Arensen, 1994; Clemmens, 2003; Smithbattle, 1995; Smithbattle, 1996; Smithbattle, 1998). Some scholars found that families take care of new babies so teenagers can return to school or find employment (Chohan & Langa, 2011; Mkhwanazi, 2010; Mkhwanazi, 2014b; Morrell et al., 2012; Ngabaza, 2011; Nkani, 2012). Sometimes, I argue, families must help with new babies just so (new) young mothers can cope. This requires adjustment and sacrifice based on each family's respective situation. The anecdotes below illustrate this.

My mother is coming from Bloemfontein. She stays with us. She helps me with the baby, teaching me. She will leave after two weeks. She must work. (Lerato, 2019)

I started working in the factory. My mother stays with the baby in the house. She is older and she cannot work in the factory. (Nthabiseng, 2019)

My grandmother helps with the baby sometimes. But when the baby is crying, then I must do it. I can't sleep. My grandmother says I'm lazy. And I must do the nappies. But sometimes she helps, and my sister too. I live with my grandparents since my father died. I miss him too much, but I see him in my dreams. (Kananelo, 2019)

My mother is sleeping with the child. She feeds the child. I am too weak. My brother helps too. But not when he has school or homework. And my grandmother helps when she comes to visit. But she is old. She comes from Lesotho. They love my baby so much. I see how my family cares. (Bohlale, 2019)

I came to stay with my mom when I gave birth. I live in Welkom with my boyfriend. But I see my mother when I come to (Robedi section) clinic for (ARV) treatment. And now, when I gave birth. My mother helps me. But what we need are Pampers or Huggies. He (the baby boy) is seven weeks but he is a

> little bit big. He's not taking size seven weeks Pampers. So, 0-3 months will be fine. Also, for Huggies, he wears size 2, size 3 or 4 for the newborn. (Dineo, 2019)

After Lerato's baby was born, Lerato's mother temporarily took time off work. Nthabiseng's mother also stopped working so she could take of the new baby. The elderly woman traded retirement for childcare. Nthabiseng started working in one of Botshabelo's factories to maintain the household income. Kananelo had help from her grandmother and older sister. Her grandmother is a pastor, and takes days off work to help with the baby. Kananelo is an orphan. Both her parents passed away after contracting tuberculosis. She tells me that she misses her father terribly, although she connects with him in her dreams. Like Kananelo's grandmother, Bohlale's mother is also a pastor. Her mother takes time off, from the church, so she can look after Bohlale's baby. Other family members – her seventeen-year-old brother and her maternal grandmother - also help with childcare. Because of her HIV and relentless opportunistic infections, Bohlale spends most of her time resting in bed. Like Bohlale's mother, Dineo's mother takes care of Dineo and the new baby. During fieldwork, Dineo had just given birth to her third child. She has had three Caesarean deliveries. She is HIV-positive. Her mother feeds, bathes, and entertains the baby while Dineo heals. After each childbirth experience, Dineo has spent almost three months at her mother's house. What Dineo suggests here is that she needs help acquiring material goods: diapers for the newborn. She seems to have enough emotional and childcare support from her mother.

In the anecdotes below, teenagers highlight reasons why their families help with childcare. Many teenagers mentioned their mothers:

> My sister and my mom help me, because my sister has her own babies so she knows things. Or it's because they love me, or because God says to help your neighbour and family. They care for me, and my baby. (Mahlony, 2019)

> My mom helps me because she loves me. She was angry about the pregnancy at first, but now, she helps me too much. I know she will help when the baby comes. (Seipati, 2019)

> My mother, she helps me with every baby. Now, this is my third child. Every time I come to live with my mother. Because the newborn is a lot of work. But I love it. And my mother loves my babies. (Dineo, 2019)

Mahlony suggests that her mother and sister help with childcare because they teach her what she does not know, and they love her. She also alludes to a faith-based motivation for familial care: helping others is what God prescribes. Mahlony is the only teenager who invoked religion in these childcare-related discussions. Like Mahlony, Seipati and Dineo suggest that their mothers help with childcare because they love their daughters and their daughters' babies. At this time, Seipati was in the final trimester of her pregnancy. Dineo's baby was two months old.

Although their families help, some teenage mothers are the primary caregivers for their babies. These teenagers prioritise childcare. They learn about parenting from mothers, sisters, or grandmothers. Thereafter, families step in if and when they are needed. Mahlony highlights this above. Her sister, and mother, help with childcare by teaching Mahlony 'how' to take care of her baby.

It is important to note that familial care is not always guaranteed. This support may only be granted over time. Other work in South Africa echoes this (Kaufman et al 2001:158, Preston-Whyte, 1993:64; Preston-Whyte et al., 1990; Varga 1998:109). In Botshabelo, some parents may be 'too' disappointed in, or angry with, their teenage daughters. Seipati describes this above. Many parents may not initially accept teenage pregnancy. By the time babies are born, however, many parents adjust and accept teenage motherhood. Most families go to great lengths to accommodate new babies.

These anecdotes offer quite profound reasons why some teenagers' mothers take care of new babies: love, empathy, self-sacrifice. It seems that these profound reasons are bundled with practical or pragmatic reasons. Many teenagers cannot 'learn mothering' on their own. Furthermore, these anecdotes highlight that familial care requires on-going negotiation. After a baby is born, many families must redistribute their resources so they can accommodate new babies, and help with childcare. For some families, helping with childcare means reorganising who works in a household and who stays at home. Most families work hard to achieve balance here. I argue that the ability to provide familial care is closely linked to the household's economy. That is, whether the household can survive with less money *and* a new mouth to feed.

In some cases, familial care may be a question of affordability. Some families may want to help teenagers with childcare, but they cannot afford to do this. Not all households can sacrifice employment, even if they want to. In Botshabelo, teenage motherhood is set against a backdrop of unemployment and poverty.

Fiona Ross (2010) has explored social relationships and household formation in Cape Town's settlements.

> …incomes may not be equally distributed within households and women's coping strategies in such contexts link people in relationships across household boundaries. Their work demonstrates that 'the household' is both a porous construct and one that disguises diverse and often conflict-filled relationships. (Ross, 2010:90)

What Ross describes here agrees with other research in South Africa. Based on his work in the Eastern Cape, Zolani Ngwane (2003) found that the making of a household is a continuous process that usually arises from conflict and compromise among families (Ngwane, 2003:688). 'The household' is a fluid concept and a goal toward which families relentlessly strive. This is also true in Botshabelo. More specifically, there are shifting contradictions embodied in 'the household'. The household is a site of tension in so far as this is a place for verbal disagreements (most often between pregnant teenagers and their mothers) about key sources of value (education, unemployment, marriage) and how teenage pregnancy has endangered these. Yet the household is also a place of refuge wherein pregnant teenagers can 'hide' from public

scrutiny and witches. This illustrates the ever-shifting nature that is the making of a household (Ngwane, 2003:635).

I think it is deeply significant that the process of "householding" (Ross, 2010:90) is taken on by women who are both carers and providers in Botshabelo. The way women cope with and safeguard household dynamics is a social project in so far as both coping and guarding relies on women's relationships with each other and their communities. This is true for older women (teenagers' mothers and grandmothers) as well as young women (pregnant teenagers and young mothers). This social project demonstrates fluidity and adaptiveness in the household. Indeed, the household (and the relationships it encapsulates) survives the scandal that is teenage pregnancy and later celebrates the joy that is welcoming a new baby.

Section 2. Returning to school

In some situations, a teenager's mother must stop working so she can take care of a new baby at home. I argue that some teenagers are only able to return to school with this kind of support and help from their families. I explain this below.

Sibongile is sixteen years old and lives with her mother, step-father, and two siblings in a one-bedroom shelter in Hlano section. When Sibongile's baby was born, Sibongile's mother stopped working. This was a huge decision for Sibongile's family. Almost three in every four people (76%) is unemployed in the Free State province (Free State Department of Health, 2014). In Botshabelo, the unemployment statistics are at least equal to this. I argue that sacrificing a job

in this context is a deeply meaningful response to teenage motherhood. This is how Sibongile made sense of her mother's sacrifice:

> …my mother will leave work, and take care of the baby. There is no one else. So, my mother will stop her work. My step-father still works. They have talked about it. They decided. (Sibongile, 2019)

Sibongile's mother worked as a cleaner in a government building in Bloemfontein. Sibongile was not included in the discussion about her mother's employment. Sibongile's mother and step-father made this decision. This was a necessary sacrifice so that the teenager could return to school. Yet this sacrifice is not only a hallmark of care and support for the teenager, and her baby. I argue that this sacrifice is also a means to a better end for Sibongile, and her family.

Sibongile aspires to be a medical doctor. She knew she needed to finish high school before applying to medical school. Sibongile's mother also desires that her daughter will become a doctor. It seems that Sibongile's career ambitions, and her mother's hopes, are rolled into one. Her education is worth the family's sacrifice. Sibongile said:

> My mother is very happy that I will be a doctor. My boyfriend will be one too. We will attend medical school together. … My mother will help me, and take care of the baby. (Sibongile, 2019)

Sibongile's future career is a rising tide that can lift her family. Just the possibility of having a qualified professional in the family is worth sacrificing her mother's employment. This sacrifice is for the good of the group (her family and her baby) and the individual (Sibongile). Even if she wanted to, Sibongile could not change her mind about applying to medical school. Becoming a doctor is the best (and perhaps only) way she can repay her family for their sacrifice. In some ways, when her mother stopped working, this was an investment in Sibongile's future, not just a requirement for it.

The welfare grant that Sibongile will claim for her baby will partly make up for the wages her mother has sacrificed. In South Africa, teenage mothers are eligible to receive a "child support grant" from the government to offset at least some financial strain (Panday et al., 2009; Hodes, Toska & Gittings, 2016; Vale, Hodes, Cluver & Thabeng, 2017). A child support grant brings ZAR400.00 into a household each month. This converts to approximately GBP17.00 or USD21.00.[9] In many cases, this grant is a teenage mother's only income. She and her baby must survive on this money, and any funds that her parents can spare. Grant income is essential for Sibongile's family. Five people - Sibongile, her mother, her step-father, and two younger siblings - live in a one-bedroom shelter in Hlano section. Her family is one of the poorest I encountered. After the baby was born, the family had to learn to survive on less. Sibongile told me that her family relied on her welfare grant and her step-fathers' weekly wages. Sibongile did not disclose her family's total income (Table 2).

[9] Currency conversions were calculated using www.exchangerates.org.uk.

Importantly, sacrificing employment was also a practical decision. How else could Sibongile finish high school? For some teenagers, like Sibongile, familial care is (at least partly) born out of necessity. Sibongile's mother needed to step in – take care of and parent the new baby - so Sibongile could return to school.

In some ways, Sibongile and her mother were trying to make the best of their situation. Sibongile's mother did not only help with childcare. She also helped to negotiate school attendance. During her pregnancy, Sibongile and her mother met with the school's principal. They agreed that Sibongile could attend school, during her pregnancy, and take time off for the baby's birth. She was scheduled to have a Cesarean delivery with no epidural medications, like most teenagers do in Botshabelo. She planned to miss ten days of school for this. As per these plans, Sibongile attended school throughout her pregnancy. Even when it was challenging to walk on swollen ankles, she was still going to class every day. When it was time, she took ten days off school for the delivery, as planned. Sibongile gave birth to a beautiful baby boy in June 2019. By the time I saw her two months later, she had been back at school for a while. Her mother had resigned from her job in Bloemfontein in order to take care of the new baby at home.

Sibongile's impressive 'back-to-school' attitude in and of itself was not enough to actualise these ambitious plans. She also needed strong support from her family – especially from her mother. In some ways, I argue that Sibongile was only able to return to school with support from her mother. This support was two-fold. First, her mother helped Sibongile "make

arrangements" to attend school during and after pregnancy (Sibongile, 2019). Second, her mother agreed to look after the baby at home so Sibongile could finish school. Sibongile said:

> This baby is a mistake. I want to be a doctor. My mom will help me… I am strong enough. I can go back to school. (Sibongile, 2019)

After the baby was born, Sibongile likely spent most of her time at school, or studying at home. Her mother took care of the baby. I knew this was true when I saw Sibongile with her newborn during our final meeting at Hlano clinic. Sibongile was awkward and clumsy around the baby as if she was unaccustomed to holding him. When the baby regurgitated milk, Sibongile almost dropped the child in her haste to get a towel. This happened more than once. It seemed as though that was the first time Sibongile was alone with the child.

What Sibongile describes is a shift in the responsibility of (child)care when teenagers return to school. When teenagers return to school, their babies are in the care of teenagers' mothers. In some sense, care has been transferred in a fluid exchange. It seems that this exchange is reversible and in constant flux. Care might suddenly revert back to teenagers when they attend clinic appointments (as Sibongile demonstrates above), during school holidays, or when their mothers return to their jobs.

Patricia Henderson (2012) has explored care based on her ethnographic work in KwaZulu-Natal.

> …instead of care being held consistently by individuals, it is shared or passed on to others. In a context of scarcity and dispersal, there may be conflicting claims to care … The passing on of care from one to another is also not necessarily smooth. … Care, therefore, may be thought of as malleable, mobile and migratory in echoing people's lived trajectories, and in constituting ongoing processes of exchange. (Henderson, 2012:19)

The 'exchange of care' that Henderson describes here might be motivated by "intergenerational reciprocity" (Henderson, 2012:12). Households cater to the needs of babies and children. Children learn "ways-of-being and forms of practical knowledge" from kin (Henderson, 2012:11). As these babies and children grow up, they contribute or 'give back' to the household. Children provide "material support" (Henderson, 2013:11) in the form of state grants especially if children adopt "orphan" identities (Meintjes & Giese, 2006:425). This is the case for Kananelo, an orphan who lives with her grandparents.

I think this notion - that children take from and give to a household – is salient for my work in Botshabelo. This notion provides further explanation as to why pregnant teenagers undergo rituals of repair, and why teenagers' mothers help with childcare. Pregnant teenagers were once babies in their households. They received care and, after taking from their households in this way, must 'repay' their families. Rituals of repair – antenatal care, acts of discretion, returning to school, learning good mothering – are ways for pregnant teenagers and young mothers to 'give back' to their households. These are also ways to repent for the catastrophe that is teenage pregnancy. This process of repair reinstates teenagers' mothers as caregivers and begins to

restore relationships with their teenage daughters. Teenagers' mothers are then able to a reciprocate by helping with childcare. Such is the continuous nature of "intergenerational reciprocity" in the household (Henderson, 2012:12). In Botshabelo, it seems that caring for new babies is a responsibility shared by teenage mothers and their families, especially their own mothers. As such, new babies are raised in and by a network of relatives. This agrees with other studies in South Africa. Helen Meintjes, Katharine Hall and Winnie Sambu (2009) explored the lives of children and orphans in South Africa. They found that these children usually receive care from "kinship networks" (Meintjes et al., 2009:105). The researchers found that family members "play a substantial role in child-rearing" (Meintjes et al., 2009:103).

Redemption plays an important role in the process of repair. In the anecdote below, Seipati talks about returning to school as a form of redemption, a way to "right her wrongs." She talks about "working hard" so she can once again "respect" her teachers. Reciprocally, she also hopes to earn their respect.

> When I was at school doing Grade 10, I worked very very hard. But Grade 11, the laziness came in. I started to disrespect teachers because everyone else was doing this. Then in Grade 12, I wanted to change because teachers were all telling me I am not going anywhere in life. I wanted to change that. I wanted to respect them again, and show them that there is a lot of things that I came here to do. There are other teenagers now in Grade 10 who believe: "I am not going anywhere so I don't have to do this." I will show them (the teachers) when I am a soldier. I will go to Grade 12 and just tell them: "Ha!" Even at school, I will

> go visit them, and say: "Hey - you must come and check me!" … …My mom will take care of the baby. She is my hero. … Then I can finish school. … I want to be a soldier in the army. I will be brave, and make lots of money for my baby. (Seipati, 2019)

Seipati is nineteen years old and lives with her mother, grandmother, great grandmother, and four siblings in an RDP home in Hlano section. Her anecdote is very telling. She suggests that teenage pregnancy is a form of disrespect to one's elders (the matriarchs in her household) and moral guardians (her teachers). By finishing school and becoming a soldier, she can repay her family and provide for her baby. Returning to school is also a way for Seipati to redeem herself and in turn redeem her moral guardians. This sense of redemption reiterates Nolwazi Mkhwanazi's aforementioned argument that regretful teenagers work hard to "suture" social relationships that teenage pregnancy has torn apart (Mkhwanazi, 2014a:116).

Although Seipati planned to take a year off school to be at home with her baby, she is determined to eventually finish her schooling. She seems determined to prove to her teachers – and perhaps also to her community – that she has made something of her life. That is, she aims to layer a mark of success (becoming a soldier) over a mark of failure (teenage pregnancy). She told me that her mother promised to take care of the new baby. The act of caring is fluid in most households, and shared by teenagers and their mothers. I will further explore ideas around 'care' and 'households' later on, in the chapter on **Familial care.** Seipati would thus be able to resume her schooling in a year or two. For Seipati, achieving success is largely possible because of her mother's support. Her mother encourages and enables Seipati's aspirations.

Based on our other conversations, I know that Seipati wants to finish school - and become a soldier - so she can give her baby a stable financial future. Other teenagers echo this. They aim to finish schooling so they can provide for babies. This was the case for Masoso.

> I was on a gap year, but I will go back to school. … I think that education is the only thing that will make me a better person. It is the key to success. … I can forget about my partner and my sister when I am fully educated. They are supportless. … I can support my child with all needs. (Masoso, 2018)

In the anecdote above, Masoso explains that she took a "gap year" during her pregnancy. This is an underlying commentary on the social function of a 'gap year' – traditionally defined as a year between the end of high school and the beginning of university, although this definition is now changing. Discussions about 'taking a gap year' are usually to be had among elite and middle-class families in South Africa. These students choose to take a year off school so they might work, do research, complete internships, travel, or achieve some level of self-development (Coetzee & Bester, 2009; Rabie & Naidoo, 2016). That is, a gap year is a choice that these families can afford. In this anecdote, Masoso reframes the term 'gap year' in an entirely new light. As is the case for most other pregnant teenagers, Masoso's time away from school was more an ultimatum more than a choice. That is, her school principial said that she was 'not allowed' to attend school during pregnancy. However, by reframing this administrative decision as her own choice, Masoso retains some shred of agency. Instead of saying she was temporarily expelled from school, she implies that she *chose* to take time away from school.

Furthermore, Masoso could not rely on her family to help with childcare. Both her parents have passed away. Her boyfriend ("partner") and sister are "supportless". I find this word to be extremely meaningful: it conveys a deep sense of despair and loneliness. Finishing her education will not only alleviate this loneliness, but it will also "make her a better person" (Masoso, 2018). Masoso talks about her education like it is her salvation. Gaining an education will help Masoso transcend her poverty, and take care of her baby in the long-term. Indeed, all she has is her baby.

Like Masoso, Kananelo values education. Yet Kananelo is mischievous, carefree and playful. She often made jokes during our conversations, or told me funny stories about her family. I therefore found it deeply meaningful that she is planning a future for herself and her baby. Kananelo says that completing her education – and pursuing architecture - is one way to take care of her baby. During one of our afternoons together, Kananelo showed me her architectural sketch for a shopping mall (Figure 7). She explained:

> I want to be an architect. I will go back to school so I can provide for my son. I want to give him everything. I want to take care of him. (Kananelo, 2019)



Figure 7. Kananelo explains her architectural sketch for a shopping mall.

Source: Moodley, S. 2019.

Kananelo practices her design skills even though she is not in the classroom. She tells me that when it is eventually possible for her to return to school, she will be ready. Kananelo must wait until her child starts school. In the meantime, she must take care of her baby at home.

Based on their mixed-methods work in the Western Cape, Rachel Bray and colleagues (2010) explored what it might mean when young people talk about becoming doctors and architects. These aspirations are voiced in a context of poverty and poor education outcomes. The scholars considered how young people actualise these aspirations across three dramatically different social worlds: Masiphumelele, Fish Hoek, and Ocean View. That is, the way young people idealistically 'dream' or realistically 'plan' for their careers as doctors, lawyers, and architects:

> …the expression of ambitious aspirations is reflective of, and responsive to, certain discourses that frame education and the transition to adulthood, and that personal expectations may not cohere with these discourses and, indeed, may be masked by them. (Bray et al., 2010:220)

Young people in the wealthier Fish Hoek community had tangible ways and means to get to university. They emulated professionals or role models in their social networks. By comparison, students in the poorer Masiphumelele and Ocean View communities did not always know 'how' to actualise their aspirations. Many individuals talked about only "studying hard" as a means to "become someone" (Bray et al., 2010:220). This literature echoes some teenagers' experiences in Botshabelo. While some teenagers can only 'dream,' other teenagers can 'dream' *and plan.* Kananelo, for example, aspires to be an architect, unlike anyone else in her family or

community. She has few, if any, people in her network that work in architecture or design. Practicing her design skills is a way for her to 'dream'. By comparison, Sibongile 'dreams' of being a doctor, and she 'plans' to do this by finishing high school. One of her family members is a doctor. That is, Sibongile has a role model in her network. Like Sibongile, Seipati also has a role model. Her cousin is a soldier, and inspired Seipati's plan to join the army. For many teenagers, having role models (to emulate) can distinguish dreams from plans.

In this context of 'dreams' and 'plans,' I think it is interesting to consider how these young women retain such a stubborn optimism despite falling job prospects, and the rising number of unemployed people with graduate degrees. In 2012, unemployment rates in South Africa increased more quickly for university graduates than those with less education (Baldry, 2016:791). Ariane De Lannoy (2005, 2007a, 2007b) worked with eight young adults living in various urban settlements around Cape Town. As was the case with my work in Botshabelo, De Lannoy found that only a few of the young adults in her study had familial role models to emulate (De Lannoy, 2007b:16-17). Moreover, her qualitative work explored the strong belief in education, as described by these young people, despite a lack of guidance and overwhelming sense of social and economic "fragility" (De Lannoy, 2007b:13). This definition of "fragility" builds on Patricia Henderson's (1999:163) earlier theoretical work on this subject.

De Lannoy found that "dreams" and "hopes" are important motivators for future success (De Lannoy, 2007b:14; Ramphele, 2002). That is, most of the young adults in her study express an unwavering belief in the value of education (De Lannoy, 2007b:25). Sometimes, however, their dreams must morph into "in-between" versions of original aspirations due to fragile

circumstances (De Lannoy, 2007b:45). Despite this, some young adults continue to reach for their dreams because they want to "give back" to loved ones, and demonstrate to elders "that even someone out of … 'the cursed generation' can make it" (De Lannoy, 200b7:23-24). This agrees with my work in Botshabelo. The 'big dreams' for which pregnant teenagers and young mothers strive are often articulated in their families' expectations for success. Seipati's aforementioned anecdote describes the teenager's wish to become a soldier and then share this achievement with her community. Her anecdote illustrates a tenacious drive to obtain success in order to 'give back' to her family (repay her mother's support, take care of her baby) and prove her elders (her teachers) wrong.

Section 3. Childcare and schooling

Like Masoso and Kananelo, some teenagers must take care of their babies during the day. Their families cannot help with childcare. These teenagers cannot return to school. This was the case for Maipato. She lives with her mother and step-father in Robedi section. Maipato planned to return to school in April 2019, after she gave birth. Her mother would stay at home with the new baby.

> One month after the baby comes, then I will go back to school. It will be April, and the new (school) term will be starting. They (the school) agreed. And my mother agreed. She will stay at home. (Maipato, 2019)

Maipato gave birth to a beautiful baby girl in March 2019. When I saw Maipato a month later, she told me that her mother did not stop work. Her family depended too heavily on her mother's wages.

> I am at home to take care of the baby. I have to. My mother must work. … She (the baby girl) is the reason I cannot go to school. (Maipato, 2019)

During the first few weeks after the baby's birth, Maipato seemed deflated and despondent. She told me she was missing school because she was "forced" to. Given a choice, she would not choose her baby over her education. As a result, Maipato seemed to blame her baby girl for her hiatus: "She is the reason I cannot go to school," Maipato told me. Her childcare reflected this attitude. Maipato did not worry about her baby's health the way other teenagers did. Maipato is HIV-positive. Her baby girl was born HIV-positive. I met Maipato's daughter when was she just eighteen days old. Maipato allowed me to hold her baby: she felt tiny, and fragile. A few weeks later, the baby tested HIV-negative. Maipato did not really talk about her baby's seroconverting. Maipato seemed indifferent. Furthermore, on more than one occasion, I saw Maipato use a dirty, damp cloth to wipe the baby's face rash. I wondered about opportunistic infections. By comparison, a few months later, Maipato was considerably more conscientious about childcare. By this time, her educational aspirations were re-invigorated. This seemed to positively influence her relationship with her baby.

> I want to be a paramedic. My mother says I can go back to school when the baby starts crèche. Then I can achieve my dreams. (Maipato, 2019)

Maipato plans to resume Grade 12 in 2020 or 2021. By that time, her child will be in crèche. The fact that Maipato will not be forced to take care of her baby is actually improving her relationship with her child. During our last few visits, I saw the baby in clean clothes, and a clean beanie. Maipato carried the child close to her body, on her back. She checked on her baby often, even while the baby slept. Both mother and baby looked happy and nourished. The teenage mother once again made me giggle with her side quips and jokes.

It was not viable for Maipato to return to school after her daughter was born. One reason for this is her family's socio-economic status – their poverty. This reiterates my argument that the ability to provide familial care is closely linked to a household's economy. Maipato lives with her mother and step-father in a two-bedroom RDP home in Hlano section. The kitchen chairs have no backs. The floor is polished with a mixture of dirt, newspaper clippings, glue, and plastic sheets. There are no electrical appliances in the kitchen. Two family members work in the house: her mother and her step-father. Maipato's step-father works in Bloemfontein. His wages are unreliable because he has an alcohol addiction. The family depends on the mother's wages. For this reason, Maipato's mother could not stop work to take care of the new baby. Maipato was the only one who could do this. In lieu of direct childcare, Maipato's mother pays for nappies, baby formula, and baby clothes.

Like Maipato's family, there are many impoverished families in this social world. Even before the baby is born, many families must make ends meet in a climate of unemployment. After the baby is born, those who have jobs must work hard to keep them. Job opportunities are scarce,

and thus extremely valuable. It makes more sense for an unemployed teenager to take care of a new baby at home. Already-employed family members must continue working to balance household economies. In some families, those who would be able - or even willing - to care for a teenager's baby must work so that the household has money.

Poverty is not always to blame for incomplete schooling. There are some families who manage to stretch the household budget after a baby is born. Sibongile's family, for example, learned to make do without her mother's income, and with a new baby to feed. A child support grant seemed to help their limited budget.

When families cannot sacrifice income, some young mothers must rely on extended relatives or (unemployed) pensioners to help with childcare. Metsi explains this. She discovered she was pregnant when she was nineteen years old, during her first year at the University of the Free State in Bloemfontein. She was pursuing a Bachelor's degree in criminology. When she found out she was pregnant, she stopped going to school. By the time her baby was born, Metsi was twenty years old.

> I did not want people to see my pregnancy on campus. And I needed money for my (tuition) fees. So, I worked at a telecommunications company in Bloemfontein. … After she (the baby) was born, I went back (to university). … Finishing a degree is the best way I can provide a future for my baby. My mother-in-law helps me do this. (Metsi, 2018)

After Metsi's baby was born, her (future) mother-in-law agreed to take care of the child. Because of this, and her telecommunications work, Metsi resumed her university studies. Her fiancé's mother is an unemployed pensioner. Metsi could resume her schooling largely because her mother-in-law helped with childcare. Metsi could not have completed her degree without this help. This is another aspect of my argument that some teenagers are *only* able to return to school with support and help from their families. While Metsi remains close to her own mother and several sisters, they could not take care of the baby. Metsi's mother and sisters work during the day. At night, her mother attends to Metsi's youngest sister who is in primary school. By comparison, Metsi's mother-in-law does not work or take care of school-going children.

Despite the very real challenges of childcare, this does not always prohibit schooling. Some teenagers find ways to do both: childcare and schooling. This was the case for Lerato. She lives with her grandfather in Hlano section. In the first few weeks after her baby was born, her mother moved from Bloemfontein to Botshabelo to help Lerato take care of the newborn. After her mother returned to Bloemfontein, Lerato started night school. She takes care of her baby in the daytime, and attends school at night. One of the most popular night-schools for adults in the township is the Professional Adult School.[10] Going to night school, in a township section far from her home, ensures anonymity. No one knows Lerato in her new school. Few see her leave her home, because she goes to school in the dark.

> I am back at school. I work hard. One day, I want to study nursing. I will make my grandfather proud. (Lerato, 2019)

[10] This school name has been anonymised to protect Lerato's identity.

The opportunity to finish her education - and pursue her career goals – seemed to reinstate Lerato's self-confidence. I realised this when I compared our first meeting to our last one. The first time I met Lerato she clumsily stumbled into the room, slipping in her sandals. She had just given birth. Her baby boy was just eleven days old. He was born HIV-positive like his mother, but he seroconverted a few weeks later. He is now HIV-negative.

I think it is important to understand how and why seroconverting takes place, and what this means for HIV-positive mothers. I reference clinical information (AVERT, 2020f; Chi et al., 2020; WHO, 2015:38) to shed some light on the seroconversion process. A baby born to an HIV-positive mother is given HIV medications (ARVs usually in the form of a syrup) soon after birth, whether the baby has HIV or not. At the earliest postnatal appointment, the baby will be tested for HIV. If the baby is HIV-positive, the baby should continue taking the ARVs. If the baby has an HIV-negative test, no treatment is necessary. If a baby who initially tested HIV-positive has an HIV-negative test at a subsequent appointment, then the ARVs can be stopped. The baby's HIV status has seroconverted. Both seroconverted and HIV-negative babies should be tested again at eighteen months old and/or when mothers stop breastfeeding in order to confirm an HIV-negative diagnosis. HIV-positive pregnant women who adhere to ARVs greatly reduce the risk of infecting their babies. In some ways, the proof of diligent ARV adherence is an HIV-negative baby. That is, an HIV-positive teenager who gives birth to an HIV-positive baby is blamed for infecting her 'innocent' baby because she did not take her ARVs. I think this is one reason why teenagers' mothers insist on antenatal care, which includes ARV care.

During this initial meeting, Lerato and I talked about breastfeeding:

> I don't have breastmilk. There is nothing. There is no food at home. … I eat cabbage and maize. (Lerato, 2019)

The teenage mother hardly made eye contact with me. She was shy, and quiet. She did not smile once. She had come to the interview because she wanted nutritional advice. Her meals were rationed. Cabbage and maize were all the household could afford. In addition to poor nutrition, giving birth to her baby aggravated her HIV. Her body was weak. By comparison, in our final meeting, she seemed totally different. She was chatty and gregarious. We chatted about her boyfriend, night school, her grandfather, and her baby. She wore sensible shoes. Her new shaved haircut was fashionable. She exuded confidence. She was organised and prepared: she carried all her baby's accessories in a neat black handbag. She smiled contentedly throughout our entire meeting, rocking comfortably in her seat. Her baby boy sat in her lap. He played with the KitKat chocolate I had given his mother. Mother and baby giggled at each other. Lerato picked up the chocolate each time the child playfully threw it on the ground.

Section 4. Childcare and HIV

For some teenagers, HIV – and not necessarily childcare or familial support – limits schooling. This was the case for Bohlale. Bohlale had tried to resume her schooling after her pregnancy. She started at a new school intended for students who wanted to finish Grade 12. After giving

birth to her baby, however, she was terribly frail and weak. Bohlale is HIV-positive. Childbirth, and the final months of her teenage pregnancy, had aggravated her HIV. I met Bohlale after her baby was born. For the duration of my fieldwork, I often spoke to her in or around her bedroom. She was not able to return to school. Indeed, she was not well enough to take care of her baby boy.

On a rare occasion, Bohlale and I were sitting on her veranda. At the time, her baby was four months old. He was HIV-negative, and delightfully chubby. Bohlale's cousins were visiting from Lesotho. They were on holiday. A small group – her younger brother, three adult cousins, and two toddlers – were sitting in the TV room watching cartoons. The bright animated characters seemed to distract the toddlers from the sweltering midday heat. I could see Bohlale's family through the doorway. They took care of Bohlale's baby, feeding the baby sweet ProNutro porridge. After an hour, her younger brother brought her baby to the veranda. He was looking for the baby's teething toy. Bohlale merely glanced at the child, never pausing her flow of words. She did not reach out for the baby, or make any effort to interact with him. I did not want her brother to feel uncomfortable because of this. I smiled at her brother, and asked to carry the baby. He obliged. When I held Bohlale's baby, the small group kept a close eye on me – with a smile. Her family was adorably attentive to the child. Bohlale said:

> They take care of my baby. They show me they accept me and what I did. (Bohlale, 2019)

Some families take care of HIV-positive teenagers *as well as* their new babies. This was the case for Bohlale. In some ways, her family supports her by loving, and protecting, her baby. This familial care shows Bohlale that her family accepts the past (her teenage pregnancy, her HIV) and embraces the present (her baby). Familial care – the way some teenagers' families take care of teenagers' babies – is an important part of teenage motherhood. For Bohlale, a teenage mother who cannot attend school or look after her baby, familial care is vital.

Section 5. Stigma

In most cases, familial care can improve teenagers' experiences with mothering (Chohan & Langa, 2011; Mkhwanazi, 2014b; Morrell et al., 2012a). In some cases, however, familial care can exacerbate teenagers' challenges. In the South African context, some scholars have found that there is social shame when a teenage mother returns to school and abandons her baby at home (Bhana et al., 2008; Bhana et al., 2010). Some teenagers try to change schools to avoid this shame, and its respective stigma (Mkhwanazi 2014b:1090). In Botshabelo, this was the case for Lerato. She started night school, in a township section far from her home, to avoid being seen. This was also the case for Lebo and Seipati:

> The baby was an obstacle. I had to take a gap year. I can't leave my baby at home. But now my child will grow up well and be strong and have strong bones. (Lebo, 2019)

> I am not going to school this year. I want to be there for my child, and take care of my child. … I know she (Seipati's mother) will help when the baby comes. (Seipati, 2019)

Lebo lives with her sister and mother in Robedi section. She suggests that having a baby limited her education. She "had to" sacrifice one year of education because she was at home with her baby (Lebo, 2019). Yet, taking care of her baby was the lesser of two evils: she could not stomach her community's judgement if she left her baby at home and returned to school. Like Lebo, Seipati takes care of her baby at home - even though her mother could help with childcare. It seemed that Seipati chose childcare over education in order to avoid the shame of 'abandoning' her baby. She also talked about protecting and loving her baby. Seipati had asked her mother to teach her about bathing, clothing, and feeding the new baby. A few weeks after the birth, Seipati took care of the baby at home. Her mother continued working in one of the township's factories. Seipati's experience highlights that prioritising childcare is not only about avoiding shame. Some teenagers want to care for their babies, in earnest.

I found that, in this social world, most teenage mothers must endure multiple stigmas. Chief among these are stigmas related to: teenage pregnancy, teenage mothering, and (for some teenagers) HIV. The latter – HIV-related stigma – can be more easily mitigated. A teenager's HIV status is usually kept confidential, hidden by ARVs. When her community is often unaware of it, they cannot discriminate against her. The former - stigmas related to teenage pregnancy and motherhood – are more pernicious. They cannot be hidden as easily. All three stigmas seem to morph into a multifaceted stigma. This collective, compounded stigma grows as the baby

does. Each month, the punishing discourse becomes more pointed. This multifaceted stigma reaches its height during the advanced stages of pregnancy.

After a baby is born, this multifaceted stigma seems to decrease. This is largely because of familial care. That is, the way some families adapt to new babies. Families not only share the burden of childcare. I argue that families also share the burden of this multifaceted stigma. When a teenager's family is taking care of her new baby inside the house, a teenager can more freely negotiate the world outside her house. To this outside world, she appears to be a 'teenager' - and not a 'teenage mother'. Her baby, unlike her pregnancy, is not physically attached to her social identity. Outside the house, she can temporarily strip away – or obscure - the 'mothering' layer of her "intersectional" identity (Butler, 1986; Collins, 2000; Crenshaw, 1989; McCall, 2005; Nash, 2008; Nash, 2016). As a result, some teenagers may experience less stigma, or punishment. Such is the power of familial care and support.

My empirical findings are consistent with some of the literature. Nthabiseng Motjelebe (2009) worked with a small group of teenage mothers and their babies in Botshabelo. She suggests that teenage mothers have diverse forms of social support from family as well as the church, friends and neighbors (Motjelebe, 2009:23-30). Consistent with Motjelebe's findings, I observed that many teenagers receive (familial) support *after the baby is born*. These findings seem to contradict some of the South African literature suggesting that teenage mothers do not receive adequate support in their communities (Philip & Straunars, 1991:103-107; Hofmeyer, 1996:364, Mkhwanazi, 2014c; Nkani, 2012; Ngabaza & Shefer, 2013).

What this multifaceted changing stigma highlights is the reality that many of these young women find themselves in a bind. If they stay away from school then they cannot get the education that will garner them jobs, respect and status. If they go to school then they are admonished for having a baby and disappointing their families. Going to school (being visible in public) flaunts pregnancy instead of hiding it. Hiding pregnancy is a way to show shame and deference. In the next chapter I will argue that teenagers who go to school are scolded by their communities, because they are seen as neglectful mothers. The punishing discourse linked to teenage pregnancy surely exacerbates the strain of being in this bind as a young mother. Yet teenagers must reconcile all of this while they make meaning of the social expectations that community members reiterate. Teenagers must provide 'good care' for their babies, a combination of money, nurturing, health, and time. It seems to me that these young mothers are trying (and expected) to be both providers and carers.

Chapter summary

This chapter describes life for new mothers and their families after child birth. In the presence of a new baby, many household economies shift. Some families work hard to include new babies, and teenage mothers. As a result, the stigma linked to teenage pregnancy seems to weaken or subside to an extent. Punishment gives way to a more measured rejoining of life for mother and baby. Some families sacrifice employment to stay at home with new babies. This kind of familial care enables some teenagers to return to school. In this sense, the role families play is crucial for teenage mothers. Not all families are in a financial position to sacrifice employment. Some families cannot survive with reduced household incomes. Often, when

families cannot help with childcare, teenagers cannot resume schooling. There are some teenagers who find ways around this: they attend night school, and take care of babies during the day. Motherhood does not seem to dim educational and vocational aspirations. Furthermore, families who cannot sacrifice work find other ways to support their teenage daughters. Some parents pay for things new babies need. Even with help from their families, I argue that many teenagers find themselves in a bind between what is expected from them and what they can actually do.

VIII. Moving on: dimensions of teenage mothering

In some ways, a teenager's family has the power to (partly) shield her from a multifaceted stigma and punishing discourse in this social world. She can therefore move one step closer to being a good mother. In the preceding chapter, I explored how families respond to new babies in the house. I argued that many teenagers can only make meaning of teenage motherhood because their families help them do this. Despite their disappointment, some kin step in when and where new teenage mothers need help.

In this chapter, I explore what happens to young mothers – and the way they live their lives - after their babies are born. I ask: how do these mothers adapt to the presence of new babies? I argue that many of them strive to be 'good' mothers, in earnest. They achieve this by loving, connecting with, and protecting their babies. I explore this in section one of this chapter. In section two, I explore mother love. Some young mothers say that loving babies means giving them what they need, not what they want. In section three, I explore connection. Some young mothers talk about feeling deeply connected to and responsible for their babies. In section four, I explore protection. Some young mothers protect their babies by providing stability and security. These mothers try to make meaning of motherhood despite the physical limitations of HIV. I discuss this 'duality of HIV and motherhood' in section five. I suggest that some HIV-positive mothers strive for 'good' mothering by planning futures for their children. These mothers may be ill in the early years of their child's life and uncertain about whether they will be present for the child's future. I argue that this is why these mothers channel their mothering work into future plans. Choosing baby names is an important part of planning among HIV-positive and HIV-negative mothers. I argue that baby names can epitomise a young mother's

hopes for her baby's future. Finally, in section six, I argue that good mothering is a form of penance, a way for some young mothers to atone for the sin that is teenage pregnancy.

Section 1. Good mothers

Scholarship on the United States describes motherhood as a "sacred role" for women and teenage teenagers (Klerman, 1978).[11] Motherhood is greatly valued in this social context (Badinter, 1981; Gerson, 1985). Being a mother is a "pinnacle" many women and teenagers aim to reach (Cutright, 1973; Fischman, 1975; Sklar & Berkov, 1975). As in the United States, motherhood is deeply important to women and teenage teenagers in other societies. In Ghana and Australia, scholars posit that motherhood is a way for teenage teenagers to "prove maturity" and/or elevate social status (Gyesaw & Ankomah, 2013; Ngum Chi Watts et al., 2015:776). Based on conceptions of motherhood in South Africa, Cherryl Walker (1995) suggests that being a mother is a particularly important experience. In some ways, mothering is at the "core of a woman's identity" (Walker, 1995:418). Other scholars agree (Cooper, Harries, Myer, Orner, & Bracken, 2007; Mkhwanazi, 2014a; Mkhwanazi, 2014b; Ngabaza, 2011:275). This is also true for some teenage mothers in South Africa (Preston-Whyte & Zondi, 1989; Preston-Whyte et al., 1990; Preston-Whyte, 1994).

Elisabeth Badinter (1981) and Ramona Mercer (1985, 2004) have explored the 'good mother' trope based on work in France and the United States. A "good mother" is loving and nurturing

[11] Please see the **Introduction** chapter for further explanation as to why work in the United States is referenced in this study.

(Chess & Thomas, 1982; Mercer, 1985). She has a good relationship with her "happy" baby (Benedek, 1959). It is a good mother's job to understand her child's behaviour and "raise the next generation" (Coser, 1982:695). The 'good' mother trope is not only a social expectation, but also a comment on an individual's womanhood in her social context. That is, a woman can summit her social rank by achieving the status of a 'good' mother (Badinter, 1981). For some women, being a 'good' mother is everything that is "desirable and good" (Chess & Thomas, 1982:213).

Given this high regard for good mothers, there can be immense social pressure to perform this trope. Scholars in Brazil and the United States observe that some mothers strive to be "ordinary, devoted mothers" when good mothering feels too taxing (Erikson, 1950; Ruddick, 1980; Scheper-Hughes, 1993:359; Winnicott, 1987:16). Donald Winnicott (1987) explored the "good enough" mother archetype as one alternative to the good mother, in the United States. Other scholars agree here. Based on work in the United Kingdom, Tessa Baradon (2010) found that 'good enough' mothers, like 'good' mothers, "bestow on the baby a sense of having been protected and cared for" (2010:229).

As much as good mothering is a social expectation for a woman, it is also an important part of caring for a baby. Scholars have explored this in the United States (Clemmens, 2003; DeVito, 2010; SmithBattle, 1995; SmithBattle, 1996; SmithBattle, 1998:31) and South Africa (Erasmus, 1990; Fouche, 1992; Macleod, 1999b:3; Mkhwanazi, 2010:357; Mkhwanazi, 2014a:108; Preston-Whyte & Zondi, 1989:60). Babies have real care needs. They must be fed, changed, and bathed constantly. The ability to properly learn about, and attend to, these needs is a mark

of a ‘good’ mother. Teaching a baby discipline and acceptable behaviours is another important, albeit challenging, part of baby care.

Constantly striving to be ‘good’ mothers can make many women feel stress, guilt, or anxiety. In the United States, for example, some mothers report that they are ‘not good’ or just ‘average’ mothers (Bernard, 1974; Chess & Thomas, 1982; Chodorow, 1978; Rich, 1976; Rossi, 1977). Two factors that influence this ‘not good’ mothering may be age, and HIV status. That is, teenage mothers and/or HIV-positive mothers can be socially categorised – or stigmatised - as ‘not good’ mothers.

Based on scholarship in the South African context, some teenage mothers are considered ‘not good’ mothers largely because they have limited schooling, healthcare and or financial resources (Jewkes et al., 2001:743; Panday et al., 2009:6). That is, many teenagers are uneducated, unemployed and impoverished. This makes teenage mothers a “problem” group given their personal, emotional, and material needs (Kruger, 2006; Morrell et al., 2012a; Morrell, Bhana, & Shefer, 2012b). Furthermore, many teenage mothers do not always have stable partners who can share parenting burdens and responsibilities. This has been explored in many settings including the United States (Bunting & McAuley, 2004:207; Clemmens, 2003; Clifford & Brykczynski, 1999; DeVito, 2007:21; DeVito, 2010:30). In the South African context, scholars have explored the role young fathers play or abdicate during teenage motherhood, and the related issue of bridewealth (Bhana et al., 2010:880; Hunter, 2010; Kaufman et al., 2001; Leclerc-Madlala, 1999b:228; Preston-Whyte & Zondi, 1992; Preston-Whyte, 1994:243; Swartz & Bhana, 2009; Varga, 1998:11). Some boyfriends deny paternity,

and end relationships, when their teenage girlfriends fall pregnant (Mkhwanazi, 2012:76; Mkhwanazi, 2014a). I observed this in Botshabelo. Many, although not all, babies must grow up without supportive father-figures – just like their (teenage) mothers did. There is tension here. Young fathers often seem to play a minor role, if any, in the lives of their babies. Yet teenage mothers are taught to yearn for these fathers (future husbands) because their commitment could wash clean the scandal that is teenage pregnancy.

In the United States, some scholars have found that HIV-positive mothers are considered 'not good' mothers if they are 'sick'. They observe that a sick mother is considered a not good mother. Sickness or disability can limit a mother's physical and emotional capacities (Grue & Laerum, 2002; Thorne, 1990). Other scholars observe that an HIV-positive mother is a not good mother, because she risks infecting her "innocent child" with HIV (Sandelowski & Barroso, 2003a:476; Sandelowski & Barroso, 2003b). Being an HIV-positive mother seems to heighten a woman's "normality and deviance" (Sandelowski & Barroso, 2003a:476). On one hand, she is 'normal' because of the uplifting social construct of motherhood. On the other hand, she is 'deviant' because of the demeaning social stigma of HIV. Deborah Ingram and Sally Hutchinson (1999a, 1999b, 2000) found that the tension between normality and deviance can place HIV-positive mothers in a "double bind". Other work agrees with these findings (De Souza, 2004; Ingram, 1996; Kirshenbaum et al., 2004; Long, 2009a; Long, 2009b). A good mother protects her child from harm like HIV. A 'not good' mother allows her child to be harmed. Because a 'not good' mother is transmitting a life-threatening virus to her baby, she is also considered a 'not good' woman. (I explore the latter in the chapter on **Being a pregnant teenager**.) In the South African context, some HIV-positive mothers are considered 'not good'

mothers because of their "dirty wombs" (Jewkes & Wood, 1999). These mothers risk infecting 'innocent' babies. This belief fuels a potent social stigma, during pregnancy and motherhood. This HIV-related stigma is consistent with what Suzanne Leclerc-Madlala calls the "female-pollution complex" (1999b). Other work agrees with these findings (Gilman, 1988; Wilton, 1997). Some scholars have explored HIV-positive motherhood as a contradicting, and tumultuous experience. Carol Long (2009a) worked with a group of HIV-positive mothers in Johannesburg. Long writes:

> Motherhood is defined as an excising of her own needs and emotions for the good of her baby and occurs within a socioeconomic context of limited resources. … Her response to being a 'bad' mother…is also typical and suggests the foe that the 'good' mother is up against: her HIV status dominates her definition of bad motherhood. (Long, 2009a:172)

Long found that most of these women make meaning of HIV-positive motherhood by putting babies' needs before their own. This priority partly comes from internalising the expectations that come with 'good' mothering. Long describes the way 'good' mothers focus on the baby rather than on the 'bad' virus (Long, 2009a:172-173).

In Botshabelo, many teenagers told me about the value of motherhood, and how they wanted to be good mothers. This agrees with most of the scholarship in South Africa and abroad. Yet I observed that achieving a 'good mother' status was challenging in their social context. Community members told me that teenagers are 'not good mothers' because teenagers are

uneducated, unmarried, and impoverished. Teenagers have little to offer new babies. Furthermore, some HIV-positive teenage mothers are considered 'sick mothers' and incapable of caring for their babies. They are considered 'not good' mothers. Despite these challenges, some teenagers manage to practice powerful dimensions of good mothering in Botshabelo. Chief among these is the way teenagers love, connect with, and protect their babies.

Section 2. Mother love

I argue that a key dimension of teenage motherhood is 'mother love.' My conversations with Letsoba explore this. As previously mentioned, Letsoba was a teenager when her daughter was born. Now, her daughter is four years old. During this research period, Letsoba was dating her daughter's father. They were making marriage plans. Letsoba told me this was especially stressful because of her boyfriend's drinking habits. In some ways, Letsoba concentrated her energy on mothering as a coping mechanism. She did not want one more thing to go wrong in her life, she said. On one occasion, we were discussing what makes someone a 'good mother.' I share Letsoba's response here:

> Let's say you give your child R2.00 for lunch in primary school. Then she will have friends in primary school. When she moves to junior school, let's say you give your child R2.00 again. But there are new friends at the junior school. They have R5.00 now. So, your child will go to her boyfriend and ask him for R3.00 to make R5.00. The mother must not give the child R5.00. The mother must give her child the lunchbox. The mother must teach her child that you get money

> when you work for it. See me, I still carry my lunchbox - even now. The mother must fill the lunchbox with nice things: all the things her child likes. If you give your child the lunchbox, she will not want the boyfriend. You must give your child the love inside the house. Then she will know that the love from outside (the house) will never be as good as the love from inside. A good mother will not give her child everything, like the whole R5.00. A good mother will not *spoil* her child, but will *take care of* her child. (Letsoba, 2019, emphasis in original narrative)

It is difficult to ignore Letsoba's underlying message here. She is alluding to sexual dangers in the outside world. Letsoba subtly blames her own mother's neglect for her teenage pregnancy. Letsoba implies that if her mother had given Letsoba love 'inside the house' then Letsoba would not have looked for love 'outside the house.' That is, Letsoba believes she would not have become pregnant when she was a teenager. Furthermore, this anecdote is meaningful because Letsoba describes a good mother's actions. That is, what she does – and will continue doing - to be a good mother to her child. She explores three facets of the love she gives her child.

First, Letsoba talks about providing food. Like Letsoba, many young mothers and pregnant teenagers talked to me about food. Some told me they would never let their babies starve. Others told me that there would always be food in the house for the child. Providing food is a powerful way for a teenage mother to show love. A lunchbox is a poignant symbol of a mother love. In South Africa, a lunchbox is usually a plastic or fabric bag containing food. A child takes the lunchbox to school, and eats the food during breaks. The lunchbox may contain sandwiches,

fruit, beverages, and snacks. For most families, it is more affordable to pack food in a lunchbox than give a child cash ('pocket money') to buy food at school. This is especially true in the Free State province, in which Botshabelo is the largest township, where more than seven out of ten (76%) people are unemployed (Free State Department of Health, 2014). A family's needs often exceed their income. Household funds are spent as sparingly as possible on electricity, groceries, clothing, or furniture. Yet, in this social economy, Letsoba prioritises her child's lunchbox. So great is this mother's love that the lunchbox must contain "all the things" - a variety of food – that her child likes. Abundant food symbolises this mother's abundant love.

Second, Letsoba addresses the tension between what a child 'wants' and 'needs.' To do this, she compares pocket money to a lunchbox. Above, Letsoba says that "a good mother will not *spoil* her child, but will *take care of* her child." Spoiling a child means giving a child what she 'wants' - namely the R5.00. A mother who spoils her child is a 'not good' mother. On the other hand, taking care of a child means giving a child what she 'needs'- namely the R2.00 and a lunchbox. A 'good' mother chooses the latter option even though this requires more time and effort.

Third, Letsoba compares a 'good' mother's love – inside the home - to the love outside a home. To do this, she shares a vivid image of social spaces. She clearly separates the space "inside" a house from the space "outside" it. A 'good' mother packs a lunchbox inside the house. This is one form of "mothering work" (Sandelowski & Barroso, 2003a). Because the lunchbox originates "inside" the house, the lunchbox symbolises love inside the home. This is a nurturing, nourishing kind of love. By comparison, the boyfriend is "outside" the house. The resources he

can provide – the R5.00 – symbolise the love outside the home. This is a material, lustful kind of love that Letsoba associates with money, boyfriends, and intimacy. By separating these social spaces, Letsoba distinguishes the love "inside" the home from the love "outside" it. A good mother must teach her child not to want the love outside the home - love from a boyfriend. Letsoba provides two reasons why. First, the love outside the home "will never be as good as the love from inside" the home (Letsoba, 2019). A good mother's love is better – and ranks higher - than a boyfriend's love. Second, Letsoba implies that a boyfriend's love can lead to sex, and teenage pregnancy. Letsoba says that teenage pregnancy is a "bad" thing (Letsoba, 2019).

Every day, Letsoba practices her 'good' mothering. She takes care of her seven-year-old brother, and her four-year-old daughter. Letsoba's mother passed away a few months after her younger brother was born. "They are both like my children, because my mother died. So, my young brother is like a son for me," Letsoba says (2019). Letsoba packs a daily lunchbox for her daughter, and her brother. Her daughter attends a nearby crèche. In a few years, when the child begins primary school, Letsoba says she will provide pocket money and a lunchbox. This is what Letsoba does for her younger brother who is currently in primary school.

Letsoba does what she does, for her child and her younger brother, in an effort to be a 'good' mother. She says: "A good mother will not *spoil* her child, but will *take care of* her child. …I will be a good mother because I love my child" (Letsoba, 2019). Love is a meaningful part of her mothering experience.

'Love' or 'mother love' has been discussed in the literature. In the South African context, Cherryl Walker (1995) found that a mother's role is to nurture, preserve, and protect her baby. Based on work in the United States, Sara Ruddick (1980, 1989) explored "maternal thought." She writes:

> Maternal thinking…is an attitude governed, above all, by the priority of keeping over acquiring, of conserving the fragile, of maintaining whatever is at hand and necessary to the child's life. (Ruddick, 1980:350)

Moreover, Ruddick found that mother love is considered "natural" (1980). Based on work in the United Kingdom and Europe, Elisabeth Badinter explored 'mother love' as a natural or nurtured trait in mothers (Badinter, 1981; Coser, 1982). That is, whether mother love is a "maternal instinct" or not (Borstelmann, 1983:566). Nancy Scheper-Hughes (1993) explored motherhood and infant mortality in Alto do Cruzeiro, Brazil. She suggests that mother love "grows slowly" (Scheper-Hughes, 1993:357). In the context of her ethnographic work - amidst poverty, starvation and infant death - this means that a mother's love grows when a child has 'proved' that he or she will survive:

> Mother love is anything other than natural and instead represents a matrix of images, meanings, sentiments, and practices that are everywhere socially and culturally produced.…Consequently, mother love is best bracketed and understood as (m)other loves…On the Alto do Cruzeiro the birth of a child is hardly a time of rejoicing, and mother love follows a tortured path, often

> beginning with a rocky start and fraught with many risks, dangers, separations, and deaths. (Scheper-Hughes, 1993:341-357)

I reference Scheper-Hughes' work not because teenage mothers in Botshabelo are facing the same kind of infant mortality or poverty that plagued Alto do Cruzeiro at the end of the twentieth century. Rather, I aim to highlight the way both types of mothers 'delay' a deep attachment to - or love for - their babies. I argue that, in Botshabelo, a teenager's love for her baby grows gradually over time.

Adult mothers in Alto do Cruzeiro 'delayed' love until their babies proved their worth. Only 'strong' babies with a will to survive ultimately gained a mother's love. Weak babies were 'returned' to God through death.

Teenage mothers in Botshabelo 'delay' love until they can overcome or reconcile the 'mistake' that is teenage pregnancy. In this social world, teenage pregnancy is the source of incredibly intense disappointment, guilt, and shame. Not to mention punishment and stigma. For many teenagers, having a baby thwarted schooling and dreams of a career, and tainted otherwise upstanding family reputations. When a baby is born, a teenager must face her new reality. Her 'mistake' has manifested as a human being. In some cases, she may understandably 'reject' the child. I did not come across this in my research. At the other extreme is the possibility that she will 'love' the child. She will at least learn to live with – co-exist - with the child. This is what I observed.

The arc of a teenager's life is forever changed after the baby is born. At the very least, she must start to see herself as a mother. This is not easy. It takes time for teenagers to connect with their babies. I argue that, slowly but surely, mother love grows. She begins to see herself as a mother, and she grows attached to her baby.

Kananelo describes this. On one occasion, she told me about her relationship with her boyfriend. Her boyfriend is a minibus taxi driver in Johannesburg. She says that "he is also a gangster" (Kananelo, 2019). The couple is not married. Yet the baby's father and his family accept responsibility for the baby. His mother is a *lithuela* - a divine healer - who lives on Kananelo's road. His mother ensures that Kananelo's boyfriend "provides for the new baby" (Kananelo, 2019). He sends large sums of money to Kananelo every month. This was arranged between her boyfriend's mother and her grandparents. I asked Kananelo if she loves her boyfriend. She said:

> I have unconditional love with my boyfriend. … I don't have this love with my baby – the love is still growing. I think the love for my boyfriend is going down, and the baby is getting more love. The baby is another person, so the love is shared. (Kananelo, 2019)

Kananelo's baby was one month old at this point in time. As a relatively new teenage mother, Kananelo shares that the love for her baby is "still growing." As the love for her baby waxes, the love for her boyfriend wanes. During this conversation, it seemed that she felt 'more love' for her boyfriend than for her baby. This love dynamic appeared to be in flux. A month later,

during a conversation in her kitchen, Kananelo told me that her boyfriend was coming to see her. He was eager to see her, and the new baby. I asked her what was happening to the love for her boyfriend, and her baby. She said:

> He is coming from Johannesburg. I am excited to see him. Right now, the love is the same for both. The love is equal. (Kananelo, 2019)

At this point in time, it seemed that Kananelo felt an equal amount of love for her baby and boyfriend. Her love for her baby had increased or 'grown' over the course of a month.

Like Kananelo, Seipati intimates that the love for her baby grows. Seipati is the only daughter for her mother. Seipati's mother was a teenager when Seipati was born. The pair do almost everything together. One result of this close mother-daughter relationship is that Seipati dreams of a similar relationship with her own (unborn) baby. During this conversation, Seipati was in the third trimester of the pregnancy:

> …the love keeps growing all the time. They all fight about who will sleep with the baby. But I know it will be me. I will sleep with my baby. I never want to see my baby cry. (Seipati, 2019)

Even before her baby's birth, Seipati suggests that her love has already started growing. She says that she "felt love for the baby" (Seipati, 2019). She goes on to say that this love continues growing "all the time" (Seipati, 2019). One aspect of this love is a promise to protect her baby

from pain: she says she “never” wants to see him cry. She plans to sleep next to her baby, and watch over him at night.

Additionally, the love her family has for the baby has also started growing. When she says “they” she means her family. Her family argues (“fights”) about who will take care of the baby at night.

What Kananelo and Seipati suggest here is that a mother’s love grows with time. This agrees with what Scheper-Hughes observed in Brazil. Letsoba agrees that a mother’s love grows over time. Furthermore, Letsoba links a ‘good’ mother’s love to acceptance and protection:

> You must love your child so much that they won’t look for love outside. I have this saying on my Whatsapp status: ‘If you don’t listen to your child when he is small then you can’t listen when he is big.’ This means that if my baby is asking me for water, but I don’t want to give it, then my baby will go outside and ask someone on the street for water. It is the same with love. The love grows as your child grows. But for a good mother the acceptance also grows, and the over-protection decreases. (Letsoba, 2019)

What Letsoba describes is the parenting she received. She suggests that her own mother did not pay attention to her needs. This is why Letsoba looked for love elsewhere. This is one reason why Letsoba became pregnant during high school. She was looking for ‘water’ – or ‘love’ –

outside the house. Letsoba created a similar spatial distinction when she described the significance of a lunchbox as a symbol of a good mother's love.

Letsoba also describes the parenting she practices. This reiterates what she explained in the earlier lunchbox analogy: she distinguishes the love "inside" the home from the love "outside" it. Here, Letsoba uses 'water' as a metaphor for 'love'. Water is a life-giving resource, as is love. According to Letsoba, it is a good mother's "responsibility and duty" to provide her baby with love (Letsoba, 2019). A child needs love - like water – to grow. Love is crucial. Water 'outside' the house symbolises other kinds of love, such as love from a boyfriend. A child, who does not feel a mother's love 'inside' the house, will search for love elsewhere. A child will look 'outside' the house, or "on the street" as Letsoba says. Now, Letsoba is a mother who prioritises the needs of her seven-year-old brother, and her four-year-old daughter. She works hard to give them love so they do not look elsewhere.

Like Letsoba, there were other young mothers who cared for more than one child during my fieldwork period. These mothers – Nyefolo, Baby-Boo, Puleng, Roni, Sphola - had multiple children (Table 2). I was curious about the type of mother-child relationship these mothers had with each of their children. How did these relationships and pregnancies differ? How did mother love and definition of the 'good' mother change, if at all, when there was more than one child to consider? Mammako explains this below. I believe this discussion offers insight into what this social world teaches young mothers about the extent of a 'good' mothering. That is, how far young mothers must stretch themselves to perform good care as they struggle to be both providers and carers.

One afternoon, Mammako, Kananelo and I were talking about Kananelo's relationship with her boyfriend. Mammako is an HIV counselor at Hlano clinic where Kananelo has her antenatal appointments. We were sitting in Mammako's office. She knows the teenager well, although the teenager is HIV-negative. I steered the conversation away from 'boyfriend love.' I asked about a teenager's love for her baby. Mammako and Kananelo were initially confused. I used an analogy. There were three apples on the table. I used the apples as I spoke about the love between a mother and her baby. We agreed that each apple symbolised a specific 'quantity' of love for a baby. If I had three babies, then I could give each baby 'one apple' of my love. Mammako agreed: "The love I give each child must be equal," she said (Mammako, 2019). What would happen if I had three apples and four babies, I asked. What would happen to each baby? Mammako took some time before responding:

> I will share the three apples for my four babies. The love must be equal for my babies. The love will grow. For me, I share the love for both my children. This is what good mothers do. (Mammako, 2019)

Mammako agrees that mother love grows. Furthermore, Mammako emphasises that each baby must receive an equal 'quantity' of love. A 'good' mother ensures this. Mammako was a teenage mother when her first baby was born, and slightly older when she had her second baby. She "shares" her love between both children, although one lives in Botshabelo and the other lives in Bloemfontein.

Seipati, Kananelo, Letsoba, and Mammako describe mother love as an ever-growing phenomenon. Their anecdotes describe love at different stages of motherhood. Seipati is in the third trimester of her pregnancy. Kananelo's baby is one month old. Letsoba's daughter is four years old, and her brother is in primary school. Mammako's children are in high school, and working, respectively. All four individuals agree that mother love grows slowly, and gradually, over time.

Section 3. Connection

I suggest that 'mother love' is one dimension of teenage mothering. I argue that 'connection' is another dimension of teenage mothering. Some teenage mothers talk about feeling deeply connected to, and sincerely concerned about, their babies. I formulate this argument quite cautiously. I am not commenting on mother and baby 'merging', or uniting as one entity. I use 'connection' to describe a mother's sincere awareness of and deep caring for her baby. I believe this highlights that some teenage mothers are extremely diligent and thoughtful about childcare.

There are examples of this mother-child connection in the literature. In Brazil, amidst poverty and infant mortality, Nancy Scheper-Hughes (1993) describes the way some mothers feel physically connected to their babies. For example, one mother, Lourdes, calls her baby "her filho eleito, her 'elect' or favorite son, her arms and legs" (Scheper-Hughes, 1993:347). She talks about her baby as if he were part of her physical body. She compares him to her essential appendages. She cannot live without her son in the same way that she cannot live without her arms and legs. In the South African context, Suzanne Maiello (2000) writes about her work

with a mother and baby in Cape Town. The scholar shares the isiXhosa term "mdlezana" to describe a woman who has just given birth:

> *Mdlezana* stands not only for the mother after delivery, but, and this is specific to African culture, it includes the child as well. It is the 'mother-and-child in their union and togetherness.' (Maiello, 2000)

This isiXhosa term exemplifies the powerful connection between a mother and her baby. Mother and baby are linked in their togetherness. In Botshabelo, there is a similar sense of connection between some teenage mothers and their babies. Letsoba describes this during one of our phone conversations in 2019.

> Sasheenie: How are you?
>
> Letsoba: I am not fine, because my baby is sick. She has been vomiting all night. She is weak.

Letsoba suggests that 'she' is not fine because 'her baby' is not fine. Letsoba is physically uncomfortable when her baby is physically uncomfortable. She is deeply concerned that her baby is 'sick' and 'vomiting.' I find her words powerful. They suggest that she feels deeply connected to her baby. Her words also highlight that the young mother feels responsible for the child. She is deeply concerned about her child's health and welfare. Letsoba confirmed this a few days later. While walking around Robedi section, Letsoba and I were talking about her

family. She explained how her older brother acted when her baby was a newborn. Her brother reprimanded her, because household costs (food, water, electricity) had increased after the birth. Letsoba was unemployed at the time. She lived in her brother's RDP home. The siblings had been orphans since 2016. Both of their parents passed away with tuberculosis, possibly as a result of HIV. Because her brother complained about costs, Letsoba limited the household resources she used:

> I use one kettle of water when we bath. And we eat from the same plate. We share one plate of food. (Letsoba, 2019)

This anecdote highlights that Letsoba cared for her baby in the same ways that she cared for herself. When she bathed, her baby bathed. When she ate, her baby ate. Her baby ate what she ate. They shared a plate of food because Letsoba did not eat enough to produce breastmilk. This empirical evidence highlights Letsoba's diligent childcare, and her connection to her child. As a young mother, she is neither negligent nor indifferent to her baby. Instead, she seems to prioritise childcare as much as she can.

Like Letsoba, other teenage mothers talk about feeling deeply connected to – and responsible for - their babies. Baby-Boo discusses this. During the research period, she was pregnant with her second baby. Baby-Boo talks about how she avoided stress during her first pregnancy in order to protect her baby:

> I think when you are pregnant you have to take it easy, because if you stress, you also stress the baby. (Baby-Boo, 2019)

Baby-Boo's comment shows that she is acutely aware of how her actions affect her baby. Despite her best efforts, however, it was difficult for Baby-Boo to avoid stress during her first pregnancy. Baby-Boo discovered her HIV and pregnancy simultaneously. As mentioned above, she was infected by her now-husband who contracted HIV perinatally. She was stigmatised in her community because (during her first pregnancy) she was a pregnant teenager *and* HIV-positive. Still, she tried to consciously manage her stress. Her mother and sister helped her to this end. She says they gave her "unconditional support" (Baby-Boo, 2019).

In Botshabelo, I observed that there is a time and place for this intimate mother-baby connection. In certain situations, some teenage mothers seem to 'separate' themselves from their babies. This was the case for Maipato. As mentioned above, she contracted HIV from her boyfriend. The relationship ended because he was unfaithful – not because of her HIV status or her pregnancy. This infidelity seemed extremely hurtful for Maipato. She spoke about her ex-boyfriend in hushed tones. Her voice would become quiet, each word more deliberate than the last. She hardly made eye contact during these conversations. I saw her fighting back her fiery tears. Despite her pain, Maipato said that she wants her ex-boyfriend to be part of, and in, her baby's life.

> I don't want to see him ever again. It is too hard. It is too painful. …I love my child, but she needs a father too. Then she will have less pain. So, he will come to visit. I don't know how I will feel. (Maipato, 2019)

I think it is interesting that Maipato's HIV infection seems to carry more pain than Baby-Boo's HIV infection. Both Maipato and Baby-Boo describe ideas of betrayal. Their respective partners did not disclose HIV. Baby-Boo's husband, however, ccontracted HIV perinatally. Her earlier anecdote suggests that this is why there is less shame linked to her husband's HIV infection. This is one reason why Baby-Boo forgave him even though he was not completely honest with her. On the other hand, Maipato's boyfriend contracted HIV sexually *and* when he was unfaithful. It seems to me that these circumstances amplify Maipato's pain and the sense of betrayal associated with her HIV infection. I think this is one reason why Maipato will not forgive him.

In her anecdote, Maipato says that she wants her baby "to have a father" unlike Maipato who did not grow up with a father. To achieve this, Maipato seems to 'separate' herself from her baby whenever her ex-boyfriend visits. This is an emotional, physical, and temporary separation. For Maipato, this separation is painful, but necessary. Inviting her ex-boyfriend back into her life, so he can be in her baby's life, is also painful. The teenage mother endures both kinds of pain to protect her baby from the pain of being fatherless. It seems to me that, because Maipato loves her baby, she wants more for her baby than she ever had. Maipato implies that her baby's joy of knowing a father will be worth Maipato's pain.

In this anecdote, Maipato recognises that she and her baby have different needs. Maipato does not want to see her ex-boyfriend, but she wants her baby to have a father. The teenage mother wants her baby to feel a father's presence. "Then she will have less pain," Maipato says (2019). What is good for the baby (feeling a father's presence) actually hurts Maipato. Yet she places her baby's needs above her own. I argue that this self-sacrifice demonstrates love and protection.

Section 4. Protection

I argue that a third powerful dimension of teenage mothering is 'protection.' The way some teenagers protect, love, and connect with their babies is a testament to good mothering. It might seem obvious that young mothers want to protect their babies. What I am demonstrating here, however, suggests that many young mothers seek innovative and profound ways to protect their babies.

Some teenagers protect their babies by providing stability. Lavas describes this: "When you are a mother, you must be responsible and be protective of your child" (2018). She tells me that she lives with her mother. Her parents are "divorced" (Lavas, 2018). She is dating her baby's father, and will continue to do so. She wants to give her child a stable home with two parents. Like Lavas, Mahlony also wants to protect her child. She says: "I want to work and give my child a home sweet home" (2019). Mahlony is engaged to her baby's father, and making wedding plans. After she discovered her pregnancy, Mahlony was determined to finish matric. This was the best way she could secure a future for her child, she tells me. In addition to

providing a house, a 'good' mother can also give her child financial stability. One way to provide this stability is by finishing school. Nator explains this. She lives with her mother, who taught her that a good mother provides for a child. Nator repeats to me what her mother taught her: "you must work to make sure your baby goes to sleep with a full stomach" (Nator, 2019). She goes on:

> My dream is I want to be a teacher and be a good mother for my child, and make my child proud of me. I want to be successful in life and make sure I don't want help from my babymaker (baby's father). … I need to study hard at school to make sure my baby is going to live in a better place, and be educated without having a father. (Nator, 2019)

Teenagers told me that education is the best way to find employment, and thus secure babies' futures. Maipato, for example, strives to be a paramedic so she can "earn a stable income" and take care of her baby (Maipato, 2019). In practice, however, education cannot always guarantee employment (Bray et al., 2010).

Although most teenage mothers strive to protect their babies, this is not always possible. HIV, for example, can limit some teenagers' physical capabilities. They are therefore unable to work, or finish school. These mothers are unable to be 'good' mothers in the ways that are socially prescribed, or expected. Despite these challenges, some teenagers manage to make meaning of teenage motherhood, in earnest. This was the case for Bohlale who is HIV-positive. At the beginning of 2019, I visited 20-year-old Bohlale in her home. After talking with Bohlale in the

front yard, her mother emerged from the house. Bohlale's baby boy was strapped to her mother's back in a brown towel. The way Bohlale's mother interacted with the baby made it seem like he was hers. The way Bohlale did *not* interact with the baby seemed to confirm this. I was struck by how detached Bohlale was. She did not check on her baby. She did not pick up his toys when they fell. She did not even flinch when her baby tripped, and started crying. Bohlale's detachment was not because of her indifference, but rather due to her lack of (physical) capacity. At the time, the baby boy was more than three months old. Yet Bohlale remained weak. HIV limited her physical capabilities. She had been sick since she gave birth. Her appearance - the way she looked - surprised me. She was emaciated. Because Bohlale could not actively take care of her child, she found another way to 'protect' him. She made plans for her baby, and his future:

> One day, I will build a school. It will offer karate and chess. Then youth won't become gangsters. … I know that life. I did it with drugs, and trucks. … My boy will finish school. The school will keep my child and other children here safe. (Bohlale, 2019)

Because she dabbled in drugs, she told me, she knew what it was like to "take risks" (Bohlale, 2019). She also dated a number of truck drivers and gangsters. Largely because of these experiences, Bohlale planned a different future for her baby. Unlike her, the child will finish school. She dreams that her baby will attend the school she will build. There, he will have the opportunity to learn karate, and chess. He will have after-school activities outside of drugs, alcohol, and dating. Outside of dreaming and planning, Bohlale has few other ways to 'protect'

her baby's future. Yet she does not want her baby boy to have "that kind of life" – the life she had (Bohlale, 2019). She does not want him to contract HIV. She does not want him to become the truck drivers, and gangsters she used to know so well. By building a school, Bohlale says she can keep her baby, and other children in the community, safe.

Other scholars have explored motherly protection in the context of HIV. Ruth Anne Van Loon (2000) worked with a group of HIV-positive adult mothers in the United States.[12] She found that some mothers hold onto their mothering roles by "looking out for" their babies, not just "looking after" them. Proactively planning child custody, for example, is one way a mother can 'look out for' her child. A mother may do this when HIV limits her childcare capabilities. Bohlale's experiences emphasise what Van Loon observed. Bohlale does not always have the capacity to take care of her baby in the 'present'. As a result, she resorts to planning a 'future' for her child.

Section 5. Duality of motherhood

The plans Bohlale makes for her baby are one result of, and thus reveal, the complicated relationship between HIV and motherhood. Margarete Sandelowski and Julie Barroso (2003a) have explored this relationship. They worked with a small group of HIV-positive mothers in the United States. These scholars suggest that there is a reciprocal, and paradoxical, relationship between HIV and motherhood:

[12] Please see the **Introduction** chapter for further explanation as to why work in the United States is referenced in this study.

> The duality of motherhood, in the context of maternal HIV infection, appeared to reside not only in the paradoxical effects that motherhood had on HIV infection and vice versa, but also in the contradictory effects of the same maternal action, and the common effects of opposing actions. (Sandelowski & Barroso, 2003a:475)

The scholars suggest that HIV can harm, or help, motherhood. For example, they discuss what happens when a mother discloses her HIV status. Telling her kin about HIV can increase the familial support she receives as a mother. Yet disclosing her HIV can also impede this support. This is how HIV paradoxically affects mothering.

Reciprocally, motherhood can harm, or help, HIV. For example, being a mother can "aggravate" HIV symptoms (Sandelowski & Barroso, 2003a:475). Yet motherhood can also boost a woman's self-esteem, and give her a "reason to live" (Sandelowski & Barroso, 2003a:475). Sandelowski and Barroso describe the paradox, and reciprocity, of HIV-positive motherhood as the "duality" of motherhood. In Botshabelo, Bohlale's experiences highlight this duality.

How does her HIV affect her mothering? HIV restricts her physical capabilities. Thus, she cannot take care of her baby. Yet having HIV has also made life more valuable to her. She wants to live long enough to see her baby grow up.

How does motherhood affect her HIV? Motherhood has exacerbated her declining health, and HIV-related infections. Yet motherhood has given her the ability to do something – make plans for her baby - at a time when she is unable to do or be anything else. Making plans – being a 'good' mother – gives her purpose.

Furthermore, motherhood has reframed the way Bohlale looks at her life. Before motherhood, her life seemed lonely. Now, she sees that her life is filled with her family. "They are so supportive," she says, "because they take care of my baby" (Bohlale, 2019). In fact, seeing the way her family dotes on her baby has improved her relationships at home. She tells me that she is grateful for her family, because she acknowledges their care and support.

The plans Bohlale makes for her baby are a form of "mothering work" (Sandelowski & Barroso, 2003a). Bohlale talks about what her baby will learn at school, the kind of career he will have, and where he will travel. This is how she connects with, and protects, her child. It is not only HIV-positive teenage mothers who plan babies' futures. Like Bohlale, Popi also makes plans for her baby's life. Popi is HIV-negative. She lives with her grandmother and four other siblings in Robedi section. Both her grandmother and her boyfriend supported her through her pregnancy. Now, her grandmother is helping Popi raise the child. Popi plans a safe and successful future for her baby:

> I have a dream for my child. I hope he can listen to me, and get educated to make me proud. I love my child with all of my heart. I hope the love that I have with him will never change. I don't want to see him being a thief or see his life end

> up being in jail, or see when he is a drug dealer. I pray all the time. I hope God will protect him during day and night. (Popi, 2018)

Popi is HIV-negative. Bohlale is HIV-positive. Both teenage mothers make plans for the future. I suggest that 'protecting babies' may be important to teenage mothers regardless of HIV status. In other words, the way teenage mothers protect their babies – by planning for the future – is part of a shared mothering experience.

Choosing baby names is an important part of planning a baby's future. I was surprised when (HIV-positive and HIV-negative) teenagers and young mothers told me that they unilaterally picked their babies' names. This is not standard practice in Botshabelo. Usually family members (especially elders) decide and choose a baby's name. This name offers protection, and welcomes a new baby into the family of his or her mother or father.

> …personal names mark an individual as belonging to a particular patrilineal group and it is membership in particular groups that marks someone as a preferred/suitable marriage partner. (Herbett, 1997:8)

The fact that a teenage mother must pick her own baby's name suggests that her baby has not been incorporated into a greater family unit. The baby does not have protection from his or her mother or father. Other South African scholarship confirms this (Kajee, 2011; Suzman, 1994).

> When children have no paternal connection they must look to others for their support, name, inheritance rights and social position. (Madhavan, Townsend & Garey, 2008:655)

In this study, most mothers told me that they named their own babies after their birth. Some teenage mothers told me that certain family members helped to choose babies' names. For example, Baby-Boo's younger sister suggested the name *Tsereletso.* I think it is significant that a younger family member (not an elder) helped Baby-Boo choose her baby's name. When a family does not name a new baby, this might be seen as a form of rejection. Even the newborn baby must pay for the calamity that is teenage pregnancy. This is yet another aspect of the punishing discourse that a teenager (and now her newborn baby) must face.

This begs the question: how do teenage mothers choose baby names? I argue that a baby's name epitomises a teenager's hopes for that baby's future. Most teenagers envision ideal futures for their babies, or the type of lives their babies will enjoy. A young mother's visions and dreams for her baby are tied into the name she gives her child. A name has profound power, which is exemplified by its (Sesotho) meaning. I provide some examples here.[13]

Dineo named her three babies *Thabang, Lethabo,* and *Boitumelo*. Their respective meanings are *happiness*, *happiness*, and *excitement.* Dineo is HIV-positive. Sibongile named her baby *Bohlokwa*, meaning *important*. Sibongile is HIV-negative. Bohlale named her baby *Tebello*,

[13] Throughout the dissertation, I have anonymised names, and used pseudonyms, for all individuals (except those who wanted their real names attached to their stories). In this part of the chapter, however, I do not anonymise babies' names. I use real names to highlight Sesotho meanings.

meaning *prayer*. Bohlale is HIV-positive. Letsoba named her baby *Amohelang* meaning *important.* Letsoba is HIV-negative. Baby-Boo named her baby *Tsereletso* meaning *protection.* Baby-Boo is HIV-positive. These examples show that baby names are a crucial part of the 'protection' dimension of teenage mothering among HIV-positive *and* HIV-negative young mothers.

The name a teenager chooses for her baby usually has a special meaning. A name describes how a parent feels about a baby. To illustrate this, Letsoba explains the importance of her own name. During our daily walk through the township, I asked Letsoba about the meaning of her name:

> My father used to call me *Naledi e pela kgwedi*. It means 'star closest to the moon'. He was the moon, and I was the star. Sometimes I look at the moon, but not all the time, because it makes me hurt. I dream of my parents. It was especially during my pregnancy. I dreamed of my father. I was sitting with him. I told him that I'm sorry for disappointing him. He said: "No, this (teenage pregnancy) is not disappointment but happiness." (Letsoba, 2019)

In this anecdote, Letsoba describes the name her father used for her: *Naledi*. She did not use this name at school or during her antenatal care at the clinic. This name was reserved for her father. Her father worked in a nearby mine, and died shortly after he contracted tuberculosis. She was in Grade 10 at the time. He died before her teenage pregnancy. Letsoba cherishes her memories with her father. "We were very close. I miss him too much," she says (Letsoba, 2019).

He called her *Naledi* because it means *star*. She was the 'star' closest to him – the 'moon'. Like moon and star are always together in the night sky, so the pair walked through life together. Father and daughter made each other brighter. Since her father died, Letsoba dreams of him. In her dreams, her father reacts to her teenage pregnancy. In this anecdote, she describes their conversations. Her father - someone she deeply respects - feels happy about her teenage pregnancy. He is not disappointed like everyone else in her life. Unlike her elder brother, who punishes and scolds her for her pregnancy, her father frames her pregnancy as joyful. It seems to me that these dreams help Letsoba. She begins to give herself permission to accept her pregnancy, her mistake, her sin.

In addition to communicating how a parent feels about a baby, names can also prophesise the kind of person the baby will become. When a teenage mother is choosing her baby's name, she thinks about the kind of life she wants for her child. This is why Baby-Boo named her baby *Tsereletso* meaning *protection*.

> This child, I want him to protect our family. He will take the family that far.
>
> (Baby-Boo, 2019)

Baby-Boo says that she wants her child to 'protect' her family. By carefully choosing her baby's name, Baby-Boo made a thoughtful investment in the future of her family and her child. This agrees with other work. Based on her theoretical work on "childhood as spectacle" and "parental involution," Cindi Katz (2008) discusses children as objects of investment.

> … the individualised investments in children as accumulation strategies are realized socially through some inchoate sense or fantasy wish-dream that they actually will 'save the world' or at least save us from ourselves and the consequences of our actions or inactions. (Katz, 2008:12)

Katz is alluding to a parent's hope that their child will accomplish more and do better than they ever could. Moreover, children might figure out ways to circumvent society's challenges (Katz, 2008:13). In Botshabelo, Baby-Boo talks about wanting her baby to 'protect' her family by taking the family to new heights. That is, she hopes her baby will go further than she ever did. Based on our other discussions, I came to understand that Baby-Boo wants her baby to surpass her efforts. During her childhood, Baby-Boo made her family proud by finishing high school. She was the first family member to achieve this level of (academic) success. She tells me that she wants her child to finish high school, and then attend university. Her child will have a chance at a successful career and protect the family from financial insecurity. This relates to Katz' work as described above. Baby-Boo says that her child will 'save' the family from the 'consequences' of poor education and/or unemployment (poverty). Such is the return on the investment that is the name Baby-Boo chooses for her baby.

Like Baby-Boo, other young mothers are extremely thoughtful about baby names. Dineo wanted all her babies to have joy and happiness. Hence, she chose names that mean 'happiness' and 'excitement.' Bohlale wanted her baby to be protected by God. Hence, she chose a name that means 'prayer.' In some ways, a name can protect a baby in the same way that an oracle can guard a destiny. Furthermore, a name can provide protection even when a teenage mother

cannot. She may be limited by HIV, poverty, employment, or even education. Yet a name can follow a baby from the present into the future.

Section 6. Good teenage mothering

In this chapter, I have argued that many teenagers and young women strive to become good mothers. Loving, connecting with, and protecting babies are three dimensions of their thoughtful childcare and mothering. I have discussed *what* these young mothers do, but *why* is good mothering so important to them?

It seems that, for some teenagers, being a good mother is a way to make up for the mistake that is teenage pregnancy. Good mothering is a form of penance, a way to atone for the sin that is teenage pregnancy. Spronky describes this. During the research period, she was pregnant with her second child. In her anecdote below, however, she talks to me about her first pregnancy when she was a teenager.

Spronky tells me that she calls her first born “my everything” or “my sweet” (Spronky, 2018). She says that she became “more responsible” after she gave birth (Spronky, 2018). This is why she is excited for her second baby, she says. Spronky implies that she values her children because she has no other family. Spronky is an orphan. She lives with her boyfriend. Mothering seems to be a crucial part of her identity. Being seen as a ‘good mother’ will obscure her identity as a ‘pregnant orphan’. She says that she loves the former part of herself. She seems to reject the latter. Here, Spronky describes how much she values mothering:

> The best thing I love about myself is that I'm a mother. I know I'm young, but I am proud and I love being myself. I am supportive towards my children because I'm that kind of loving and caring mother. (Spronky, 2018)

Spronky describes an intrinsic joy linked to motherhood. This joy makes Spronky love herself. Furthermore, she says that she is a loving, caring, supportive mother. These traits edify her sense of self, and her 'good' mothering identity. This identity seems to combat some of the punishment and stigma linked to teenage pregnancy. Spronky suggests this when she says: "I know I'm young *but I am proud*". The young mother hints that, even after a teenage pregnancy, a young woman can be proud of being a mother if she is a 'good' mother.

I argue that good mothering is a means to mute the punishing discourse in a space and time when teenagers can do little else. Demonstrating responsibility and diligence seems to be a way for some teenagers to prove society wrong. The punishing discourse scandalises teenage pregnancy largely because teenagers are uneducated, unmarried, and too young. Good mothering serves to undo these labels. Good teenage mothers love and connect with their babies. They dedicate continuous effort over time, and love grows as a result of this. Some teenagers show maturity beyond their years when they invite ex-boyfriends back into their lives for the babies' benefit. Additionally, good teenage mothers protect their babies with financial stability, and plans to secure employment and education. These mothers are conscientious about planning babies' futures even if this only means choosing a meaningful baby name.

Chapter summary

In this chapter, I have described how young mothers adapt to babies. I think that the way some of these young women make meaning of motherhood in this social world is remarkable, although sobering. Most try - to the best of their abilities - to be ‘good’ mothers. They do this by practicing various dimensions of good mothering, despite difficult circumstances. Their actions suggest that there is no right or wrong way to achieve good mothering. Instead, there are many ways to love, connect with, and protect, their babies, in earnest. Even when HIV limits teenagers’ capabilities, some young mothers still manage to practice good mothering by planning babies’ futures and carefully choosing baby names. Some young mothers must do this when their families fail to provide baby names. This is another painful punishment that young mothers, and their babies, must endure. Good teenage mothering is important because this is a way to mute the punishing discourse linked to teenage pregnancy.

IX. Discussion

In this penultimate chapter, I deepen and connect the distinct parts of my analysis in order to reiterate my conceptual argument: despite the stigma and punishment linked to teenage pregnancy, pregnant teenagers and their families endure pregnancy and prepare for motherhood.

In this dissertation, I argue that teenagers and young women face multiple pervasive contradictions throughout teenage pregnancy and motherhood. Moreover, pregnant teenagers and young mothers are chastised for transgressing a moral order that has eluded others, including their own mothers. Teenage pregnancy threatens key sources of moral value in this society: marriage, employment, education, and (for HIV-positive teenagers) physical well-being. Despite all the admonishing, some teenagers and young women manage to eke out positive meanings of mothering by reframing teenage pregnancy as a providential test and becoming a 'good' mother. Mother love grows slowly and gradually as young mothers learn to overcome the punishing discourse and multifaceted stigma linked to teenage pregnancy. I suggest that an important part of transcending this negativity is the process of repair. Teenagers and young women are diligent about medical routines and childcare practices. I argue that acts of deference, penance, and repentance altogether embody rituals of repair.

This study reveals a gap between how teenagers *should* live and how teenagers *actually* live. That is, society teaches pregnant teenagers and young mothers to follow a prevalent and espoused moral order (what society expects from pregnant teenagers and young mothers) instead of replicating a prevailing social order (what these young women see other people do).

I argue that teenage mothering must occur in this gap. I suggest that the arc-like trajectories of both repair and stigma are crucial here. A waxing sense of repair and waning stigma create space for the practice of good mothering and familial care.

Section 1. Contradictions

When it comes to marriage, other people (especially elders) tell teenagers that they must be married before having a baby. Yet some teenagers – Seipati, Letsoba, Bohlale, Baby-Boo - told me that these same elders had their first babies when they were unmarried and/or in their adolescence. I suggest that there is a powerful emphasis on marriage because it offers social and financial protection (Bledsoe & Cohen, 1993; Kaufman et al., 2001; Preston-Whyte & Zondi, 1992; Varga, 1998:18). I discuss this in the chapter on **Being a pregnant teenager**. In Botshabelo, I observed that a married woman can rely on two families for emotional support and help with childcare. In the chapter on **Being a pregnant teenager**, Letsoba teaches us that marriage has the power to transform a punished (Black) teenage mother into a 'good woman.' Teenagers are told that they should not have fallen pregnant outside of wedlock. This jeopardised their futures. Other people tell teenagers, and teenagers tell others like me, that teenage pregnancy is a 'mistake.' On the other hand, many of the individuals who preach this prose are guilty of the same 'mistake' - that is, teenage pregnancy or early motherhood. The social expectation that marriage can 'save' a pregnant teenager is juxtaposed with declining marriage rates in Botshabelo, as in other parts of South Africa (Ross, 2010:79). It is possible that this social expectation exists precisely because marriage rates and employment are declining. There is pressure on teenagers and young women to 'recover' these things and rescue

their families from a fragile reality. This is perhaps why Letsoba mentioned international celebrities. She suggests that wealth, race, and socioeconomic class has the power to protect or prosecute pregnant teenagers. In the chapter on **Discovering and disclosing teenage pregnancy,** Letsoba says that her society did not reprimand international celebrities Justin Bieber and Selena Gomez when they had a baby, even though they were young and unmarried. The celebrities were not 'punished' for pregnancy because they were White and wealthy. Letsoba implies that, as a poor Black teenager, she did not enjoy this pardoning. She hints at a race- and class-based specificity of the stigma linked to teenage pregnancy. This has salience in South Africa's historical context where economic wealth and social status was the purview of White citizens. The meaning of class and race in a context of teenage pregnancy is beyond the scope of this study. This is an interesting topic for further research, and would build on a salient theoretical discussion by Catriona Macleod and Kevin Durrheim (2002).

When it comes to schooling, this social world preaches that education is a 'key' to success, the way to unlock a financially stable future. Masoso explains this in the chapter on **Familial care**. She says that she will use her education to provide for her child. Her education makes her a better person, a better mother. Despite the success that education brings, school principals and teachers implement local school policies that do not allow pregnant teenagers to attend school. Sister Mohlare and Sister Mookodi commented on this in the chapter on **Being a pregnant teenager**. Mohlare suggested that it is unsafe for pregnant teenagers to attend school because there are no nurses to take care of them there. Mookodi said that allowing pregnant teenagers in the classroom would wrongfully condone teenage pregnancy. The literature underscores this. Pregnant teenagers are kept away from schools because they could "contaminate" or "pollute"

(Nkani, 2012:175) their peers (Varga, 1998; Vilakazi, 1962). In the chapter on **Discovering and disclosing teenage pregnancy,** I explore Mary Douglas' work in so far as pregnancy is matter out of place in a teenage body and/or outside marriage. In the same chapter, Letsoba explains a gendered double standard where local school policies in Botshabelo affect teenage girls more than their male peers. This is consistent with some of the literature (Bhana et al., 2010; Panday et al., 2009). In Botshabelo, there is also tension between schooling and repair. Other people teach pregnant teenagers that having an education will help to secure financial stability for their families and unborn babies. Yet other people also say that staying away from school is an act of obedience, a way to show shame and deference, a ritual of repair.

When it comes to abortions, teenagers are 'coerced' into avoiding these medical procedures. Mmami explains this in the chapter on **Being a pregnant teenager**. Her abortion appointments were consistently cancelled at the antenatal clinic until she passed the twenty-week mark. Beyond this point, South African law does not sanction abortions in government clinics (Maforah et al., 1997; Varga, 2002). Yet teenagers are taught that teenage pregnancy is 'bad.' Lerato explains this in the chapter on **Discovering and disclosing teenage pregnancy.** Even though teenage pregnancy is bad, it must continue. Abortion is 'not allowed' in this social space. I argue that, as much as preventing abortions is a part of the punishing discourse, this is also a way for nurses to protect pregnant teenagers from further stigma. Community members and nurses alike tell teenagers that having an abortion would be a further wrong, beyond the mistake that is teenage pregnancy. For example, Lebo talked about abortion as a "sin". This is consistent with other work in South Africa (Harries et al., 2007; Kumar et al., 2009; Maforah et al., 1997; Varga, 1998). Based on her work with young people in the Western Cape, Nolwazi Mkhwanazi

(2014b) found that abortion was considered "wrong" (2014b:1092). Terminating a pregnancy subjected a teenager to a "discourse of shame and regret" (Mkhwanazi 2014b). Christine Varga (2002) observed a "double stigma" among pregnant teenagers contemplating abortion. These young women faced social criticism because they are young *and* choose abortions. The abortion discourse in Botshabelo presents another contradiction. The act of preventing abortions serves to punish yet also protect pregnant teenagers.

When it comes to witches, most teenagers hide in the house to avoid being harmed. I discuss this in the chapters on **Discovering and disclosing teenage pregnancy** and **Being a pregnant teenager.** Hiding could be interpreted as an act of deference showing that teenagers respect their mothers' pregnancy-related precautions. Teenagers' mothers warn that witches have the power to harm babies and/or teenagers. What makes these pregnant teenagers special targets of witchcraft? In other words, what makes teenagers believe that they are being targeted by witches? I explore this below.

In the chapter on **Discovering and disclosing teenage pregnancy**, Lerato explains why she does not attend school. She says that witches do not want teenagers to have "good things" (such as education or financial success) or "do well" (by becoming 'good' mothers). Lerato suggests that witches do not want teenagers to obtain these key sources of moral value, which represent status.

Isak Niehaus (2002) describes witchcraft, envy and status in Bushbuckridge, South Africa.

> Motivated by envy, elderly witches caused fertile younger women to abort or to miscarry. … In labour-exporting areas with very few employment opportunities for women, they [women] achieved status through motherhood. (Niehaus, 2002:292)

Niehaus goes on to explain that witches (through abortions) deprive pregnant women of the opportunity to achieve status. I find that something similar is happening in Botshabelo. The discourse surrounding witches and witchcraft suggests that witches thwart teenagers' efforts to improve their lives and, thus, to elevate their social status. That is, pregnant teenagers are special targets of witchcraft because these young women are doing something – achieving educational success and performing 'good' mothering – to elevate their social status. Witches are envious of this. Kananelo suggests this in the chapter on **Discovering and disclosing teenage pregnancy**. She says that her grandmother warned her about "jealous witches" (Kananelo, 2019). There is an uncomfortable contradiction here. On one hand, witches are envious of the status that pregnant teenagers achieve through education and motherhood. On the other hand, pregnant teenagers are in a position few envy given the punishing discourse and shame linked to teenage pregnancy that requires repair. These contradictory realities seem to co-exist in the lives of many pregnant teenagers and young mothers, and serve to emphasise the "undecidable" (Macleod, 2003:422) social position in which these young women live. I explore this in the next section of this chapter.

Extrapolating national unemployment data suggests that at least seven out of ten women 15-20 years old are unemployed in Botshabelo (Statistics South Africa, 2019). Achieving motherhood

is a way for young women to achieve a level of status that is otherwise difficult to obtain through employment or professional careers. I find it interesting, however, that most of the young women in this study talk about achieving some kind of status or success beyond just motherhood. These young women are becoming 'good' mothers, repairing familial relationships, returning to school, and/or working toward their professional dreams. I explore this in the chapters on **Familial care** and **Dimensions of teenage mothering**. Lerato takes care of her baby during the day and attends school at night. Kananelo is taking steps toward being an architect. Sibongile is finishing high school so she can attend medical school and become a doctor. Even though these young women will only reap the benefit of their labour in the future, they continue working hard. They hold onto their "dreams" and "hopes" (De Lannoy, 2007b:14; Ramphele, 2002). These young women are balancing motherhood and education in spite of the punishment and pregnancy-related challenges in the past. These young women are finding ways to succeed.

If these young women continue to move forward, they will arguably achieve more than the witches who live among them. Both these young women and witches live in the same context of poverty, low rates of matriculation, and high rates of unemployment. Yet these young women are prospering while witches are not. I suggest that this inspires envy, malice and jealousy among witches. As with Niehaus' work in Bushbuckridge, I found that witches are rumoured to be "envious elders" in Botshabelo (Niehaus, 2012:41). Envious witches practice "vengeance magic" (Niehaus, 2012:39) that is intended to harm unborn babies. This is why pregnant teenagers must avoid witches during pregnancy. Doing so protects unborn babies. Teenagers' mothers teach teenagers that witches will hurt the baby, that is, cause miscarriages. I suggest

that witches thwart pregnancies in an attempt to stop teenagers from achieving more than witches themselves. Teenagers who do not give birth to full-term babies cannot be 'good' mothers. I wonder if witches' actions are, at their core, another form of punishment linked to teenage pregnancy. This is a worthy topic for future research, as is a deeper exploration of the connection between teenage pregnancy and witchcraft.

Furthermore, in the chapters on **Discovering and disclosing teenage pregnancy** and **Being a pregnant teenager**, I suggest that some mothers use witches and precautions as scapegoats for a variety of social ills including gossip, ridicule, stigma, and society's pernicious curiosity. This is how teenagers' mothers convince their daughters to 'hide' in the house. It seems to me that some mothers are trying to protect themselves. Hiding and witches seem to be manifestations of the same thing: maternal shame. By this I mean that a witch is a projection of a mother's shame onto others. This would be the case if a teenager's mother thinks that others want to attack or harm her, or her pregnant daughter. She has displaced or externalised her negative emotions (shame, aggression, contempt) onto others. Witches are an available resource in the cultural repertoire, which enables this process.

Section 2. Undecidability

I think another significant contradiction is a pregnant teenager's social position. She uncomfortably straddles two seemingly distinct experiences: adulthood and childhood. She must endure pregnancy-related challenges and process her emotions like an adult. Yet she is chided like a child.

Catriona Macleod (2003) explores this tension. Based on her work in South Africa, she suggests that teenagers occupy an 'undecidable' space (Macleod, 1999b; Macleod, 2002; Macleod, 2003; Macleod & Durrheim, 2002). The idea of "undecidability" was first presented by Jacques Derrida (1976, 1978). Derrida describes an "undecidable" as something that is "the 'between', whether it names fusion or separation, that thus carries all the force of the operation" (Derrida, 1981:220). Macleod posits that the state of adolescence is an 'undecidable' period. A young person's identity is "not child, not adult, but simultaneously both" (Macleod, 2003:422). Adolescence occupies (yet fails to occupy) two seemingly disparate states. Macleod suggests that teenage pregnancy heightens this undecidability. A pregnant teenager shows her community that she is capable of intimacy or "adult practices" because she is pregnant (Macleod, 2003:426). Yet she might also showcase her childish irresponsibility and anxiety. Macleod emphasises:

> A pregnant teenager is thus adult, but not adult, child, but not child, an undecidable. (Macleod, 2003:426)

Macleod suggests that teenage pregnancy is seen as a "transgression of the child/adult boundaries" (Macleod, 2003:426). This transgression is quite impossible to ignore because pregnancy is so overt. Other scholars agree here. Annette Lawson (1993) worked with pregnant teenagers in Britain. She explored the "problem" of teenage pregnancy and sexuality (Lawson, 1993:102). She suggests that teenage pregnancy "pollutes" the child identity, and renders the adult identity "deviant" (Lawson, 1993:105). Teenage pregnancy as something that disorders

social identities echoes Mary Douglas' theoretical ideas about "matter out of place" that disorders a system (1966:35). These studies agree with my empirical evidence.

In Botshabelo, community members and kin deny a pregnant teenager her adulthood when they call her pregnancy disappointing and shameful. In turn, she denies her childhood as she fights to be recognised as a woman capable of passion and love. This was the case for Bohlale. She highlights her internal struggle between adulthood, and childhood:

> My mother always told me not to do things. She told me not to get pregnant when I am young. Then I got pregnant. Now I see why she told me not to do this thing. (Bohlale, 2019)

The way her mother 'told' her what to do - and what to avoid - signals Bohlale's social position as a child. Her pregnancy signals her social position as an adult. The tension between these two identities epitomises her 'undecidable' social status. Unfortunately, to Bohlale's dismay, pregnancy could not bridge the gap between the adult she hoped to become, and the child her mother wanted her to be.

I argue that, because pregnant teenagers like Bohlale occupy an 'undecidable' position in this society, they straddle the murky line between adulthood and childhood. On the one hand, a pregnant teenager is expected to go to school and finish her education. That is, she must take responsibility for her pregnancy, and try to continue her life like an adult would. I discuss this in the chapter on **Dimensions of teenage mothering.** On the other hand, she is 'not allowed'

to attend school and forced to 'hide' in her house. That is, she is effectively 'grounded' the way a child would be. I discuss this in the chapter on **Discovering and disclosing teenage pregnancy**.

Section 3. Intergenerational disappointment

Beyond these contradictions, there is a strong sense of disappointment associated with teenage pregnancy. Furthermore, in various anecdotes throughout the dissertation, there is talk about teenagers as 'failures' because they are pregnant and unmarried.

In the chapter on **Being a pregnant teenager**, Metsi said that seeing a parent's disappointed face is as painful as being smacked across the face. Other teenagers – Lebo, Barbie, Botho - echoed this. Teenage pregnancy brings shame to the family (largely) because teenagers are unmarried and young (Mkhwanazi, 2014a:110). Many teenagers said that their pregnancies deeply disappointed their families. Many mothers were disappointed that their teenage daughters had followed in their footsteps (became pregnant in their teenage years) instead of obeying expectations. This, in turn, disappointed teenagers themselves. Many teenagers said that they had 'failed' their mothers. There is a sense of intergenerational disappointment here: both teenage daughter and her mother are disheartened or dismayed by teenage pregnancy. What is perhaps more disappointing than her own pregnancy is the possibility of her child's pregnancy. In some ways, a teenager's mother transfers the disappointment she felt during her own teenage pregnancy onto her teenage daughter. This leads to an intergenerational 'transmission' of disappointment. Disappointment persists if or when a teenage mother has a

daughter who becomes a pregnant teenager herself. Some teenagers talked about this in the chapter on **Discovering and disclosing teenage pregnancy** and **Being a pregnant teenager.** This transmission of disappointment could lead to a 'double burden' of disappointment. Mothers are disappointed because they wanted more for their daughters. Daughters are disappointed because they let mothers down. Going back to school or getting married are means to correct and repair this disappointment for a teenager and her mother.

Despite all this disappointment, most families prepare to help their teenage daughters after the baby is born. Some families are even excited about the new baby. I explore this in the chapters on **Familial care** and **Dimensions of teenage motherhood**. In the latter chapter, Seipati explains her family's excitement. Her family playfully argued over who would sleep with the new baby at night. There is power in the process of repair in so far as repair allows families respond to teenage pregnancy. This power resides in the mundaneness of everyday activities. The ever-shifting process of "householding" (Ross, 2010:90) changes after babies are born, as young mothers and their own mothers cope with the responsibilities of caring and providing. I explore this in the chapters on **Familial care**. Teenagers' mothers sacrifice employment or long-awaited retirements so they can take care of teenagers' babies at home. I think this sacrifice is deeply meaningful in a context of poverty. This sacrifice seems to be a weighty short-term decision with long-term benefits. Helping with childcare means that a teenager can return to school. She can, in time, find stable employment that could uplift her entire family. Sacrificing employment, and helping with childcare, is an investment in a teenage teenager's - and the family's - future. This was the case for Sibongile. I discuss this in the chapter on **Familial care**.

Perhaps teenagers' mothers help their teenage daughters because these mothers were once teenage mothers too. Some teenagers' mothers empathetically know the work that childcare requires, the burden of responsibility, and the painful stigmas associated with teenage pregnancy or (for some teenagers) HIV-positive teenage pregnancy. These mothers help their teenage daughters just like their mothers helped them. There is profoundness and practicality in the way teenagers' mothers respond to new babies. Cortez and Seipati explain this in the chapter on **Familial care**.

Yet not all families can afford to help with childcare. Maipato discusses this in the chapter on **Familial care.** In these situations, some families offer financial support. They pay for baby clothes, baby formula, and toiletries. Many teenage daughters cannot resume schooling unless their families help with childcare. Sometimes, HIV (not families) prevents teenagers from finishing school. This was the case for Bohlale who is HIV-positive. Despite these many limitations, some teenagers remain determined to make meaning of motherhood and continue the process of repair, even amidst HIV's menacing presence. I explore this in chapter on **Familial care**. I write about Maipato who is HIV-positive and made plans to return to school after a year. I also share Lerato's story. She is HIV-positive and started night school because she was taking care of her baby during the day.

Section 4. Arc of stigma

The contradictions, undecidability and intergenerational disappointment exacerbate the stigma linked to being a pregnant teenager, being an unmarried young mother, and (for some teenagers)

having HIV. I suggest that the stigma teenagers and young mothers face in Botshabelo is multifaceted, and (at least) three-fold. Each stigma compounds the others. The resulting multifaceted stigma is more severe than any single stigma would be on its own. Yet, despite this multifaceted stigma, teenagers must persevere, rising to meet each new day with a brave smile. I explore this multifaceted stigma below.

First, a pregnant teenager (HIV-positive or HIV-negative) faces stigma and judgement because she is too young to be capable of childcare. She is uneducated and unemployed. I explore this in the chapter on **Discovering and disclosing teenage pregnancy**.

Second, an unmarried teenager (HIV-positive or HIV-negative) faces stigma because she is facing motherhood without a husband, or a husband's family. I explore this in the chapter on **Being a pregnant teenager** where Letsoba says that a pregnant teenager is not a 'good woman.'

Third, an HIV-positive teenager is judged because HIV does not allow her to fulfill her mothering responsibilities. She is too sick to do this. Bohlale discusses this in the chapter on **Familial care**. Furthermore, society blamed Bohlale for not being able (enough) to take care of her baby.

Additionally, an HIV-positive teenager can face stigma because society blames her for infecting an unsuspecting or 'innocent' baby with HIV. Baby-Boo discusses this in the chapter on **Discovering and disclosing teenage pregnancy**. Baby-Boo worried what her friends and community members would say when they discovered she was pregnant *and* HIV-positive.

> At first I was thinking: 'Ooh! I'm gonna die with a child with HIV!' (Baby-Boo, 2019)

These three stigmas - linked to being a pregnant teenager, being an unmarried young mother, and (for some teenagers) having HIV – are messy and convoluted. These stigmas are layered onto a teenager's "intersectional" identity with each layer inviting its own trauma, challenges and consequences (Butler, 1986; Collins, 2000; Crenshaw, 1989; McCall, 2005; Nash, 2008; Nash, 2016). When all three stigmas are at play, they can situate some teenagers in a 'triple bind'. HIV-positive women face a "double bind" because they are 'sick' yet expected to sustain their mothering responsibilities (Ingram & Hutchinson, 2000). The nurturing motherhood norm is "negated" by HIV (Ingram & Hutchinson, 2000:119). It is not socially acceptable to be an HIV-positive mother (Ingram & Hutchinson, 2000:119). On one hand, an HIV-positive mother is 'normal' because of the uplifting social construct of motherhood (Sandelowski & Barroso, 2003a:476). On the other, she is 'deviant' because of the demeaning social stigma of HIV (Sandelowski & Barroso, 2003a:476). When an HIV-positive mother is a teenager, she must endure additional scolding from her community and/or kin. She is three things: normal, deviant, *and unmarried*. She is too young, too immature, too irresponsible to be a 'good' mother.

Furthermore, I suggest that this multifaceted stigma does not comprise three 'equal' stigmas. The stigma linked to teenage pregnancy can seem more severe than the stigma linked to HIV. This is (at least partly) because of visibility. I explore this in the chapter on **Discovering and disclosing teenage pregnancy**. Something that is more visible (pregnancy) is more urgent to

disclose. It follows that pregnancy attracts more stigma because it can be seen more easily than HIV. Pregnancy – a baby bump - is external and soon-to-be visible. Yet HIV is internal and hidden in the blood in its early stages. Vero explains this in the chapter on **Discovering and disclosing teenage pregnancy**. She is HIV-negative and attends Leshome clinic. Contrastingly, Baby-Boo explains that the stigma linked to HIV was more severe than the stigma linked to teenage pregnancy. Baby-Boo is HIV-positive and lives in Tshelela section. Other scholars note this link between visibility and urgency (Bray et al., 2010).

I argue that this multifaceted stigma is fluid, and more dynamic than static. It waxes and wanes as pregnancy progresses.

When a teenager initially discovers her pregnancy, other people scold her. I discuss this in the chapter on **Discovering and disclosing teenage pregnancy**. The quoted words that follow have been lifted from narrative in the preceding empirical chapters. They tell her that pregnancy is a "mistake" and that she should be "ashamed." Teenage pregnancy is something that has "disappointed" her family. Teenage pregnancy is "bad" yet a baby is "good." A baby is a "blessing." These words have power in so far as they show the way stigma waxes. The admonishing and stigma increase quite dramatically. This stigma continues to grow as teenagers are relentlessly scolded by other people for becoming pregnant. This is part of the punishing discourse that I discuss in the chapter on **Being a pregnant teenager**. As the baby bump becomes more obvious, the stigma reaches its peak.

After the baby arrives, the stigma begins to wane. Community members do not gossip as much as they did before. One reason for this might be that teenagers are less visible toward the end of pregnancy. They hide. Teenagers are out of sight, and (at least somewhat) out of mind. I discuss this in the chapter on **Being a pregnant teenager**. Another reason might be that, after a teenager gives birth, there is no longer any physical indication that she was a pregnant teenager, or is a teenage mother. After the baby is born, she can escape her reputation if she goes to school in a new area or finds employment outside Botshabelo. The new baby is not attached to a teenager in the same way that her pregnancy was. She is a 'teenager' - instead of a 'pregnant teenager' – when she starts at her new school. Her family's support is instrumental here. I discuss this in the chapter on **Familial care.** She can conceal her identity (as a young mother) outside the house when her family takes care of the baby inside the house.

I argue that familial care may ease the burden of stigma when families distribute childcare responsibilities. When a new baby receives love and protection from a teenager's family, society can view a teenage mother as a "good mother" (Badinter, 1981; Mercer, 2004). At the very least, she is one step closer to being a good mother. It may not necessarily matter that the baby receives love and protection from a collective group – her family - and not the teenage mother alone. A 'good' teenage mother is not admonished as frequently as a 'bad' teenage mother. This is one reason why teenage motherhood seems less catastrophic and less severe than teenage pregnancy. The latter is treated as a calamity, for which a teenager is punished and condemned. The former, however, is closely linked to familial care and support. Most families accommodate and protect new babies. These families seem to focus on practicality, more than

crisis. I argue that, in doing so, these families shield their teenage daughters from (some of) this multifaceted stigma.

I suggest that this stigma softens, and becomes more gentle, after the baby is born. Perhaps this is because a new baby, a human being, needs to be incorporated into family life even if the circumstances surrounding his or her birth were less ideal than imagined. Some elders might be bitter that teenagers are not getting married in the way elders imagine they should (Jones, 2009). When the dust has settled, however, life does in fact go on.

I argue that, because of this waxing and waning, this stigma has an arc-like trajectory. The stigma begins when a teenager first discovers, and discloses, her pregnancy. This stigma peaks when the baby bump becomes obvious. By the time the baby is born, this stigma moderates. Its impact is less pernicious. I suggest that this arc-like trajectory strongly influences the 'mothering' relationship between a teenager and her baby. Teenagers are punished because there is stigma linked to different layers of their identity: teenager, mother, and (for some teenagers) HIV-positive patient. Many young mothers take a while to connect with, and accept, the baby. In some ways, babies have 'caused' this stigma. Yet, when the stigma becomes more gentle and when families share the stigma burden, young mothers seem to have the space to focus on mothering. I discuss this in the chapter on **Dimensions of teenage mothering**.

Section 5. Arc of repair

I have suggested that, when families step in and share the burden of childcare, they inadvertently shoulder some of the multifaceted stigma linked to teenage motherhood. How does this come to pass after the moral transgression that is teenage pregnancy? Why and how do families do this?

Beth Vale (2016, 2017) has explored repair among HIV-positive teenagers and their families in the Eastern Cape. Her ethnographic work considers the politics of intergenerational familial relationships and the process of "rebuilding sociality" in a setting of perinatal HIV infection (Vale, 2016:489). In Vale's study, most teenagers contracted HIV from their absent (deceased) mothers. Grandmothers are tasked with taking care of their HIV-positive teenage grandchildren. In this context, ART emerges as a form of biomedicine and social repair.

> …rather than completing the work of dead mothers, the living may seek to un-do or re-write their mistakes in the present. Here, adolescents might 'carry' their mothers' 'absent bodies' through disciplined pill-taking and sanctioned behavior. (Vale, 2016:497)

Vale found that adhering to strict ART regimens ("pill-taking") was a way for teenagers and grandmothers to "reconstitute fragile and fragmented generational ties" (Vale, 2016:497). When grandmothers reminded teenagers to take ART medications, these grandmothers demonstrated care and concern beyond the mistakes of teenagers' mothers. Chief among these mistakes was contracting HIV and leaving an orphan in the care of a relative. When teenagers

listened to their grandmothers' prompts and swallowed ART pills, these actions of repentance could undo their absent mothers' mistakes. In these ways, grandmothers and teenagers co-exist in a state of "intergenerational care" (Vale, 2017:520). This relates to the 'care' that Henderson (2012:19) describes, which I explore in the chapter on **Familial care.**

In Botshabelo, I found that 'rituals of repair' play a crucial role in teenage pregnancy and young motherhood. I explore this in the chapter on **Being a pregnant teenager.** These rituals are embodied in teenager's acts of deference, repentance, discretion, and remorse. Teenagers perform these acts to serve their mothers and their families. Bohlale explains this:

> No. I don't put myself first. Life is not about me. There are people who are close to my heart. I must put them first. (Bohlale, 2019)

Families seem to recognise teenagers' efforts to repent for the transgression that is teenage pregnancy. This recognition inspires a sense of repair that begins to restore the authority and caring role of the teenager's mother. Seipati explains this in the chapter on **Familial care**. She describes how her mother will assist with caregiving when the new baby arrives. Moreover, Seipati talks about how her family dotes on the unborn baby and fights about who will sleep with the baby at night.

Some teenagers perform these rituals of repair to serve themselves as well as their families. Puleng emphasises this:

> It is good to be a mother but to be a *teenage* mother - it's not easy when you find obstacles that make you feel frustrated. (Puleng, 2018, emphasis in narrative)

Like Vale, I found that repair is a way for teenagers to 'undo' mistakes, that is, teenage pregnancy. Considering the intergenerational disappointment that is linked to teenage pregnancy, these rituals might also be a way for teenagers to rewrite their mothers' mistakes (their mothers' teenage pregnancies). Unlike in Vale's Eastern Cape study, in this study most teenagers' mothers are alive and present. They bear witness to their daughters' deference and discretion. This in turn lessens some of the shame teenagers' mothers carry. I find it interesting that the labour of social reproduction falls squarely on the shoulders of women. That is, teenagers, and their mothers or grandmothers are tasked with responsibility to making meaning of repair, care, and family. This reiterates Letsoba's comments about gender discrepancies in the chapter on **Being a pregnant teenager.**

Vale identifies the practice of ART as essential to the process of repair. This was also the case in Botshabelo. In the chapters on **Being a pregnant teenager** and **Dimensions of teenage mothering,** Baby-Boo talks about attending ART classes during her pregnancy. She walked to these classes at the clinic, despite the stigma linked to being visible and pregnant in her neighbourhood. Her mother, sister, and husband encouraged her ART care. Adhering to her treatment regime was a way to reciprocate their support, and suture the negativity associated with her teenage pregnancy, incomplete schooling, and new HIV-positive diagnosis. Moreover, she implies that she did attended these classes to protect her baby from HIV. When she learned

that her baby was HIV-negative, she said she was happy that he was "normal" (Baby-Boo, 2019).

I found that ART is one of many forms of repair for pregnant teenagers and young mothers in Botshabelo. Other rituals of repair include abiding by school policies during pregnancy, hiding in the house, wearing blankets while accessing antenatal care, learning 'good' mothering, and attaining moral salvage. I explore these rituals below.

In the chapter on **Being a pregnant teenager,** I show how others reprimand teenagers because they are young, unmarried, and pregnant. I argue that this relentless admonishing is part of the punishing discourse associated with teenage pregnancy. Despite this reprimanding, teenagers are told to think of babies as 'blessings.' Perceiving babies in this way is a way to repent for the transgression that is teenage pregnancy.

Another ritual of repair is the deference pregnant teenagers show by staying away from school. I discuss this in the chapter on **Discovering and disclosing teenage pregnancy.** Sister Mookodi explains that pregnant teenagers are temporarily 'expelled' because their presence in the classroom could condone teenage pregnancy. It is true that informal school policies (school principals and teachers) do 'not allow' pregnant teenagers to attend school. Yet some pregnant teenagers choose to attend school in spite of these social rules. Mahlony explains this in the chapter on **Discovering and disclosing teenage pregnancy.** It seems that the presence of pregnant teenagers at school shows an apparent lack of shame. When teenagers abide by school policies, however, they show deference and discretion. Although there is gossip attached to a

pregnant teenager who remains in the house and stays away from school, this gossip is part of her repentance. Kananelo explains this in the chapter on **Discovering and disclosing teenage pregnancy**. She stays in the house so that her neighbours will not gossip about her grandfather. It seems that intentions to be discrete and 'show shame' effectively motivate pregnant teenagers to 'hide' in the house. In the chapters on **Discovering and disclosing teenage pregnancy** and **Being a pregnant teenager**, I suggest that hiding also functions to protect teenagers from envious witches. Hiding is a form of penance and thus part of the arc of repair. Being less visible is a way to show remorse and enact a "discourse of regret" (Mkhwanazi, 2014a:116).

Medical routines are another important part of repair. Because babies are such valuable 'blessings,' other people teach pregnant teenagers to prioritise antenatal care. Most teenagers' mothers insist on this. I suggest that attending antenatal appointments is a pregnant teenager's act of deference. Yet walking to a public clinic can be difficult when teenagers are trying to remain out of sight. This is why many teenagers use blankets when they are walking to the clinic, regardless of the weather. Using blankets is a way to show discretion, another ritual of repair. I explore this in the chapter on **Being a pregnant teenager**. I found that even opportunistic HIV-related infections cannot stop teenagers from attending antenatal appointments. This was the case for Bohlale. She is HIV-positive yet prioritised antenatal care at the clinic even though she was in and out of the hospital. Contrary to my empirical evidence, some South African literature suggests that teenagers do not prioritise antenatal care. Some scholars observe that teenagers delay antenatal care (Godding, 2008; Goldberg & Craig, 1983; Helleringer, 2017; Jones et al., 2013; Mushwana et al., 2015; Richter & Mlambo, 2005; Ronen

et al., 2017; Varga, 1998; Woldesenbet et al., 2015). This is sometimes because of stigma in the clinic (Burman, 1992; Varga & Brookes, 2008).

Being a "good mother" (Badinter, 1981; Mercer, 1985; Mercer, 2004; Walker, 1995) is yet another way to repent for the 'mistake' that is teenage pregnancy. Nurses and teenagers' mothers teach teenagers that these babies 'deserve' good mothers. Mammako explains this in the chapter on **Discovering and disclosing teenage pregnancy**. Good teenage mothering is a ritual of repair and a priority for most young mothers. I found that young women who achieve a 'good mother' status can potentially repair their social reputations and/or their familial relationships. Letsoba and Maipato explain this in the chapter on **Dimensions of teenage mothering**. Teenagers try to take care of their babies, in earnest. I found that they do this by protecting, loving, and connecting with their babies. This contradicts some South African studies showing that teenagers neglect or do not prioritise their babies (Cunningham & Boult 1996; Nash, 1990:147; Preston-Whyte & Zondi, 1989:60). Other work, however, suggests that teenagers work hard to take care of their babies (Delius & Glaser, 2002; Mkhwanazi, 2012).

In Botshabelo, some of these young mothers cannot always achieve 'good' mothering on their own or in the way society prescribes. In the chapter on **Dimensions of teenage mothering**, Bohlale describes HIV as limiting her physical capabilities and, therefore, her mothering capabilities. As a result, her family helped with childcare and Bohlale seemed less attached to her child. I argue that this was not for lack of caring. In fact, Bohlale found other ways to be a 'good' mother. She made plans for her baby boy's future and chose a name that would protect him. Other young mothers, including those who are HIV-negative like Popi, describe similar

things. I discuss this in the chapter on **Dimensions of teenage mothering**. Carefully choosing baby names might be an act of "eternal mothering" (Barnes et al., 1997). Future plans and baby names can protect babies even when young mothers are not around. Based on her work with HIV-positive mothers in the United States, Donna Barnes and colleagues (1997) observed that HIV-positive mothers use 'eternal' mothering to become omnipresent. This is how they support their babies even after their own deaths. Like these mothers in the United States, young mothers in Botshabelo are finding ways 'to be there' for their babies - not necessarily because of death.

Another ritual of repair is striving to attain that which holds great moral value in this social world: employment and education. Most teenagers must overcome punishment and stigma in order to keep sight of professional dreams or career goals. I think this shows great strength and determination. Maipato explains this in the chapter on **Discovering and disclosing teenage pregnancy**. Frances Nkani (2012) describes a similar kind of strength. Some teenage mothers have a "resilience" that spurs them to prioritise their babies, and finish school, despite many crippling challenges (Nkani, 2012:123). In the chapter on **Familial care**, Masoso talks about her education as if it is her salvation, a way to overcome her transgressions and be a "better person" (Masoso, 2018). In the same chapter, Sibongile explains that her mother will take care of the new baby so that Sibongile can return to school. This is the first step in Sibongile's journey to medical school. The promise of future success will positively influence the reputations of Sibongile and her family. I suggest that her willingness to undertake this journey is an act of repentance, an important part of repair in her household. Her mother's willingness to help with childcare is a recognition of this effort to repair. It is also true, however, that her mother's actions are pragmatic. Her mother has not lost hope in the dream that is 'success

through education.' Finishing school is a way to obtain employment, something that holds great moral value. The idea of employment and education as sources of moral redemption contrasts the idea of teenage pregnancy as a moral sin.

There are strong ideas about moral salvage wrapped into teenagers' rituals of repair. Teenage pregnancy offends society's expectations and upsets the moral order. Both religion and morality come to bear on the ways pregnant teenagers make meaning of repair in the context of punishment and scandal. In the chapter on **Being a pregnant teenager,** Letsoba reframes teenage pregnancy as 'a shake' or a providential test, not a calamity. In the same chapter, Mmami says that nurses prevented her abortion. This protected the teenager from further admonishing, as discussed above. In addition, it seems to me that not having an abortion – and thereby protecting the unborn baby's life - is another act of repentance. Also in the chapter on **Being a pregnant teenager,** Kananelo explains that antenatal care is a way to protect her unborn baby, a 'blessing.' Yet attending antenatal appointments at the clinic is also a ritual of repair, a way for Kananelo to repent and mend her relationship with her grandparents. Some of these young women have grown up in deeply religious homes while others have not. It seems that religion is baked into the moral order of this social world. As a result, the shame linked to teenage pregnancy might come from teenage pregnancy as a 'religious sin.' This shame might also have roots in 'failed motherhood' in so far as a teenager's mother could not save her daughter from teenage pregnancy.

I argue that teenagers and young mothers enact 'rituals of repair' (acts of deference and discretion) in order to repent for the 'mistake' that is teenage pregnancy. Yet repair is also a

pragmatic approach young mothers take to gain their families' support. Families are similarly pragmatic, incorporating new babies into the household, and realising that teenagers cannot learn mothering practices on their own. Repair is a way for teenagers to show remorse and care, and begin reconciling familial relationships.

It seems that the process of repair has an arc-like trajectory. There is a great sense of despair during the first few months of teenage pregnancy. In the previous section, I suggested that the 'arc of stigma' begins to wax in the midst of intergenerational disappointment, the punishing discourse linked to teenage pregnancy, and a growing multifaceted stigma. All this negativity establishes a need for reconciliation between pregnant teenagers and their loved ones. Both punishment and stigma create a need for repair. As a result, many teenagers perform rituals of repair. These rituals show deference and repentance for the transgression that is teenage pregnancy. The sense of repair waxes, and familial relationships are somewhat restored. Once the baby arrives, there is less need for repair. New babies bring joy and happy moments in their wake. Young mothers and their families work hand in hand to perform "householding" (Ross, 2010:90) while "caring" (Henderson, 2012:19) for a new human being.



Figure 8. Lerato and I watch Mammako with her baby.

Source: Moodley, S. 2019.

Section 6. The gap

In my empirical chapters, I have shown that there are expectations for what life should be like, or the way life should be lived. A multifaceted stigma and need for repair complicates these expectations. These expectations are imposed on teenagers by others – mothers, relatives, neighbours, teachers. Others expect most teenagers to follow social rules in order to obtain a 'good life.' This means finishing school, getting married, finding employment, and then having babies. Others encourage teenagers to chart a "linear life course" from childhood to adolescent education to adulthood employment (Everatt, 2002:25). This "traditional sequencing of transitions" describes the way education, employment, and marriage precede parenthood (Panday et al., 2009:9). This means that pregnancy would ideally happen after marriage. Even then, pregnancy must not happen too soon or too late. Letsoba explains this in the chapter on **Discovering and disclosing teenage pregnancy**.

Teenage pregnancy fractures the expectations for a linear life, a good life. I discuss this in the chapter on **Being a pregnant teenager**. Most pregnant teenagers are not married. Moreover, teenagers experience parenthood before education and employment. This is (at least partly) what makes teenage pregnancy such a calamity. Yet teenage pregnancy is much closer to the social norm than this 'linear life' discourse suggests. There is a powerful, and uncomfortable tension here: teenage pregnancy is part of what life is, and defies what life should be. The punishing discourse and multifaceted stigma associated with teenage pregnancy flags this discrepancy. All in all, there seems to be a gap between how teenagers *should* live (a prevalent moral order) and how teenagers *actually* live (a prevailing social order).

Jeremy Jones (2009) has identified a similar tension in Harare, Zimbabwe. He explored elopement among young people, especially young men. Older people say that young people are 'not getting married'. They say that this is a social crisis largely because unmarried men cannot transition into 'social adulthood.' On the contrary, young people *have* in fact transitioned into a form of adulthood. There is discomfort here. This form of adulthood is one that their elders do not recognise. Many young men have adapted their inherited social markers of adulthood to fit their circumstances. It seems that many young men are married "in one way or another" (Jones, 2009:4). They have houses, are fathers, commit to daily tasks in the household, have relationships with the family of their wives, and are paying (or beginning to pay) bridewealth.

Jones suggests that young people are "not failing" to reach social adulthood, if social adulthood means being married (Jones, 2009:4). Marriage *does* exist albeit through elopement. It seems that marriage is changing form.

> In short, young people are getting married, but they are doing so in a way that typical constructions of 'tradition' find difficult to absorb, even if it is itself 'traditional.' (Jones, 2009:10)

Jones' discussion is useful because of the way he describes the tension between 'what marriage should be' and 'what marriage actually is.' In Zimbabwe, elopement is closer to the social norm than others want or expect it to be. He highlights a tension between 'social expectations' and 'social norms.'

I observed a similar tension in Botshabelo. Teenage pregnancy is closer to the social norm (the prevailing social order) than others want or expect it to be. This was evident when pregnant teenagers and teenage mothers told me that their own mothers (and sometimes even grandmothers) were also teenage mothers. Others say that teenage pregnancy is a social crisis, a social problem. This is echoed in other parts of South Africa (Hoque & Hoque, 2010; Macleod, 1999c; Mwaba, 2000; Nash, 1990). This is because teenagers are unmarried or unemployed, and do not finish school. Yet teenagers do all these things – in time. They get married. They finish school. They find employment. It seems that the difference between 'social expectations' and 'social norms' is timing. Teenagers fulfil these social expectations out of order, instead of linearly. As with young people who elope and then make marriage payments in Zimbabwe, teenagers in Botshabelo become mothers and then (in time) do everything that 'should' have come before.

Furthermore, Jones identifies an incongruity between elopement as 'traditional' but also 'not traditional. I understand this to mean that elopement is part of what is 'normal' yet also 'not normal'. Jones suggests that what makes elopement "improper" is the way "'tradition' itself is framed" (Jones, 2009:10). Tradition dictates that "cultural hierarchies and procedures must be reproduced exactly" (Jones, 2009:10). Eloping complicates this expectation. As a result, eloping is framed as "a crime" (Jones, 2009:10). The trouble with tradition is that it "is always said to be dying; we might even say that it is traditional to say that tradition is dying" (Jones, 2009:10). Even if respected community elders eloped when they were teenagers, these facts are erased as traditional expectations are reiterated to young people over time, and through

generations. Some elders claim that they were not as promiscuous, not as irresponsible, not as disrespectful as teenage teenagers today. Jones writes:

> Historical consciousness is structured in such a way that each generation is seen as departing from the traditions that were supposedly upheld by the previous one, which in turn reflected timeless principles. (Jones, 2009:10)

Similarly, in Botshabelo, teenage pregnancy is 'traditional' in so far as it seems to repeat through generations. Yet teenage pregnancy is also 'not traditional' because it does not fit into society's expectations for a good and linear life. Even though some elders were once pregnant teenagers themselves, they erase these facts as stories of their own pregnancies and mothering are reiterated and embroidered over time. Elders say that 'teenagers love sex' or 'teenagers have too many rights'. Letsoba discusses this in the chapter on **Discovering and disclosing teenage pregnancy**. The South African literature echoes this (Hodes, 2017b; Mkhwanazi & Bhana, 2017).

Section 7. Teenage mothering in the gap

The mothering relationship - between a pregnant teenager and her baby - is situated in the gap between how teenagers *should* live and how teenagers *actually* live. This gap is at the crux of the story about teenage pregnancy and teenage motherhood. For it is in this gap - and amidst contradiction, disappointment, stigma and repair - that teenagers must become mothers. Teenagers must form relationships with their babies in a climate of severe and relentless

punishment that is in fact linked to their babies. How is this possible? How do teenagers overcome this punishment, if at all?

It seems that some teenagers are detached from and 'reject' their babies early on in their pregnancies. These babies have brought punishment and pain into teenagers' lives. Over time, however, some teenagers manage to connect with their children. Accepting pregnancy, and reframing it, makes this possible. Maipato and Letsoba explain this.

In the chapter on **Discovering and disclosing teenage pregnancy**, Maipato reframes her teenage pregnancy and her HIV as possibility. She says that pregnancy and HIV "do not make her less" because her "life is full of possibilities." She reframes these challenges as opportunities that inspire her to finish school, pursue a career, buy a house and car, and be a good mother.

In the chapter on **Being a pregnant teenager**, Letsoba reframes her teenage pregnancy as a providential test, a 'shake' from God. Letsoba effectively rejects the punishing discourse linked to teenage pregnancy. She denounces her admonishing by suggesting that she was fated to be a teenage mother. Teenage pregnancy is not seen as a 'mistake,' but rather something that was meant to be.

Both Maipato and Letsoba rebuff the punishing discourse linked to teenage pregnancy. In doing so, they reject the guilt and shame that others project. I think this is extremely meaningful. By rejecting the punishment linked to teenage pregnancy, I argue that a teenager no longer

considers her baby as the cause of her suffering. She need not blame or reject her baby. Instead, she can begin to embrace an opportunity for a mother-child relationship. By reframing the biggest 'mistake' of her life, a teenager can allow herself to connect with, and take care of, her baby. This happens gradually during pregnancy, and into motherhood.

In the United States and Sweden, some scholars found that this delayed connection might flag a 'not good' mother (Britton, Gronwaldt & Britton, 2001; Klaus & Kennell, 1916:14; Klaus & Kennell, 1977; Mercer, 2004; Siddiqui & Hagglof, 2000). In the United States, scholars observed that mothers play a "highly significant" role in shaping their babies' lives and development (Chess & Thomas, 1982:215). Contrastingly, over the past few decades, other scholars have re-examined the notion that (only) good mothers should be deeply and immediately attached to their babies. Based on her work in France, Elisabeth Badinter (1981) found that mother love is neither immediate nor instinctual. Mother love is earned, and forged over time, as mother and child interact with and learn from each other. In a New York Times article by Nan Robertson (1981), Badinter says:

> Maternal love is not a given but a gift … It is a human feeling, and like any feeling it is uncertain, fragile and imperfect. (Badinter in Robertson, 1981:2)

Moreover, in the United States, some scholars have found that mothers *and fathers* have a responsibility to connect with, and raise a child (Lamb, 1983). Children must be able to rely on 'good parents' instead of only 'good mothers'. More recently, literature in the United States suggests that mother and baby are connected to the people around them in crucial, and at times

painful, ways (Essex et al., 2006). Based on work in South Africa, Linda Richter (1997) discusses the notion - initially introduced by British paediatrician Donald Winnicott - that there is "no such thing as a baby" (1997:97). That is, a baby does not exist as a sole entity by itself. Richter explains:

> …a baby is not an element apart; rather, an infant or young child is always attended by caregivers and so is part of a community of others. (Richter, 1997:97)

My empirical work – with *teenage and young* mothers – echoes this literature focusing on *adult* mothers.

First, I argue that mother love is not immediate. Kananelo explains this in the chapter on **Dimensions of teenage mothering.** It took time for Kananelo to become attached to, and connect with, her baby. She talks about sharing her love between her boyfriend and her baby. She suggests that, during pregnancy and after birth, mother love grows.

Second, I have shown that many people (not only a teenage mother) raise, discipline, and take care of a baby. A good mother raises her baby with her family. That is, the child is dependent not only on a 'good mother', but also a 'good family'. The baby depends on, and is raised by, everyone connected to the teenage mother. This is important because mothering (and the associated mother-child relationship) cannot always be a priority for teenagers, even if they want it to be. They are necessarily distracted during, and even after, pregnancy. When teenagers

first discover pregnancy, they must make tough decisions about school. I discuss this in the chapter on **Discovering and disclosing teenage pregnancy**. For the duration of the pregnancy, most teenagers must deal with punishment, admonishing, and scolding because they are unmarried and young. I discuss this in the chapter on **Being a pregnant teenager.** After the baby is born, families step in. Rituals of repair, reconciliation and acceptances precede this. When families help with childcare, some teenagers can return to school. I discuss this in the chapter on **Familial care.**

Third, I argue that a teenager strives to be a 'good' mother even if she is not capable of achieving this. Good mothering is part of the arc of repair. For some teenagers, HIV limits the capability to be a good mother. Bohlale explains this in the chapter on **Dimensions of teenage mothering**. Despite her HIV and opportunistic infections, Bohlale found ways to connect with her baby. She carefully chose a baby name, and constructed dreams and plans for her child's future. She was not able to be a 'good' mother in the conventional sense. Nonetheless, she found ways to perform mothering. This is different to what some HIV-positive *adult* mothers experience. In South Africa, scholars have explored the mother-child relationship in the context of HIV (Bigelow et al., 2010; Cooper et al., 1999; Cooper et al., 2009; Cooper et al., 2014; Davies et al., 2011; Doherty et al., 2006; Hartley et al., 2010; Maiello, 2000; Perez et al., 2005; Palin et al., 2009; Rochat et al., 2011; Richter, 1995; Thairu et al., 2005; Tomlinson et al., 2005; Tomlinson & Landman, 2007; Visser et al., 2012). These scholars have found that HIV can seriously compromise the mother-child relationship. HIV can exacerbate maternal depression. This can hinder a baby's physical and emotional development.

Based on work with HIV-positive teenage mothers in Johannesburg, Adeagbo Josephine (2019) writes:

> …there is no one model of mothering – Mothering is not inborn or inherent but shaped by contextual and circumstantial realities. (Josephine, 2019:8)

This agrees with some of the global literature (Glenn, 1994) and my empirical work. In Botshabelo, young mothers showed me that there are many ways to practice 'good' mothering, even in the face of HIV.



Figure 9. Letsoba and I pause for a picture in Robedi section.

Source: Moodley, S. 2019.

Section 8. Theoretical contributions

This study has the potential to contribute to the fields of public health, childhood and youth studies, and sexual and reproductive health in so far as these fields deal with issues surrounding girlhood, womanhood, and young motherhood. Moreover, this research adds to a growing body of literature exploring what life is like for (HIV-negative and HIV-positive) pregnant teenagers and young mothers. There is limited research on this topic to date, especially in the South African context (Long, 2009a; Long, 2009b; Josephine, 2019; Stinson & Myer, 2012).

In this section, I summarise the specific theoretical contributions of this study. I reference other sections in this chapter where necessary.

The empirical chapters in this dissertation focus on four main threads: how others perceive teenagers, how teenagers experience others, how teenagers perceive themselves, and how teenagers perceive their babies. I suggest that these threads weave a story about teenage pregnancy, motherhood, and HIV. These threads intersect and complicate each other as teenagers try to make sense of what it means to be pregnant and (in time) to be a young mother.

I found that these threads are fraught with contradictions when it comes to teenagers' experiences with witches, marriage, abortion, and schooling (see section one). I suggest that these are 'contradictions' because they describe a sense of hypocrisy, that is, the ways others (community members, kin, nurses, teachers) say one thing to teenagers and young mothers yet do another. Families tell pregnant teenagers to hide in the house and avoid witches in order to protect themselves and unborn babies. Yet hiding serves to protect teenagers' mothers.

Teenagers' mothers, grandmothers, and neighbours punish teenagers because teenagers are unmarried and pregnant. Yet many of those who punish and scold teenagers are guilty of this very same thing. Nurses prevent pregnant teenagers from having abortions. Yet teenagers are repeatedly told that teenage pregnancy is a 'mistake' or a sin. This social world reprimands teenagers for being pregnant. Yet teenagers are told that babies are blessings. Teachers and school principals do 'not allow' most teenagers to attend school while they are pregnant. Yet they tell teenagers that education is the key that unlocks a successful, financially stable future. Families and teenagers' mothers teach teenagers that pregnancy is a disappointment. Yet they also tell teenagers to prioritise babies' needs. Teenagers must work hard to care for the very thing that causes pain, isolation, and worry.

I suggest that these contradictions situate a pregnant teenager as neither a child, nor an adult (see section two). She sits in the "undecidable" space between these social positions and experiential worlds (Macleod, 2003).

Many teenagers and young women are chastised for transgressing a moral order that has eluded most others around them. The contradictions summarised above are part of this chastising. This sense of moral order relates to the idea that there are key sources of moral value in this community including marriage, employment, education, and physical well-being. These are under threat, and must be regained. I think this is why families are desperatately trying to recover these sources of moral value, through their teenage daughters. Yet teenage pregnancy thwarts families' attempts to achieve this morality. This leads to an intergenerational sense of disappointment where teenagers have 'failed' just like their mothers (see section three).

Alongside this disappointment is a punishing discourse linked to teenage pregnancy. Families, nurses, teachers, and neighbours scold teenagers for being pregnant yet unmarried, uneducated, and poor. Punishment serves to exacerbate a multifaceted stigma (see section four). I found that this stigma changes as pregnancy progresses. The 'arc of stigma' waxes in the initial months of pregnancy and then wanes after the baby is born.

This sense of morality 'being under threat' seems to create a context of fragility, which exacerbates the punishment and social sanction that teenagers and young women carry. This sense of fragility begs repair, which is a major component of the huge responsibility young women bear for moral salvage. Like stigma, repair seems to follow an arc-like trajectory (see section five). Teenagers perform 'rituals of repair' by hiding in the house, using blankets, and following to medical routines. These are ways to protect unborn babies, clear the slate, and offer penance for the sin that is teenage pregnancy. These acts of deference, discretion and redemption grow the sense of repair and reconciliation between teenagers and their families. Given teenagers' hard work, the need for repair lessens once the new baby arrives. The arc of repair plateaus as young mothers work consistently and continuously in order to take care of babies and obtain the sources of moral value their families prioritise.

The contradictions, punishing discourse, multifaceted stigma, good mothering, and rituals of repair expose a gap between how teenagers *should* live and how teenagers *actually* live (see section six). Even though they must live in this gap, most teenagers and young mothers work hard to be "good mothers" (Badinter, 1981; Mercer, 1985; Mercer, 2004; Walker, 1995). It is in this space, this gap, that teenage mothering occurs (section seven). Even as these young women grapple with what life *should* be and what life *is*, they work hard to reconcile with their

families, and connect with, protect, and love their babies. Teenagers and young mothers have the ability to cope with (at times) debilitating pressures and social challenges. Moral redemption and familial care are important parts of this coping, as is the slow-growing mother-child relationship.

X. Concluding thoughts

This study is based on layered narrative work with 88 teenage teenagers and young women, and time- and energy-intensive ethnographic work with 30 of these women. This research is intended to be an ethnographic exploration of – and tell a story about - the way teenage pregnancy, teenage motherhood, and HIV influence life in Botshabelo.

I begin this story with the chapter on **Discovering and disclosing teenage pregnancy**. Visibility, secrecy, and shame are important parts of these experiences. Discovering an HIV positive status at the same time as pregnancy is a double blow for some teenagers. Most HIV-positive teenagers try to conceal their HIV. They only confide the pregnancy. Pregnancy is more urgent, more visible, than HIV. As pregnancy progresses, many teenagers hide in their homes. They do this to avoid witches who could harm unborn babies. They follow the pregnancy-related precautions that mothers teach. I suggest that teenagers' mothers keep their daughters hidden in the house so they can hide their own (maternal) shame. The witch discourse and pregnancy-related precautions are means to this end. In this chapter, I argue that teenage pregnancy is so shameful (largely) because teenagers are unmarried. Yet there is tension here. It seems that pregnant teenagers and teenage mothers are blamed for the decline of an institution (marriage) that began eroding generations before they were born. Pregnant teenagers are punished for childbearing out of wedlock even though this is not that far from the social norm. This might be one reason why some teenagers reject this shame. They recast pregnancy (and even HIV) as possibility, instead of adversity.



Figure 10. Posing with our research certificates

Source: Moodley, S. 2019.

The next part of the story sheds light on what it is like to be young and pregnant. I discuss this in the chapter on **Being a pregnant teenager**. Community and family members alike scold and reprimand teenagers because teenagers are pregnant yet unmarried, uneducated, and unemployed. Most teenagers cannot attend school during pregnancy, even though they (and their families) greatly value education. This is a punishment for teenage pregnancy. There is tension here. Teenagers effectively reject social expectations for a structured and moral (linear) life when they carry unplanned teenage pregnancies to term. Furthermore, some families blame 'teenage pregnancy' when their daughters drop out of school. Yet not finishing school is closer to the social norm than most people admit. Another aspect of the punishing discourse is the fact that most teenagers are 'not allowed' to have abortions. This is also a way for nurses to protect teenagers from making another 'mistake.' Furthermore, teenagers are (repeatedly) told that they have disappointed their families by becoming pregnant. For teenagers' mothers who were pregnant teenagers themselves, their daughters' pregnancies are painful reminders of their own punishments. More than this is the fact that these mothers cannot protect their daughters from this punishment. All this pain gives way to an 'intergenerational' sense of disappointment. This unending reprimanding manifests as a punishing discourse that pushes teenagers further into hiding. They do not leave the house for fear of gossip. Interestingly, some teenagers reframe the punishment linked to teenage pregnancy as a providential test. In doing so, they seem better equipped to take care of and protect their babies. Hiding in the house is also a way for pregnant teenagers to repent through discretion and remorse. I suggest that hiding is a ritual of repair much like when teenagers sacrifice their own comfort - and adhere to medical routines - to protect their babies. Teenagers prioritise antenatal care so they can check on unborn babies. HIV-positive teenagers diligently adhere to HIV treatments to prevent infecting their babies.

Teenagers cover themselves with blankets when they attend antenatal appointments. Following medical routines is an act of moral salvage because this is a way to show care, diligence and responsibility - values which are thought to be absent among pregnant teenagers. Prioritising medical routines is also a form of repair in so far as teenagers can please boyfriends, and reconcile with their mothers.

After the baby is born, life changes again. In the chapter on **Familial care**, I argue that families play a crucial role in teenage motherhood. The repair work that teenagers do during pregnancy leads to reconciliation and, once the baby is born, a sense of acceptance. This repair also restores the authority of a teenager's mother as a caregiver. Some teenagers are able to return to school because their mothers can help with childcare at home. Familial care is crucial for some HIV-positive teenagers. HIV and opportunistic infections limit their childcare capabilities. Moreover, some teenagers' mothers must sacrifice their employment to do this. This is deeply meaningful in a context of mass unemployment. Finishing high school is a rising tide that can lift entire families. Education can also reinstate a teenager's confidence, and help her provide for her baby. It seems that some teenagers' mothers want more financial security, employment opportunities, and stability for their daughters. Education is a first step toward obtaining some of this. Not all teenagers can rely on their mothers to help with childcare. This is a luxury some families cannot afford. In these situations, teenagers must take care of their babies at home. These teenagers cannot resume schooling. Yet their families still find ways to provide support. Most families pay for baby clothes, food, toys, and other costs. Sometimes, families must take care of babies *and* teenage mothers.

In the fourth and final empirical chapter, **Dimensions of teenage mothering**, I describe the love and intrinsic joy that teenage motherhood invites. Many teenagers work hard to be "good mothers" by loving, connecting with, and protecting their babies (Badinter, 1981). As the 'arc of repair' plateaus, good mothering is a ritual of repair that teenagers must sustain. Mother love grows with time, especially after the punishing discourse that most pregnant teenagers face. Providing a child with love is like packing a lunchbox for school: a good mother provides everything her child may need, but not necessarily everything they may want. Connection between a mother and her baby is also important. A teenage may see her baby deeply connected to her embodied self. This invokes a profound sense of responsibility. Part of being responsible is protecting babies by providing financial stability. I learned that education is often the best means to this end. In the final part of this chapter, I discuss the "duality of motherhood" (Sandelowski & Barroso, 2003a). That is, the ways HIV-positive teenagers work to become good mothers when they cannot physically take care of their babies. Because they cannot always look after their children, some teenagers instead look out for their children. To this end, some teenagers make plans for the future, or carefully choose baby names that will keep their children safe and happy. The fact that a teenage mother must choose her own baby's name shows that her baby has not been incorporated into the greater family unit. This suggests that even the newborn baby must pay for the "crime" that is teenage pregnancy (Jones, 2009:10). This is yet another punishment that a teenager must endure. Still, many teenagers try to be 'good' mothers to the best of their abilities and their circumstances. When teenagers cannot do much else – because of HIV-related ailments, unemployment, incomplete schooling, or an unmarried social status - being a mother is something teenagers *can* do.

After sharing four empirical chapters that describe what life is like for pregnant teenagers and teenage mothers, I offer some final analysis and theoretical contributions in the **Discussion** chapter. I argue that the path many pregnant teenagers must walk is fraught with contradictions and tensions related to marriage, schooling, medical routines, and good mothering. Moreover, there is a multifaceted stigma linked to being young, pregnant, and (for some teenagers) having HIV. This stigma heralds (at least) three intersecting vulnerabilities that most teenagers must face (Figure 1). I suggest that this stigma has an arc-like trajectory as teenage pregnancy shifts into teenage motherhood. Furthermore, pregnant teenagers seem to occupy an "undecidable" position in this society (Macleod, 2003). Many teenagers straddle the murky line between adulthood and childhood. The contradictions and punishment associated with teenage pregnancy create a dire need for repair. Most pregnant teenagers and young mothers make meaning of repair through acts of deference, discretion, and remorse. These rituals of repair allow some pregnant teenagers and young mothers to repent for the calamity that is teenage pregnancy and, in doing so, reconcile with their families. This sense of repair also restores the authority of the teenager's mother as a caregiver. As a result, families help with childcare, which in turn allows some young mothers to return to school.

The contradictions, punishing discourse, multifaceted stigma, good mothering, and rituals of repair expose a gap between how teenagers and young women *should* live and how they *actually* live. That is, most pregnant teenagers and young mothers must follow a prevalent moral order instead of replicating a prevalent social order. The former describes what life should be like: finishing school, getting married, finding employment, and then having babies. Ideally, life should follow a linear path. Teenage pregnancy fractures society's expectations for a moral

life, a linear life, a good life. Most pregnant teenagers are unmarried, unemployed and do not finish high school. Yet teenage pregnancy might be closer to the social norm than this linear discourse admits. Some pregnant teenagers and teenage mothers told me that their own mothers (and sometimes even grandmothers) were also teenage mothers. Teenage pregnancy is simultaneously traditional and not traditional. It is in this gap - between how teenagers *should* live and how teenagers *actually* live - that teenage pregnancy and teenage mothering are performed.

Teenage pregnancy, teenage motherhood, and HIV change the way life is lived in Botshabelo. Yet we know too little about how teenagers and their families react to and experience these changes. This research provides important insight to this end. This dissertation describes what some (HIV-positive and HIV-negative) teenagers and their families endure and embrace during pregnancy and motherhood.

I hope that this ethnographic exploration can add to what we already know about these experiences, in South Africa and the world. This study stands alongside research exploring girlhood, womanhood, and young motherhood in the fields of youth studies, gender studies, and sexual and reproductive health. Moreover, this work aligns with scholarship beckoning more empathetic, compassionate perspectives and awareness. This is essential to understanding what teenagers and young women face during pregnancy and motherhood. American filmmaker and photographer, Danny Lyon (2018) highlights this:

> The pictures do not ask you to help these people, but something much more difficult; to be briefly, intensely aware of their existence, an existence as real and significant as your own. (Lyon, 2018)

This DPhil work stands alongside ethnographic scholarship exploring teenage pregnancy and teenage motherhood. Clearly, these are messy and intricate experiences. Being uncomfortably aware of what some teenagers must endure could perhaps alter our perception of the 'problem' that is teenage pregnancy. This research strives to complicate our understanding of what it means to be young, pregnant and (for some teenagers) HIV-positive in a moment when these things herald punishment, stigma, repair, care, and love.

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Appendix

Appendix A: Summary of discussions with practitioners in the field (2017-2018)

	Date	Practitioner	Organization	Position	Location	Summary
1	23.10.17; 16.11.17; 22.11.17; 19.12.17; 28.02.18	Ms. Ntswaki Lesole-Tsoai	Centre for HIV and AIDS Prevention Studies (CHAPS)	Recruiting Manager	Free State (South Africa)	Discussed: HIV/AIDS youth in Botshabelo, parent-child relationships in clinic, antenatal care/support groups, PMTCT procedures in Botshabelo clinics, ethical approvals. Arising questions: how do we support pregnant teenagers? Why do these teenagers start/refuse ART? How does the disclosure of pregnancy/HIV status affect antenatal care and ART regimen?
2	24.10.17	Dr. Diana Cooper	University Western Cape	Professor	Western Cape (South Africa)	Discussed: narrative analysis methods, gender norms, ideal age group. Arising questions: how do young people with HIV/AIDS speak to each other?
3	31.10.17	Dr. Eve Mendel	Desmond Tutu Clinic & Youth Centre	Medical Doctor	Western Cape (South Africa)	Discussed: teenage pregnancy and ART for young people, HIV disclosure.
4	02.11.17	Dr. Elona Toska	University of Cape Town	Post-Doctoral Student	Western Cape (South Africa)	Discussed: HIV disclosure, parent-child relationship.
5	06.11.17	Dr. Millicent Atujuna	Desmond Tutu HIV Foundation	Social Behavioural Scientist	Western Cape (South Africa)	Discussed: young and pregnant HIV positive women. Arising questions: research topic: how do young, pregnant HIV positive women interact with ART through pregnancy?
6	16.11.17	Ms. Lesley Gittings	University of Cape Town	Doctoral Student	Western Cape (South Africa)	Discussed: HIV-positive adolescent health needs, ethical approvals.
7	26.11.17	Mr. Mervin Govender	Pinpoint Solutions	CEO	Free State (South Africa)	Discussed: HIV prevention programs in Free State, ethical approvals, participant sample size. Arising questions: where and when do young women test for pregnancy? What kind of support exists for HIV-positive women? Why do women need support?
8	05.12.17	Dr. Lee Fairlie	WITS Reproductive Health and	Director of Maternal and Child	Gauteng (South Africa)	Discussed: HIV-positive pregnant mothers, ethical approvals for minors

			HIV Institute (WRHI)	Health Research Department		or in cases of rape, participant consent for minors, reducing risk.
9	05.12.17	Members of Trinity House	Trinity Community Ministries & Rehabilitation Centre	Members	Atlanta (America)	Discussed: parent-child relationships for sick or addicted parents.
10	06.12.17	Ms. Sue Paget & Ms. Marion Bunch	Rotarians for Family Health and AIDS prevention (RFHA)	CEO & CEO Emeritus	Gauteng (South Africa)	Discussed: HIV prevention with CDC, PEPFAR, SABC, She Conquers (National Department of Health initiative).
11	19.01.18	Dr. Candice Fick	WITS Reproductive Health and HIV Institute (WRHI)	Medical Doctor, Lecturer	Gauteng (South Africa)	Discussed: PMTCT and antenatal care for HIV-positive women, participant consent for minors, ethical approvals, language and translation. Arising questions: is there more follow up and support before/during/after pregnancy? how do we meet young women who do not come to the clinic? how can we learn more about teenagers' experiences with HIV and pregnancy?
12	22.01.18	Ms. Namhla Sicwebu	University of Cape Town	Doctoral Student	Western Cape (South Africa)	Discussed: theories and methods, Body Mapping, Theater of the Oppressed, recruitment methods, ethnography and observation.
13	21.02.2018	Dr. John Imrie	WITS Reproductive Health and HIV Institute (WRHI)	Director of Adolescent Innovations Project (AIP)	Gauteng (South Africa)	Discussed: HIV-positive mothers lost to follow up, ART adherence for pregnant women, work schedule (timeline), impact and outcomes, ethical approvals.
14	23.02.2018	Dr. Jean Elphick	Afrika Tikkun	Director of Youth Programs	Gauteng (South Africa)	Discussed: theories and methods, Transformative Research Paradigm, Narrative Research Method, snowball sampling, Theatre of the Oppressed, ethical approvals, clinics.
15	28.02.2018	Ms. Dimakatso Tsoaeli	University of Free State	Undergraduate Student	Free State (South Africa)	Discussed: ethical approvals, skills transfer, unemployment.
16	28.02.18; 06.03.18; 25.05.18; 30.05.18	Dr. Ariel Torres	Botshabelo Hospital	CFO	Free State (South Africa)	Discussed: ethical approvals, participant age group, Botshabelo township demographics.
17	14.03.2018	Dr. Chikobvu & Dr. Zakhura	Free State Department of Health	Department of Research &	Free State (South Africa)	Discussed: ethical approvals.

				Department of HIV/TB Prevention		
18	15.03.2018	Dr. Alfred Bere	Prevention HIV & TB Branch at Centers for Disease Control and Prevention	Chief of Department	Gauteng (South Africa)	Discussed: participant age group, teenage pregnancy in SA, impact. Arising questions: who is infecting who? What are the male partners doing? What is SA doing to achieve 90-90-90 targets or 95-95-95 targets in the global acceleration plan?
19	01.05.2018	Ms. Lizzie Chapel	University College London	Doctoral Student	London (UK)	Discussed: quantitative research on pregnancy, HIV, infant HIV testing in KwaZulu-Natal.
20	25.05.2018	Sister Flora	Lesedi Clinic (Free State)	Clinic Manager, Nursing Sister	Free State (South Africa)	Discussed: social media among youth, media effect on teenage pregnancy.
21	25.05.2018; 30.05.2018; 31.05.2018	Sister Theku	Centre for HIV and AIDS Prevention Studies (CHAPS)	Clinic Manager, Nursing Sister	Free State (South Africa)	Discussed: recruitment, ethical approvals, nurse-patient communication.
22	25.05.2018	Mr. T.P. Koalepe	Botshabelo Hospital	District Clinic Manager	Free State (South Africa)	Discussed: ethical approvals.
23	30.05.2018	Sister Masilo	U Section Clinic in Botshabelo	Clinic Manager, Nurse	Free State (South Africa)	Discussed: ethical approvals, dissemination and sharing research with clinic leadership.
24	30.05.2018	Mr. Manamatela	F Section Clinic in Botshabelo	Clinic Manager, Nurse	Free State (South Africa)	Discussed: ethical approvals, dissemination and sharing research with clinic leadership.

Appendix B: Community advisor report

Preface

The following report was compiled for ethics committees by the DPhil candidate Sasheenie Moodley for this social science research. This report is based on individual discussions with community leaders (below). The DPhil candidate scheduled meetings with all individuals in this advisory group. The DPhil candidate consulted all individuals with the same questions to gain insight into best (community-specific) practice for this research.

Community Advisors who participated

- Ms. D. Tsoaeli: University of Free State undergraduate student, Mother, Botshabelo resident
- Sister N. Lesole-Tsoai: Pinpoint/CHAPS Clinic manager (Botshabelo), Mother
- Sister N. Theku: Pinpoint/CHAPS Clinic manager (Botshabelo)
- Mr. M. Govender: CEO Pinpoint, healthcare provider of medical male circumcision (Botshabelo)
- Dr. N. Zakhura: Head of TB, Free State Dept. of Health
- Dr. P. Chikovo: Ethics Advisor, Free State Dept. of Health
- Dr. A. Torres: CEO Botshabelo Hospital (local partner)
- Dr. A. Bere: Global Health Specialist, Center for Disease Control and Prevention (South Africa)

Questions for Community Advisors

Question 1: What do you think about the current relevance of the chosen participant group, pregnant woman 15-20 years who are HIV positive, for HIV research in South Africa?

- This is a good research group to work with. We need to focus on young women in South Africa because young women (15-24 years) are 8 times more likely to be infected with HIV compared to young men in the same group. This is a public health concern, especially when we realize that South Africa has a very high teenage pregnancy rate.
- This research fits nicely into the 90-90-90 targets, and is focusing on the second "90" by looking at adherence to HIV treatment among pregnant adolescents.
- It is good to focus on this age group for pregnancy: out of 2500 births/deliveries in Botshabelo Hospital per year, approximately 25% of these deliveries are from HIV-positive women. We therefore need to understand more about how to cater for these individuals.

Question 2: What is the best (most culturally-appropriate) way to recruit and interview participants?

- The DPhil candidate should actively seek out pregnant adolescents in Botshabelo. This is because adolescents isolate themselves in the community when they are pregnant. Recruitment method: purposive sampling
- Consent should be informed, written consent. Oral consent is not culturally appropriate and has additional ethical concerns that a local South African ethics committee will not endorse.

- The DPhil candidate should spend time in the maternity ward of Botshabelo Hospital to learn about pregnancy services. Thereafter, the DPhil candidate can recruit participants from the community centre/waiting room attached to Botshabelo Hospital Maternity ward.
- The DPhil candidate should spend time with participants, conducting both informal and formal interviews to learn about participants' experiences.
- The DPhil candidate should conduct interviews with participants in a public space, like the community centre close to Botshabelo Hospital. Conducting interviews in a public space will help to avoid unintended disclosure: if community members learn a participant has HIV because of association with the DPhil candidate. However, if a participant feels more comfortable in a private space then the DPhil candidate should conduct interviews in that private space.

Question 3: Should the DPhil candidate work with a translator?

- Yes, DPhil candidate should work with a research assistant/translator who is locally based in Botshabelo.
- The research assistant should already be linked to Botshabelo Hospital so that the DPhil candidate does not create an employment gap when the research is over.
- The DPhil candidate should pay the research assistant for time spent during interviews/discussions with participants based on market-related, part-time employment. The DPhil candidate should also explore what skills the research assistant can gain during this research.
- The research assistant should be female: a male research assistant may make some participants feel uncomfortable when talking about pregnancy and other intimate details.

Question 4: What kinds of compensation should participants receive for their time and participation?

- The DPhil candidate should compensate participants for their time. Compensation should not be a coercive incentive. The DPhil candidate should therefore consider providing participants with things they may need for their babies e.g. nappies and soap. The DPhil candidate can also give each participant a "Certificate of Participation" at the end of the research, as others NGOs have done.
- The participants should also feel they can contact the DPhil candidate at any time with questions/concerns about the research. The DPhil candidate should consider providing monthly airtime vouchers (maybe R15.00-R20.00 vouchers) to participants so they can use the airtime to text/call the DPhil candidate as needed. NGOs in Botshabelo provided airtime to patients, in 2016, after medical male circumcisions so patients could contact nurses/healthcare workers.

Question 5: How will the DPhil candidate know a participant has HIV during recruitment?

- The DPhil candidate should not ask participants if they have HIV directly: this could be dangerous/uncomfortable for participants if a community member overhears.
- The DPhil candidate should ask participants if they are "taking treatment" or "taking chronic medications" as a proxy for being HIV-positive. If a participant answers no, then DPhil candidate should not recruit that participant as they are likely HIV-

negative. If a participant answers yes, then the DPhil candidate should spend more time with the participant (who is likely HIV-positive) to learn more about that participant. With more time spent in informal discussion, the participant will likely disclose their HIV status to the DPhil candidate, and the DPhil candidate can formally recruit the participant.

- The DPhil candidate must know this is a time-intensive process. Time is needed to protect participant privacy so that a participant can disclose their HIV status if they want to.

Question 6: How can the DPhil candidate share research information with the community to ensure responsible research?

- The DPhil candidate should share learnings with the partner, Botshabelo Hospital, so healthcare providers can improve pregnant-specific health services for adolescents.
- The DPhil candidate should share information with the members of this advisory group so everyone can learn.
- All information shared must be anonymized to protect patient privacy.

Appendix C: Ethical trainings completed

- University of Oxford: “Vicarious [secondary] trauma workshops” (Social Sciences Division training course). Completed October 2017.
- University of Oxford: “Fieldwork in practice: before, during, after fieldwork” (Social Sciences Division workshop). November 2017.
- University of Oxford: “Preparation for safe and effective fieldwork in the social sciences” (Social Sciences Division workshop). November 2017.
- University of Oxford: “Research integrity online training” (online). Completed 17/01/2018
- US National Institutes of Health Office of Extramural Research: “Protecting Human Research Participants” (online). Completed 19/01/2018
- World Health Organization: “Research Ethics online” (Global Health Network online). Completed 19/01/2018
- Collaborative Institutional Training Initiative (CITI) online training: “IRB for Health Sciences Research (IRB-HSR): ALL RESEARCH” course. Completed 26/09/2016
- Oxfordshire Safeguarding Children Board online training: “An Introduction to Safeguarding”. Completed on 26/03/2018

Appendix D: Ethical guidelines consulted

- Human Sciences Research Council (South Africa): Code of Ethics
- Medical Research Council (South Africa): Guidelines on Ethics for Medical Research General Principles including research on children, vulnerable groups, international collaboration and epidemiology (2002-2004)
- National Department of Health Ethics in Health Research (South Africa): Principles, Structures, Processes (2004)
- Central University Research Ethics Committee (CUREC) (University of Oxford): Ethical Guidelines
- Anthropology guidelines - Association of Social Anthropologists of the UK and Commonwealth
- Social Research Association (UK): Ethical Guidelines
- South African legislation: Children's Act
- South African legislation: National HIV/AIDS guidelines namely "South African National Consolidated Guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults" (2015)
- European Commission (EU): Data protection and privacy ethical guidelines.
- European Commission (EU): FP7 Ethics in Research and International cooperation.
- European Commission, & Pauwels, E (EU): Ethics for Researchers-facilitating research excellence in FP7 (2007)
- European Commission (EU): A comprehensive strategy on how to minimize research misconduct and the potential misuse of research in EU funded research (2010a)
- European Commission (EU): Guidance Note for Researchers and Evaluators of Social Sciences and Humanities Research (2010b)

Appendix E: Information sheet

School of Interdisciplinary Area Studies
University of Oxford
12 Bevington Road, Oxford OX2 6LH

Principal researcher: Sasheenie Moodley [PI name]
DPhil Student (Area Studies)
sasheenie.moodley@area.ox.ac.uk (+44-7864-797-659) or (+27-83-647-0880)

[PhD Research: Experiences of Pregnant Youth Living with HIV/AIDS in South Africa]
May 2018 - December 2019

INFORMATION SHEET

(English version)

Ethics Approval Reference: [R57304/RE001]

About the research

1. ***What is the purpose of this research?***
   - We want to learn about your experience with pregnancy.
   - We want to understand what kinds of support you receive from your family, friends, boyfriends, and people in the hospital.
2. ***Why are we doing this research?***
   - There are many teenage pregnancies in townships like Botshabelo.
   - The hospital and government wants to understand how to support pregnant women and help them after pregnancy.
   - Teenage moms and babies should live healthy lives with support from their communities.
3. ***Who is doing this research?***
   - We work with the hospital in Botshabelo, and the Free State Department of Health.
   - We work with the University of the Free State and the University of Oxford.

About you and your information

4. ***Why are you asking me to help with this research?***
   - You are a pregnant teenager or mom (15-20 years old) living in the Free State.
5. ***What will happen to the information you share?***
   - We will share your experiences with the hospital so doctors/nurses can improve pregnancy services for young women. Your name and details will not be shared with the hospital.
   - We will write about your experiences for university students and teachers. Your name and details will not be shared.
6. ***How will we protect your privacy?***
   - All information will be locked in a cupboard on a computer hard drive with a password. Only we will access your information.
   - Your name and details will be written separately to ensure no one can match your experiences to information you share.
   - After 10 years, all information from this research will be deleted so no one can use your information.
7. ***Do you have to do this research?***
   - You do not have to do this research.
   - If you do not want to do this research, please tell us. We thank you for your time.

If you want to do this research

8. ***How do you participate?***
   - If you are over 18 years old, we will ask to sign a permission slip (consent form). Then we will find a time to meet and interview you.
   - If you are under 18 years, we will ask you and your caregiver to sign a permission slip (consent form). Then we will find a time to meet and interview you.
   - We will ask if we can tape your voice during interviews. No video will be taped.
   - If you or your caregiver gives permission now but you later decide you do not want to do this research, please tell us. You can stop this research at any time.
   - At that point, we will ask if we can use your information without your name OR if we should remove all your information.

11. ***What will I get? Are there benefits for me?***
- You will get a small baby hamper (nappies, lotion, soap).
- You will get R20 (£1.20) airtime vouchers each month.
- You can use to contact us with questions or concerns - 24-hour phone number (+27-83-647-0880). Contact card below.
- You will receive a Certificate of Participation.
- Your experiences will help us improve health programs and services for pregnant teenagers.
- You will not be paid for interviews.

10. ***Will I be in danger? Are there risks for me?***
- Other people may see you talking to us and learn about your pregnancy or other health issues.
  - We will prevent this by talking to you in the Botshabelo youth center (unless you prefer a more private space).
- Other teenagers helping with this research could learn about your pregnancy or other health issues.
  - We will prevent this by interviewing each person separately.
  - We will ask everyone doing this research not to talk about the research and respect everyone's privacy.
- Someone could learn about your pregnancy or other health issues if they read our research notes.
  - We will prevent this by locking our notes in a cupboard. We will save our notes on a computer hard drive with a password. Only we will access your information.
  - Your name and details will be written separately to ensure no one can match your experiences to information you share.
- You may tell us about abuse like assault, harassment, abuse, or rape.
  - We will discuss this privately with you. If you are in immediate danger, then we will ask you if we can tell someone and ask for help. We can tell your caregivers or hospital counsellors.
  - If you do not want us to tell someone, and you are NOT in immediate danger, then we will tell you about resources including Child Emergency Line (free locally: 0800 123 321), Child Welfare SA (hotline for reporting abuse: 0861 424453), Child Line (free locally: 0800 055 555), and other social welfare agencies.
  - If you do not want us to tell someone, BUT you are in immediate danger, then we will ask for help from the hospital counsellors and other social welfare services. If you tell us about rape that happened in the past 3 days, then we will talk to you about HIV testing and 'responsible reporting' if/when you choose.
  - If your abuse will get worse when we tell a caregiver (if the caregiver is abusing you) or hospital (if someone in the hospital is abusing you) then we will talk about protection services (like ACVV), and other social welfare for you. We will report the abuse to the hospital management after talking to you.

9. ***Who can I call with questions or complaints?***
- Please call Sasheenie Moodley (+27-83-647-0880) or email (sasheenie.moodley@area.ox.ac.uk)
- You can email the university committee at the University of Oxford (ethics@socsci.ox.ac.uk)
- You can email the university teachers: Professor Lucie Cluver (lucie.cluver@spi.ox.ac.uk), Professor Jonny Steinberg (jonny.steinberg@africa.ox.ac.uk)

Contact card

You have questions or concerns, please contact:

Sasheenie Moodley (+27-83-604-8347)
email: sasheenie.moodley@area.ox.ac.uk

University of Oxford
email: ethics@socsci.ox.ac.uk

Thank you for your time. Please let us know if you have questions.

Appendix F: Participation certificate for participants



Appendix G: Participation certificate for interpreters



Appendix H: Approval letter from Free State Department of Health (DoH)

health
Department of Health
FREE STATE PROVINCE

04 October 2018

Miss S Moodley
2267 Millhaven STR.
Georgia, USA
30080

Dear Miss S Moodley

Subject: Experiences of Youth Living with HIV/AIDS in South Africa.

- Please ensure that you read the whole document, Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation in the study must be voluntary.
- A written consent by each participant must be obtained.
- Serious Adverse events to be reported to the Free State department of health and/ or termination of the study
- Ascertain that your data collection exercise neither interferes with the day to day running of the Daniel Ngatate, Maletsatsi Mabaso, and Pule Sefatsa Clinic nor the performance of duties by the respondents or health care workers.
- Confidentiality of information will be ensured and please do not obtain information regarding the identity of the participants.
- **Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).**
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of Free State and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol or investigators must be submitted to the Ethics Committee of the Free State and to Free State Department of Health.
- **Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to** sebeelats@fshealth.gov.za or lithekom@fsheatlh.gov.za **before you commence with the study**
- No financial liability will be placed on the Free State Department of Health
- Please discuss your study with the institution manager/CEOs on commencement for logistical arrangements
- Department of Health to be fully indemnified from any harm that participants and staff experiences in the study
- Researchers will be required to enter in to a formal agreement with the Free State department of health regulating and formalizing the research relationship (document will follow)
- You are encouraged to present your study findings/results at the Free State Provincial health research day

Trust you find the above in order.
Kind Regards

Dr D Motau
HEAD: HEALTH
Date: 17/10/18

Head : Health
PO Box 227, Bloemfotein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfotein
Tel: (051) 408 1646 Fax: (051) 408 1556 e-mail:khusemj@fshealth.gov.za@fshealth.gov.za/chikobvup@fshealth.gov.za

Appendix I: Permission letter from Dr. Torres (CEO, Botshabelo Hospital)

botshabelo hospital
Department of Health
Botshabelo District Hospital
FREE STATE PROVINCE

Dear Ms. Moodley

University of Oxford

Re: Permission to conduct PhD research "Experiences of Youth living with HIV/AIDS in South Africa during pregnancy"

Approval will be granted to you for the conduction of the above-mentioned research provided the following criteria are met:

1. You have obtained permission for the same research from the FSDoH Ethics committee
2. You have obtained ethical clearance from the Human Research Ethics committee of University of the Free State
3. Access to the patients will not interfere with the daily service provision
4. Due informed consent is sought from the relevant patients

Yours Sincerely

Dr. Ariel Torres: CEO

Dr A Torres
CEO
Botshabelo Hospital

signed: on 27 February 2018

Appendix J: Permission letter from Mr. Koalepe (Director, Botshabelo clinics)

health
Department of Health
FREE STATE PROVINCE

INTERNAL MEMO

DATE:	31 MAY 2018	FILE NO:	
TO:	U,F & B CLINIC BOTSHABELO	FROM:	Mr T.P KOALEPE Acting Assistant Manager BOTSHABELO PHC

SUBJECT: DR SASHEENIE MOODLEY

Good day.

Kindly note that permission is granted to Dr Sasheenie Moodley to conduct research about pregnant youth living with HIV/Aids at U,F&B clinics starting from the 31st May 2018.

Your cooperation and support will be highly appreciated.

Kind regards,

OBO Koalepe TP ..... Date: 31.05.2018

Mr T.P KOALEPE
Acting Assistant Manager
BOTSHABELO PHC

Mr. T.P. Koalepe
Acting L.A.M.

31 -05- 2018

Botshabelo PHC

Appendix K: Approval letter from University of Oxford (observation)

SOCIAL SCIENCES & HUMANITIES
INTERDIVISIONAL RESEARCH ETHICS COMMITTEE

Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD
Tel: +44(0)1865 616576 Fax: +44(0)1865 280467
ethics@socsci.ox.ac.uk

25 April 2018

Sasheenie Moodley
School of Interdisciplinary Area Studies
University of Oxford

Dear Ms Moodley,

Research Ethics Approval (CUREC 2)
Ref No: R56936/RE001
Title: Experiences of Youth Living with HIV/AIDS in South Africa: Preliminary Visiting and Observation

The above application has been considered on behalf of the Social Sciences and Humanities Interdivisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

Please note that you may be required to submit an annual progress report on each anniversary of study approval, until the study is completed, and that your study may be selected for review by the SSH IDREC during an annual audit. External funders may also request ethics audits of any studies they have funded.

Yours sincerely,

Claudia Kozeny-Pelling
Research Ethics Manager and Secretary SSH IDREC

cc: Prof Lucie Cluver, Prof Jonny Steinberg, Erin Gordon

Appendix L: Approval letter from University of Oxford (formal research)

SOCIAL SCIENCES & HUMANITIES
INTERDIVISIONAL RESEARCH ETHICS COMMITTEE

Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD
Tel: +44(0)1865 616576 Fax: +44(0)1865 280467
ethics@socsci.ox.ac.uk



12 June 2018

Ms Sasheenie Moodley
Interdisciplinary Area Studies
University of Oxford

Dear Ms Moodley,

Research Ethics Approval (CUREC 2)
Ref No: R57304/RE001
Title: Experiences of Pregnant Youth Living with HIV/AIDS in South Africa

The above application has been considered on behalf of the Social Sciences and Humanities Interdivisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

Please note that you may be required to submit an annual progress report on each anniversary of study approval, until the study is completed, and that your study may be selected for review by the SSH IDREC during an annual audit. External funders may also request ethics audits of any studies they have funded.

Yours sincerely,

Claudia Kozeny-Pelling

Claudia Kozeny-Pelling
Research Ethics Manager and Secretary SSH IDREC

cc: Prof Lucie Cluver, Prof Jonny Steinberg, Erin Gordon, Francesca Tucci

Appendix M: Participant consent form

School of Interdisciplinary Area Studies
University of Oxford
12 Bevington Road, Oxford OX2 6LH

Principal researcher: Sasheenie Moodley [PI name]
DPhil Student (Area Studies)
sasheenie.moodley@area.ox.ac.uk (+44-7864-797-659) or (+27-83-647-0880)

[PhD Research: Experiences of Pregnant Youth in South Africa]
May 2018 - December 2019

PARTICIPANT WRITTEN CONSENT FORM

(English and Sesotho)

Ethics Approval Reference: [R57304/RE001]

If you are 15-20 years old, please sign each block below
Haeba o di lemong tsa 15 – 20, kopa o tekene blokising bo ka tlase

*If you have reading difficulty, please tell us so we can explain the research and you can sign with a cross.
haeba ona le bothatha bah o bala, ka kopo re jwetse re kgono ho hlalosetsa ka di patlisiso hape o ka tekena ka lebokising.

		*Sign in box**
1	I have read and understand the information sheet. I have asked questions. Ke badile mme ke utlwisisa boitsibiso. Ke botsistse di potso I know researchers want to learn about my experience with pregnancy, and support I received. Keya tseba bafupitsi ba batla ho ithutha ka boiphihlelo baka ba bo imana le tshehetso e ke tholang. I know there is no hospital treatment involved. Key a tseba haona kalafo e amehang.	
2	I know I will be asked to do interviews. I know that my voice will be taped during interviews. Keya tseba hore ke tlo kopuwa ho etsa dipuisano. Keya tseba hore lentswe laka le tla hatiswa Nakong ya dipuisano.	
3	I know that do NOT have to do this research. I can stop participating at any time, without giving any reason, and without anything bad happening to me. Keya tseba hore haka tlameha ho etsa dipatlisiso. Nka nna ka emisa hon ka karolo hake batla, kantle ho fana ka lebaka le ntho tse mpe ho etsa hala honna.	
4	I know who is doing this research: Botshabelo hospital, Free State Department of Health. Keya tseba ke mang a etsang dipatlisiso: Sepatala sa Botshabelo,Lefapheng la bophelo bo bottle. I know who is doing this research: University of Free State, University of Oxford. keya tseba ke mang a etsang dipatlisiso: Univesithi ya Forei Stata, Unvesithi ya Oxford.	
5	I know what will happen to the information I share. Keya tseba hore hotla etsa halang ka boitsibiso boo ke bokopanelang.	

6	I know how researchers will protect my privacy. Keya tseba ka tsela eo bafupitsi baka tshireletsang boinotsi baka.	
7	I know that I will not be paid for my participation. I will receive a baby hamper, R20 airtime per month, and a Certificate of Participation. Keya tseba hore hake tlo thola moputso honka karorolo. Ketla thola hampara ya ngwana, le moya wa R20 kgwedi le kgwedi le setifikeiti sa hon ka karolo.	
8	I understand how to raise a concern or make a complaint. Ka utlwisisa ka ho hlaisa matsoenyeho le ditletlebo	
9	I agree to take part in this research. I hereby assign to the researcher all copyright in my contribution for use in all work stemming from this project and future projects. Ke dumela ho nka karolo dipatlisisong tsena. Ka hona ke fa bafuputsi matla a ho phahlalatsa karolo yaka ho e sebedisa mosebetsing yohle ho otlolla ho tloha projekeng le projekeng tse tlang.	

Your name	Date	Signature*
Lebitso la hao	Letsatsi	Motekeno

Please think of a different name we can use when we are writing about this research.
Ka kopo nahana ka lebitso le leng le eseng la ha oleo oka le sebedisang diphuphutsong tsena

You can pick any name you want:
O ka kgetha lebitso le leng le leng o le batlang:

Thank you for your time.
Please let us know if you have questions ☺

Re lebohela nako ya hao.
Re kopa o re tsibise haeba di potso di teng ☺

Contact card
You have questions or concerns, please contact:
Sasheenie Moodley (+27-83-604-8347)
email: sasheenie.moodley@area.ox.ac.uk

University of Oxford
email: ethics@socsci.ox.ac.uk

Appendix N: Guardian consent form (English)

School of Interdisciplinary Area Studies
University of Oxford
12 Bevington Road, Oxford OX2 6LH

Principal researcher: Sasheenie Moodley [PI name]
DPhil Student (Area Studies)
sasheenie.moodley@area.ox.ac.uk (+44-7864-797-659) or (+27-83-647-0880)

[PhD Research: Experiences of Pregnant Youth Living with HIV/AIDS in South Africa]
May 2018 - December 2019

WRITTEN CONSENT FORM FOR GUARDIAN

(English and Sesotho)

Ethics Approval Reference: [R57304/RE001]

Contact card
You have questions or concerns, please contact:
Sasheenie Moodley (+27-83-604-8347)
email: sasheenie.moodley@area.ox.ac.uk

University of Oxford
email: ethics@socsci.ox.ac.uk

Your name	Date	Signature*
Lebitso la hao	Letsatsi	Motekeno

Hello ☺
If you give permission for your daughter to join this research, please read each line and sign in each box.
You can sign with "X"
Please ask us so we can help you with the reading.

		Sign in box (Tekena)
1	I have read and understand the information sheet. All my questions have been answered. Ke badile mme ke utlwisisa pampiri ya boitlaleho. Ke botsitse dipotso.	
2	I know my daughter will do interviews. I give permission for researchers to audio record my daughter's interviews (no video). Ke ya tseba ngoanaka otla etsa dipuisano. Ke fana ka tumello ya ho hatisa lentswe la ngaonaka kantle le ho hatisa video.	
3	I know I do NOT have to do this research. I or my daughter can stop interviews at any time, without giving any reason, and without anything bad happening. Keya tseba hore haka tlameha ho etsa dipatlisiso. Nna kapa ngoanaka re ka emisa ka dipuisano ka nako engwe le engwe kantle le ho fana ka mabaka, le kantle ho ntho empe eka etsa halang.	
4	I know who is doing this research: Botshabelo hospital, Free State Department of Health, University of Free State, University of Oxford. Keya tseba ke mang a etsang dipatlisiso : Sepatala sa Botshabelo, Lefapha la Bophelo bo Botle, Univesithi ya Foreisetata, Univesithi ya Oxford	
5	I know what will happen to the information my daughter shares. Keya tseba hotla etsa halang ka tlhahiso le seding eo nqwanaka atlae hlahisa. I know people at the University of Oxford will look at this information and protect my daughter's privacy. I agree to these people accessing this information.	
6	I know how researchers will protect my and my daughter's privacy. Keya tseba bafuputsi batla tshireletsa boinotsi baka le ba ngoana.	
7	I know my daughter will not be paid for my participation. My daughter will receive a baby hamper, some airtime, and a Certificate of Participation. Keya tseba ngoanaka a keke a patalwa honka karolo. Ngaoanaka otla fuwa hempara ya bana, moya wa R20 kgwedi le kgwedi, le setifikeiti sa honka karolo.	
8	I understand how to raise a concern or make a complaint. Ke utlwisisa tsela yah o hlahisa ditletlebo le matshwenyeho.	
9	I agree for my daughter to take part in this research. Keya dumela hore ngoanaka anke karolo dipatlisisong tsena.	
10	I give permission for researchers to quote me or my daughter directly without my name. Ke fana ka tumelo ho bafuputsi ho sebedisa mantswe aka le ngoanaka kantle le ho hlahisa mabitso.	

Thank you for your time. Please let me know if you have questions ☺
Re lebohela nako ya hao. Re kopa o re tsibise haeba di potso di teng ☺

Appendix O: Approval letter from University of Free State (formal research)

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

21-Jun-2018

Dear **Miss Sasheenie Moodley**

Ethics Clearance: **Experiences of Youth Living with HIV/AIDS in South Africa**

Principal Investigator: **Miss Sasheenie Moodley**

Department: **External Association**

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2018/0212/3107**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

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Hidden Realities: Lived Experiences with Teenage Pregnancy, Motherhood, and HIV in Botshabelo, South Africa

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Dissertation submitted in fulfilment of the requirements for the DPhil in Area Studies (Africa) in the Oxford School of Global and Area Studies at the University of Oxford

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