# A DESCRIPTIVE STUDY ON EXPERIENCES OF TEENAGE MOTHERS ATTENDING NOTYATYAMBO HEALTH CARE CENTRE, EASTERN CAPE WITH REGARD TO CHILD CARE


**BY**

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**DECLARATION**

I declare that this study is my own work, that it has not been submitted before for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Signed: ..... Date: 30/03/2011.....

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## ABSTRACT

### Introduction

Teenage sexual activity is associated with pregnancy and child care problems. The aim of the study was to assess the experiences of teenage mothers with regard child care.

### The purpose of the study

To describe the experiences of teenage mothers attending Nontyatyambo Health Care Centre regarding child care.

### Study method

A descriptive study of forty teenage mothers aged 13-19 years, attending the family planning services at Nontyatyambo Health Care Centre situated in Buffalo City Municipality was conducted. The sample was teenage mothers with live children. This was a quantitative descriptive research design where a convenience sample of forty participants between the ages of 13-19 years was selected. The participants were in grades 8 to12, but some had dropped out of school due to pregnancy and to take care of their children.

### Results

The study showed that 74% of the participants fell pregnant in grades 9- 10 at ages lower than 16 years. Sixty percent of the participants did not use any contraceptive devices. Anaemia and depression disorder were the most commonly experienced complications during pregnancy by these participants. Sixty nine, two percent had problems of looking after their children. Sixty one, five percent did not receive any form of support from the father of the child. While 71. 8% had financial problems.

### Recommendations

The study recommended that more emphasis should be placed on providing contraceptive services for teenagers and the adoption of a more purposeful and holistic approach. Health workers need to design programmes that will equip teenagers with the kind of education and skills they require. Health education ought to be pursued before children reach the teenage stage and before they become sexually active. Parents should also play their role in

discussing pregnancy and its responsibilities with their children. Better support for teenage mothers should be offered, including encouraging them to return to school.

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# CHAPTER 1: INTRODUCTION

## 1.1. CONTEXT OF THE STUDY

Adolescent motherhood continues to be a common and complex phenomenon in the world accounting for almost 500,000 births born annually (Ventura, Curtin and Mathew, 2000: 2).Teenage sexuality is associated with maternal and child health care problems. Teenage pregnancy is increasing and has been an alarming issue in South Africa. Mwale (unpublished) reports that children born to young girls (under 20 years) have higher mortality rates compared to children born in the middle reproductive years. There are many causes of child mortality, and their impact varies from country to country. In South Africa, children under five die of respiratory diseases, diarrhoea, fever, ear problem and mostly, Human immunevirus. According to Raatikan ,Heiskanen, Verkaselo and Heinonen (2005: 6) teenage pregnancy has been associated with foetal growth restriction, low birth weight, preterm birth and neonatal mortality. These could be due to biological immaturity, lifestyle factors or inexperience in maternity. Young mothers are inexperienced and lack parental skills. The mother's age is associated with the child's chances of survival. Teenage mothers do not usually have any financial support and they usually turn to the government for support. What do we do as society? This will be answered later within the section on recommendations that need to be implemented.



Teenage pregnancy is a major social problem in South Africa. In the Eastern Cape, teenage pregnancy is relatively high. Wood and Jewkes (2006: 2) state that about a third of teenagers in South Africa became pregnant before the age of twenty, despite contraceptives being free and mostly accessible. Half of all young people between 13 to 19 years of age reported having had sex. By the age of 19 years, close to 80% of South African women have had sex, about 37% have been pregnant. The number of teenage pregnancy in the Eastern Cape Province is double the number of Gauteng province, which has 2 336 pregnancies as against 4667 in the Eastern Cape Province in 2000.The figures were revealed by the Department of Education MEC, Johnny Makgato in a written reply to questions in the legislature about teenage pregnancies (Department of Health, 2001: 3). The highest teenage birth rate occurs in sub –Saharan Africa and this is confirmed by one in five adolescent females giving birth each and every year (WHO, 2004).

In 2005, the preliminary birth rate for teenagers declined by 2% falling to 40,4 births per 1 000 girls aged between 15 to 19. The decline was mainly among teenagers between 15 to 17 years old. The rate of teenage pregnancy between 18- 19 years remains stable at 69,9 births per 1 000. The birth rate for young teenagers remain unchanged at 0,7 birth per 1 000 females (Brady, Ariddi, Martin, Kodanek, Strobino and Giyer, 2007: 7).This confirms the escalating teenage pregnancy rate mostly among school going girls. Pregnant teenagers are at risk of health problems including anaemia, hypertension, renal disease, pre-eclampsia and depressive disorders (Gilbert, 2007: 3).Teenagers suffer depression during pregnancy which may be continuous and can lead either to continue with pregnancy or terminate the pregnancy (Reardon and Cougle, 2005). Early pregnancy can result to complications that can lead to death of either pregnant mother or the baby. Other associated factors include increase of infant morbidity and a range of social, psychological, and economic effect on the young mother (Lefrancois, 2001:3).

There is a known link between early pregnancy and HIV (WHO, 2004). The older men tend to have sex with young women because older men are working and can pay or buy and these older men can infect the teenager with sexually transmitted diseases. These sexually transmitted diseases, if not treated, can predispose to human immune virus (Pettifor, Rees, Kleinschmidt, Annie, MacPhail, Hlongwa- Madikizela, Vermaak and Padian, 2005: 2). Unprotected sexual intercourse is a risky behaviour associated with both unintended pregnancy and HIV infection. Adolescents are greatly impacted by the HIV/ AIDS pandemic (WHO, 2004). Teenage pregnancy changes the teenager's lives forever and in most instances, in a negative way. That is, in many cases the birth of a baby marks the end of schooling for teenage mothers (Grant and Hallmark, 2006: 6). They leave school and never return because of a need to take care of their children. The teenage mother misses out her own development, and can no longer have the experience that other teenagers can, because she has a greater responsibility to her child. Career dreams and goals are shattered (Pillay, 2008: 1).

Contraceptive knowledge is high, but its use is low among teenage groups both females and males. Teenagers have a low level of knowledge about some aspects of reproductive health, thus often leading them to conceive in the middle of the ovulatory cycle (Tawiah, 2002: 5). About 71% of females aged 15-19 years used contraceptives the first time they had sex. In

contrast, only 68% reported using contraceptives the last time they engaged in sex (Kirby, 2001: 14).

Teenage pregnancy is accompanied by stress in the family, partner disapproval and peer avoidance. Although some teenage mothers experience conflict with their parents, peers, and partners, some experience less pressure from the named people. It is expensive to raise a child when considering food, clothing and medical care. Teenage childbearing reduces the chances of schooling as pregnant teenagers will often quit school due to parenting responsibilities (Chevalier and Vitanen, 2005:410). The majority of teenage mothers are unemployed. Most are dropouts from school and some are deserted by their partners. This constitutes a most disturbing social trend in our society because of the implications for family life and community stability. Teenage mothers are prone to live in poor conditions, lack financial resources, suffer high stress, encounter family instability and have limited educational opportunities (Letourneau, Steward and Brankfather, 2004: 511). These factors contribute to inadequate parent-child interactions and diminished infant development.



Against the background of health related problems and social challenges, there is still an increase in teenage pregnancy. Teenagers who engage in unprotected sex put their own health at risky, not only through sexually transmitted diseases but also through the complications of pregnancy.

## 1.2. STATEMENT OF THE PROBLEM

Teenage pregnancy results in various problems which may occur during delivery or after birth. A teenage mother has to take care of the newborn, while she is not yet experienced in handling such responsibility. Infant mortality is often linked to child birth by inexperienced teenage women (Mwale, unpublished: 129).Early pregnancy can result in a number of complications that can be harmful to the mother and the baby. These include the financial costs involved during pregnancy, delivery, and subsequent child rearing. Teenage mothers have the responsibility to care for their children while still depending on their family members for support. This study will assess experiences faced by teenage mothers with regard to child care.

## 1.3. THE PURPOSE OF THE STUDY

- To describe the experiences of teenage mothers attending Nontyatyambo Health Care Centre regarding child care.

## 1.4. SIGNIFICANCE OF THE STUDY

The recommendation from this study will assist in the improvement of health education on aspects related to sexual and reproductive health for teenagers. It is important for teenage females to differentiate whether it is good to have children during adolescence or to wait for the later stage. Health personnel will be informed about the experiences of teenage mothers with regard to child care which can help in their planning of health programs for teenagers regarding prevention of pregnancy.

## 1.5. STUDY QUESTIONS

The study set out to respond to the following questions:



- What are the demographic characteristics of teenage mothers?
- What are the health related risk associated with teenage motherhood and among the group?
- What are the social and financial encountered by the teenage mothers regarding child care?

## 1.6. OBJECTIVES OF THE STUDY

- To document the demographic characteristics of the teenage mothers who utilize the family planning services at Nontyatyambo Health Care Centre for the period of July to August 2009.
- To identify the health related risks associated with teenage motherhood.
- To describe the social and financial problems with regard to child care by teenage mothers.

## 1.7. DELIMINATION OF THE STUDY

The study took place at Nontyatyambo Health Care Centre at Nu.2 Mdantsane within the Buffalo City Municipality of the Eastern Cape Province. The Health Care Centre renders services to a number of units in Mdantsane and local neighbouring areas, as it is the referral centre to Cecilia Makiwane Hospital. The participants were teenage mothers with live children living with their own parents or relatives. The sample was selected from teenage mothers attending family planning services at Nontyatyambo Health Care Centre. The data were collected during July and August 2009. The study used forty participants which were selected randomly. The participants were given consent forms as the proof of agreement that they were taking part in this study. No one was forced to participate. The researcher investigated the challenges that teenage mothers undergo with regard to child care.

## 1.8. DEFINITION OF TERMS / OPERATIONAL DEFINITIONS

The following frequently used terms are defined:



TEENAGER YEARS refers those between 13-19 years of age, and is a period of transition from childhood to adulthood, during which enormous physical and psychological changes occur (Berry and Hall, 2009: 11).

TEENAGE MOTHER is an adolescent or teenage female with a live baby. For the purpose of this study, we refer to a teenager with a live baby or child.

INFANT MORTALITY RATE is the number of children under 1 year per 1 000 live birth for a defined community.

CHILD MORTALITY RATE is the number of deaths at year 1-4 in a given year per 1 000 children in that age at the midpoint of the year concerned (Vlok, 2005: 392).

TEENAGE PREGNANCY is defined as teenage pregnancy in ages of 13-19 of age. According to WHO (2004), teenage pregnancy is defined as ages from 15- 19 years. The term adolescence is used synonymously with teenager. For this study's purpose, it will refer to ages between 13-19 years.

## 1.9. DELINEATION OF CHAPTERS

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|---|---|
| Chapter 1 | Introduction |
| Chapter 2 | Literature review |
| Chapter 3 | Research Methodology |
| Chapter 4 | Results |
| Chapter 5 | Recommendations and conclusion |

## 1.10. SUMMARY

This chapter provided an introduction to this study, background for the study, and how the study may contribute to the experience of other teenagers and assist health care workers. Operational definitions were briefly discussed. Chapter Two reviews the literature on identification and description of the problems faced by teenage mothers with regard to child care.

## CHAPTER 2: LITERATURE REVIEW

### 2.1. INTRODUCTION

In this chapter, the researcher will review literature which deals with the experiences of teenage mothers with regard to child care. This chapter covers the following:

- Teenage ,
- Health risk problem based on child mortality, child morbidity, maternal morbidity, human immune- virus / acquired immune deficiency syndrome,
- Parenting problems
- Financial constraints
- Poor education due to dropping out and child care responsibilities,
- Female headed families.
- Experiences of teenage mothering such as:
    - Depression, and
    - Feelings of frustration.
- Social support.



### 2.2. TEENAGE / ADOLESCENCE

Teenage is a transitional period between childhood and adulthood, which begins with biological changes, influenced by cultural factors, which, to a large extent, determine the identity and sexuality of the adolescent (WHO, 2000). During this period, adolescents often spend less time with their parents and more with their friends, they are more interested in the opposite sex and are characterized by uncertainty, conflict and struggle over appropriate avenues of expression. The need to manage this, is a major feature of the adolescent experience (WHO, 2000). Biological changes that occur during this stage prepare the teenager for the reproductive function (Lefrancois, 2001: 5). This phase is marked by a crisis of identify as adolescents seek acceptance in the adult world and their peers. This process

involves possibly experimenting with drugs, alcohol, sex, and putting their health of other people's lives in danger. During this time of experimentation with high-risk behaviours, individuals may engage in early sexual activity which could result in early pregnancy. This, in turn, can be associated with increased maternal mortality and increased infant morbidity, social, psychological and economic effects (Lefrancois, 2001: 3). Teenagers, in many developing countries, have emerged as one of high risk where unplanned pregnancies, HIV, STI infection and sexual assault occur (Kirby, 2001: 14). Taiwah (2002:7) noted that early childbearing in teenagers has social, health and economic costs with which the teenagers cannot cope.

## 2.3. HEALTH RISK PROBLEMS

### 2.3.1. CHILD MORTALITY

Child mortality refers to the probability of dying between the first and fifth birthday. There are many causes of childhood mortality in the developing world, and their impact varies from country to country (Mwale, unpublished: 123). Pneumonia, diarrhoea, malaria, measles and malnutrition cause more than 70% of death in children under five years old of age, particularly in developing countries (WHO, 2005: 4).

Teenage mothers are inexperienced in identifying when children are suffering common childhood illnesses. Even if the teenage mother has been informed about the condition of the child, it is not easy for her to cope with that because of her lack of knowledge and lack of skills. Hence, there is an increase in child mortality rate associated with young mothers. According to Mwale (unpublished), the mother's age at birth is also associated with child survival. Children of mothers under 19 years of age are especially vulnerable, particularly in the first month of life.

### 2.3.2. CHILD MORBIDITY

Raatikanan, Heiskanen, Verkaselo, and Heinonen (2005: 160) have identified, that early pregnancy in very young mothers is prone to health problems regarding the off springs, such as growth restriction, low birth weight, preterm birth and neonatal mortality. Complications can lead to the death of either the pregnant mother or the baby. In a teenage pregnant woman who suffer pre-eclampsia, the child is at risk of experiencing foetal distress which may result

to death. The World Health Organization identifies the care of pregnant teenagers and safe delivery and the care of their babies as an area of need which has not been adequately addressed, yet it is crucial to the pregnant mother and the child (McIntyre, 2006: 11). Some of these complications may result in long term treatment which may affect the development of the child. What the child experiences during the early years sets a critical foundation for their entire life course (Irwin, Siddiq and Hertzman, 2007: 9).

### 2.3.3. MATERNAL MORBIDITY

Teenage mothers are at risk of illness and death and are less likely to seek medical help for problems or complications related to their reproductive health (David, Heather, Desmond, Stephen, Mary and Sara, 2003:624). For instance, some complications have long term effects for the child at the later stage, thus affecting the child's developmental stages or milestones. Teenage mothers may not only risk own health, but their children suffer some consequences, too. Unplanned pregnancies may lead to a lack of closeness in the relationship between the mother and the child. Children may be abandoned hence we find streets kids (Hoffman and Maynard, 2002). Research indicates that pregnant teens are less likely to receive prenatal care, often seeking it in the third trimester, if at all (Gilbert, 2007: 6).



Guttamacher Institute Reports (1999: 3) indicated that one third of pregnant teens receive insufficient prenatal care and their children are more likely to suffer from health issues in childhood or to be hospitalized than those born to older women. Therefore teenagers are afraid to report their pregnancy in time and positive outcomes in teenagers are more difficult to achieve as they experience late confirmation of their pregnancy (David et al, 2003: 625).

### 2.3.4. HUMAN IMMUNO-VIRUS/AQUIRED IMMUNE DEFICIENCY SYNDROME

The HIV/AIDS epidemic has become a leading cause of maternal and child death, particularly in South Africa (WHO, 2000). Jewkes, Vundule, Maforah, and Jordan (2001: 5), identify that currently, one in five pregnant teenagers is infected with HIV. Human immune virus and sexually transmitted infections are the major causes of global mortality and morbidity among teenagers and are the most common health problem in the area of sexual and reproductive health in the world today (WHO, 2000). Teenagers tend to be more vulnerable to the psychological risks of unsafe sex as well as poverty. Sexually active

teenagers are at risk of contracting HIV and other sexually transmitted diseases (Kirby, 2001: 10).

Females are more vulnerable to HIV, especially teenage girls, due to the immaturity of their reproductive system as well as likelier exposure to sexual coercion (Shisana, Rehle, Simbayi and Mbelle, 2008: 10). HIV prevalence was 29% in teenagers in South Africa aged 15-19 years in 2005. Women who were mostly affected were aged between 15-19 years of age in the Sub- Saharan Africa. In urban Eastern and Southern Africa, epidemiological studies showed that 17-22 % of girls aged 15-19 are already HIV infected, compared with 3-7% of boys of similar age (UNAIDS,2003).

According to Manzini (2001: 47), unplanned pregnancy leads to vulnerability to sexually transmitted diseases which can result in infection with human immune virus and AIDS. The human immune virus has been widely associated with teen pregnancy. The estimated national HIV prevalence by the age group was 14.1% for 2008, the prevalence rate was13.1 % for the year 2007 and 13.7% for the year 2006 (Department of Health, 2009: 9).



Teenage mothers avail themselves to ante- natal services only at a very late stage and are often diagnosed as HIV-positive during delivery or after delivery. Risks during pregnancy, delivery and pueperium to the mother and the child are associated with HIV. There may be mother-to-child transmission of the virus, children may be orphaned, or die (WHO, 2005).

## 2.4. PARENTING PROBLEMS

Young mothers are unprepared for the task of parenting, which results in the mother doubting her own abilities and competence in nurturing her infant. Europa (2005: 12) identified that the first few months after having the baby are a difficult time for the first time mother. During motherhood, girls endure social, and economic changes. Europa (2005:13) revealed that it is important to note that it is the motherhood aspect that is difficult for teenagers, as opposed to pregnancy. As long as a pregnant woman has regular prenatal care, her age is rarely an issue. Teenagers may not be socially and personally mature enough to assume the new roles imposed on them by parenthood. Young mothers lack parental skills. They are impatient, insensitive, irritable and inclined to administer corporal punishment on the baby (Cronin, 2003: 5). Teenage mothers may easily become overwhelmed with their new burden. Without

an adequate support system and positive coping skills, they may contemplate suicide (Cronin, 2003: 7). For some, motherhood is the impetus to change direction and consider a career, because they have someone else for whom they are responsible (Seamark and Lings, 2004). Children are left with grandmothers and neighbours because there is no close family member to support them. Some teenagers do not have babysitters and their parents tell them the baby is their responsibility. Cultural and traditional beliefs contribute in the sense that teens may become pregnant because they want to show their womanhood (Kaufman, De Wet, and Standler, 2001: 148).

Sole–supporting during the teenage years is a difficult struggle for young women, because of their youth, their lack of preparation for womanhood and their reliance on others (Barbara, James, Ross, Richard, Lloyd, Jo Anne and Laura, 2001: 5).Teenage mothers lack parenting skills when compared to older mothers. They tend to communicate less with their children and are less expressive as is evident in lower levels of play and interaction (Barbara et al, 2001: 9)



## 2.5. FINANCIAL CONSTRAINTS

The problems for the teenage mothers are that the financial burden of rearing her child eventually falls on her own shoulders. Although parents and relatives may assist, but in the long term, it is the mother who is finally responsible. This phenomenon is of concern because teenage mothers are reported to be disadvantaged financially, educationally and cognitively in the both short and long term (Barbara et al, 2001: 6).The study revealed that some teenage mothers fall pregnant so as to gain the child support grant as a source of living and they will fall pregnant again so as to get more money. However, some teenage mothers have realised that this is not right because children suffer in the end. Speculation that child support grant could be acting as an incentive for young girls to fall pregnant prompted the Department of Social Development to undertake a formal investigation (Richter, Norris and Ginsberg, 2007: 6). When the child support grant was initiated in 1998, it was in the form of monthly transfer to a poor children aged 0-7 years. Since 2003, the eligibility for the grant has been extended to children age 14 years. This has resulted in an increase in the trend of teenage pregnancy (Bullen and Kenway, 2001:14).

This study highlights that teenage mothers cause more challenges to their grandmothers, because they have to spend more time and money on their grant children. The money that they receive from their work has to support the teenage mother and her child as well. Child support grant is not only contributory factor to teenage pregnancy; there are other factors that need to be clearly identified (Makiwane, Desmond, Ricter and Udjo, 2006: 3).

## 2.6. POOR EDUCATION FOR THE YOUNG MOTHER

According to Richter et al (2007: 10) recent concerns over teen pregnancies have centred on the disruption that childbearing causes to the educational and occupational trajectory of young women, consequently maintaining and exacerbating poverty. While many teenage mothers considered academic qualifications to be very important, they may not be able to succeed academically if the support they need to complete their studies is insufficient (Chigona and Chetty, 2008:265). Teenage pregnancy has contributed to teens not completing high school and becoming vulnerable to poverty since early teenage pregnancy has a long lasting effect on the socio-economic well-being of both the mother and the child (Gustafsson and Worku, 2007: 13). Teenagers are likely to suffer from sexual abuse as result of having sex with partners who are not at school and who are likely to have other girlfriends (Jeus, 2001: 15).



Arlington Public Schools (2004: 3) reported that teenage mothers face difficulties and undue pressure from parents, peers and teachers. They may receive little support from school and their homes, and they are usually misunderstood (Arlington Public schools, 2004: 3). Therefore an early pregnancy and birth can be said to indirectly reduce the chances of occupational status and earnings, through its negative effects on schooling opportunities (Arlington Public schools, 2004: 5).

## 2.7. FEMALE HEADED FAMILIES

Some researchers believe young women who have been raised by single parents are more likely to have non-marital sexual intercourse than young women from intact families. Lack of social support is a risk factor for the adjustment and development of both young mother and their children (Richter et al 2007: 16). Makiwane et al (2006: 3) observed that teenage pregnancy has been associated with psychological harm to teenage mothers and their

children. This can be confirmed by the increase of teenage pregnant girls who are less likely to marry the father of their children. Teenage pregnancies and births have become more popular and single mothers models have increased due to children being born out of wedlock (Richter et al 2007: 16). Lassa (2006:5) raised a concern about single teenage motherhood and poor young women becoming parents. The researcher identified four major issues including:

- transforming their lives,
- opportunities for change,
- accommodating the challenges and,
- tolerating the abandonment of support and living publicly examined lives.

The children of teenage mothers do not develop and progress at optimal level and are more likely to be disadvantaged because of their risk of growing up in a single parent environment (Lassa, 2006: 3).



## 2.8. EXPERIENCES OF MOTHERING

### 2.8.1. DEPRESSION

Feeling depressed as a teenage mother following the birth of a baby includes experiencing a scared feeling with the sudden awareness of motherhood and feeling confused between responsibilities of adolescence and motherhood, feeling neglected by partners and peers (Clemmens, 2002: 556). Reardon and Cougle (2005:11), teenagers suffer depression which may result into a number of outcomes which may be either to continue pregnancy or to terminate it.

Teenage pregnancy and child care is accompanied by stress in the family and other relationships such as in parental disapproval and through peer avoidance. Although some teenagers experience conflict with their parents, peer and community, some experience less pressure from the above. According to earlier the study, some teenage mothers have reported that they lose their friendship with their peers due to their pregnancy and motherhood, and yet teenagers need to realise that after birth of the baby, they will be unable to maintain the same

social life as before (Europa, 2005: 13).Cronin (2003: 8) identified that the teenage parent may experience a lack of communication with own parents. The lack of support from family or friends and the isolation during pregnancy is likely to affect mental health negatively. Hence this can be identified as a factor that leads to depression (Clemmens, 2002: 556). Social isolation and the sense of abandonment that many teenage mothers experience can deepen depression and this highlights the need to keep these women attached to their families. Although adolescent depression is not as well researched as adult depression, it is important to understand what adolescent depression is, what may cause it and what be done in order to help and support adolescents who are experiencing depressive symptoms (Gouws, Kruger and Burger , 2000: 10).

### 2.8.2. FEELING OF FRUSTRATIONS

Richter et al (2007: 17), observed that having a child is the time of changes in a women's life, both in the biological, psychological and in the social sense. These changes can contribute to personal growth, but also result to frustration. Hence the researcher found that teenage mothers are depressed at times. Barbara et al (2001: 8) suggest that teenage mothers may experience negative public attitude directed towards them wherever they go, including their visits to community health centres. Teenage mothers experience turmoil during teenage lives. Lack of finance to buy food for the child, to take the child to the doctor or clinic are real difficulties faced by adolescent parents. Thus they resort to government for support and that increases the number of children who receive child support grants. Shong-King, Abraham and Giese (2000: 16), lament the stress that teenage mothers undergo when the child is sick and highlight number of visits to the clinic because the child had to be immunised, or sometimes the child was sick as these are responsibilities that teenage mothers are obliged to undergo.

A study by Bunting and McAulley (2004: 209) showed that teenage mothers were frustrated because the partners were not available for support as some were still at school, some were having other responsibilities because they are married, and some do not care. Other partners were devastated at first time when the news were broken to them, as they would ask the women why was she not using contraceptives and how will they look after the child when both are still at school. Some partners were thrilled by the news, but vanish after some time

as they had other responsibilities, for example, old men who are married or are engaged to other relationships (Bunting and McAulley, 2004: 209).

## 2.9. SOCIAL SUPPORT

Social support is vital during the transition to parenthood for adolescents. Many women feel lonely after giving birth (Hudson, Elek and Campbell, 2000: 447) and the demands of motherhood leave little time for other relationships. As a result, the teenage mother may feel isolated from her family or peers. Social support refers to the personal reactions of at least two individuals to a shared social interaction and the shared meaning that these individuals jointly construct and attribute to their interaction (Badhr, Acitel, Duck and Carl, 2001). The members of a social support network include the family, close friends, neighbours, co-workers and professionals.

Makiwane et al (2006: 5) perceived of teenage fertility as leading to the tendency for early childbirth to initiate a trajectory of lifetime poverty for a young mother and her child. Poverty may be the result of mediating factors such as expulsion or exclusion from education and lack of material and lack of social support. Most teenage fertility occurs outside of marriage which arises from various quarters, such as moral perception, cultural rules and pragmatic concern, such as poor support from the father of the child. According to Taiwah (2002: 84), early childbearing by teenagers has social, health and economic costs with which teenagers cannot cope. Women who have their first birth early in life tend to have more children than those who start childbearing later. Thus showing that child survival and child development can be influenced by the environment where children grow up, live and learn. The parents, caregivers, family and community will have the most significant influence and impact on the child's life.

Every child has the right to family care, parental care, or to alternative care, to basic shelter and social services and to be protected from maltreatment, neglect, abuse or degradation (Shong-King et al 2000: 9). This means that the government has an obligation to make these rights a reality for all South African children. Hence, it is important for the parents to take their children to health care centres for immunisation and when the child is sick, the child has to be attended to by the professional health care worker without being charged any cost,

mostly for children under six years old. It is a responsibility of the parent to take the child to the nearest service ( Shong-King et al 2000: 9).

Marteleto, Lam and Ranchhod (2006: 11), teenage mothers who live with paternal grandparents substantially increase the chance of enrolling in school right after birth, which suggests that the availability of child care may be an important factor in school continuance. This study revealed too much responsibilities done by teenage mothers, such as to wake up in the morning, wash the baby, and wash the baby nappies almost every day. Hence found it difficult to concentrate the following day at school and that it affects their progress at school. They forfeited school extra mural activities and teenage social activities (Arlington Public School, 2004: 5).

## 2.10. SUMMARY

Literature review in this study gave the researcher a picture of the difficulties in falling pregnant at an early age. Teenage mothers are vulnerable to health problems and experience multiple challenges. Many researchers highlighted these difficulties such as economic insecurity, the lack of skills that enable them to obtain employment, and the social and financial burden of caring for the child.

## CHAPTER 3: RESEARCH METHODOLOGY

### 3.1. INTRODUCTION

This chapter explained the methodology in terms of research design, population and sampling, instrumentation, validity and reliability of the instrument, data collection, ethical considerations, method of data analysis, and summary.

### 3.2. RESEARCH DESIGN

The researcher conducted the study using a quantitative research method and descriptive design for describing the experiences of teenage mothers with regard to child care. According to Burns and Grove (2005: 23), quantitative research is conducted to describe and examine relationships and determine the causality among variables. The purpose of this design is to achieve greater control and thus improve validity of the study in examining the research problem.



### 3.3 STUDY SETTING

The study was carried out at Nontyatyambo Health Care Centre at Nu.2. Mdantsane, within the Buffalo City Municipality of Eastern Cape Province. The study was based on the population of teenagers between the ages of 13-19 years old residing in Mdantsane in the Eastern Cape Province. Nontyatyambo Health Care Centre renders comprehensive services to a number of units around Mdantsane and local neighbouring areas as it is the referral centre to Cecilia Makiwane Hospital. The Health Care centre is situated close to the shops and taxi rank. Hence, there is an influx of clients to the centre. It is well structured and the staff are available, although not enough for the number of patients and clients attending. The family planning unit where the study was conducted has only two staff nurses who man the clinic. They render services to almost 40-45 clients a day and out of these clients, 20 are teenagers who need time to identify any problems pertaining to their sexual reproduction and correct use of contraception. The health care centre opens at 07h30 and closes at 16h30. The majority of teenagers visit the centre at about 14h00 as they are attending school earlier during the day. All primary health care services are rendered five days a week to all age groups.

### 3.4. STUDY POPULATION

The population comprised of teenage mothers attending family planning services at Mdantsane clinics, Nontyantyambo Health Care Centre from the period of July and August 2009.

### 3.5 STUDY SAMPLE

Study sample composed of teen age mothers with live children, between the age of 13-19 years attending family planning services Nontyatyambo Health care centre at the Mdantsane Township. All teenage mothers with live children will be included in the study and teenage mothers without live children were excluded

### 3.6. THE SAMPLING PROCEDURE

The family planning attendance register consisted of an average of eighty teenage mothers who attended the services over two months. The researcher then selected forty participants. The family planning attendance register has been used to derive a suitable research sample which was forty participants. Convenience sampling which is a type of non- probability sampling was used to select the sample (Brink, 2006: 132). Through convenience sampling, forty teenage mothers from the ages 13-19 years, Xhosa speaking, who were living with their families were selected and used as sample of this study. Convenience sampling is the study of subjects because they happened to be at the right place at the right time (Burns and Grove, 2009: 353).



### 3.7. THE INSTRUMENT (QUESTIONNAIRE)

A self-administered questionnaire was selected to examine specific variables of this study. It measured the reliability and validity of the study. Reliability is concerned with how consistently the measurement technique measures the concept. Validity is the extent to which the instrument actually reflects the abstract being examined (Brink, 2006:165). Teenage mothers were asked, both open and closed ended questions (see Appendix D - Questionnaire).

The questionnaire was divided into three sections. Section One was on personal characteristics such as age, educational level, and knowledge about family planning. Section Two required responses on mode of delivery, any complications suffered during pregnancy which could affect the child after delivery, and any problems encountered such as support during child care. Each item on the questionnaire had a response space for the question to be answered.

The main aim of these questions was to encourage participants as teenage mothers to describe their challenges with regard to child care. The questionnaires were given to forty participants who were included in the study. They all completed the questionnaire within 20-30 minutes and they understood the questions.

### 3.8. VALIDITYAND RELIABILITY OF THE INSTRUMENT

Validity refers to the accuracy or truthfulness of a measurement. It refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Brink, 2006: 165). All items used in the questionnaire went through some validation, by checking the questionnaire for correct translation of English language to isi-Xhosa. The questionnaire was piloted among different teenage mothers who were not participants for the study to identify any misunderstanding or mis-interpretation. Then, the researcher tested these questions and the researcher did not find any challenges, as the questions were clearly answered, and the method used (that is structured questionnaire) facilitated the process for both the pilot sample and the research study, thus underpinning the validity of the study.

Reliability is synonymous with repeatability or stability. Reliability is a matter of whether a particular technique, applied repeatedly to the same object, would yield the same result each time (Brink, 2006: 165).To ensure reliability of the questionnaire, the pilot study of ten clients whose demographic characteristics were similar to the study were used. According to Burns and Groves (2009: 537) defined reliability as the consistency of the measure obtained. The researcher's interest in the study, the use of isiXhosa, her skill in gathering information and the experience in working with youth helped to ensure that reliable information was obtained.

## 3.9. LIMITATIONS OF THE STUDY

The nature of the study limits generalization. Generalization involves the application of trends or general tendencies (which are identified by studying a sample) of the population from which the research from the research sample was drawn (Burns and Groove, 2009: 24). The focus was on teenage mothers with live children. The questionnaire was designed for participants to describe their experiences with regard to child care. Use of convenient sample prevented generalization. Time was found to be a challenge as the researcher had to be at the family planning clinic at certain hours, did not find the relevant participants at that time and had to come back again. The participants had to wait for some time in the clinic, and had to come back with signed consent form from their parents or relatives. Language was also found to be a problem, a barrier in this study, as translation of English concepts to Xhosa became a problem. For example there was a difference between the terms "difficulties" and "challenges" in English or in isiXhosa. The questions were in English and had to be translated into isiXhosa as participants spoke isiXhosa.



## 3.10. METHOD OF DATA COLLECTION

The data collection commenced during 29 July 2009 and ended on 28 August 2009. The questionnaire were given to forty participants who were included in the study. They all completed the questionnaire within 20-30 minutes. Each clients was taken to a private consulting room where explanations on the purpose of the research were given. The researcher had access to the family planning register during consultation times. The questionnaires were handed voluntarily to the clients as they presented themselves to the clinic with a full explanation of the content.

## 3.11. ETHICAL CONSIDERATION

The research proposal was submitted and approved by the University of Fort Hare Research and Ethics Committee. The Research Co-ordinator from the Research and Epidemiological unit, Department of Health, Bhisho, gave the permission for the study to take place within Buffalo City municipality district. Permission to access the clients at the health care centre was requested from the Buffalo City district manager. Consent from the respondents to be used for the study was requested prior to their participation. The participants were given

forms to take home for parents approval. Respondents were informed that their situation may not be changed by their co-operation and participation. Participants were made aware of their rights to withdraw if they objected to the study. Issues of respect and privacy were observed.

Confidentiality was ensured. The real names of participants were not used. They were numbered, and only the researcher knew about which number tallies with the real name. The information was kept separate from the data, and in a locked cupboard.

### 3.12. METHOD OF DATA ANALYSIS

The data was examined for completeness and accuracy of the forms. No forms were incomplete, thus all questions were accurately answered. The participant's form was coded to maintain confidentiality. The researcher numbered the participants forms to identify any missing participant. The data was analysed and presented in the form in the graph and tables using Microsoft excel version 7.

### 3.13. SUMMARY



In this chapter, the sample, instrumentation, ethical consideration, and method of data analysis were discussed. The following chapter reports the results obtained from the questionnaires.

## CHAPTER 4: RESULTS

### 4.1. INTRODUCTION

This chapter aims at discussing the information gathered from the participants using self administered questionnaires. The researcher presented the results in graphs and in a tabulated form, to show how teenage mothers responded to the questionnaires. The tables will contain the actual responses by the participants. The results were presented under the following subheadings: age ranges of participants, level of education, number of participants who were still at school, use of contraceptives, method of delivery, pregnancy was intentional or not intentional, number of participants who suffered from anaemia, hypertension, pre-eclampsia, and depressive disorders, percentage of participants who had financial problems, social support problems, father support problems, caring for the child and discussion. During data analysis the participants were divided into two groups, namely those whose age was below 16 years and those whose age was above 16 years for comparison.

### 4.2. BRIEF BACKGROUND ABOUT THE SAMPLE OF THE STUDY



The forty participants of teenage mothers under this study was a convenient sample drawn from clients who visited the family planning service for the purpose of accessing family planning devices during the period of data collection. Forty teenage mothers from ages 13-19 years, Xhosa speaking, who were living with their children were used as a sample of this study. The sample consisted of teenage mothers with live children. Participation was voluntary and no one was forced to take part. The participants were informed that they could withdraw at any time.

## 4.3. DEMOGRAPHIC CHARACTERISTICS

### 4.3.1. Age distribution of the participants

Figure 1 shows the age distribution of the forty respondents. The result showed that 40% of the participants with live children were aged less than 15 years, 42.5% ranged from ages between 16-17, and 17.5% were over 17 years of age.

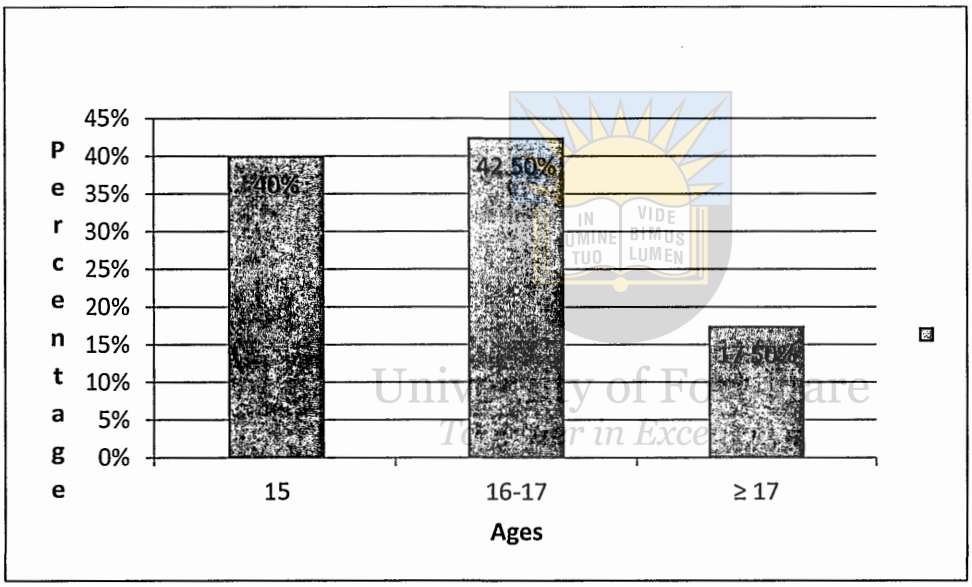


**Figure 1. Age distribution of the participants**

### 4.3.2. The number of participants according to two groups

Later the ages were divided into two groups for comparison analysis, less than 16 years and more than 16 years of age as indicated on the table 1 below. The table below indicated ages of participants according to two groups into which they were divided, namely those below 16 years and those above 16 years and were 72.5 % (29) and 27.5% (11) respectively.

**Table 1. The ages of participants according to two groups**

| Ages | Number | Percentage |
|---|---|---|
| ≤ 16 | 29 | 72.5% |
| ≥ 16 | 11 | 27.5% |
| Total | 40 | 100% |

### 4.3.3. Level of education of participants

Results in Figure 2 below show that 74.3% (29) were in Grades 9-10, 2.9% (1) of the participants were in Grade 8 and 22.8% (10) of the participants were above Grade 10. The majority of the participants were in Grade 9-10.



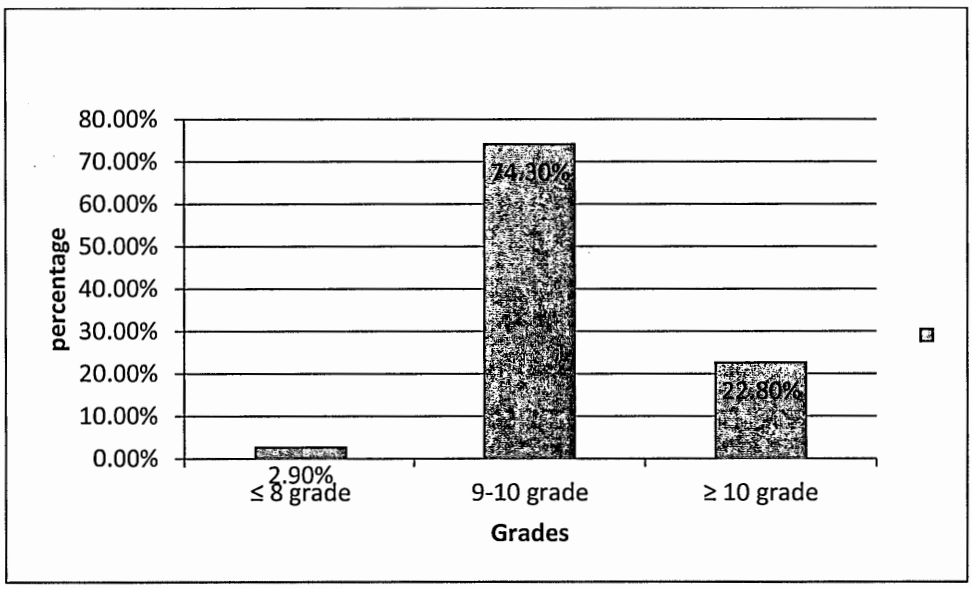


**Figure 2. Level of education of participants**

### 4.3.4. Number of participants who were still at school when they become pregnant

Table 2 below shows that 90% of teenage mothers were still at school when they became pregnant, and 10% of them had already dropped out of school.

**Table 2.Participants who were still at school / out of school when they became pregnant.**

| Participants | Number | Percentage |
|---|---|---|
| Still at school | 36 | 90% |
| Out of school | 4 | 10% |
| Total | 40 | 100% |



### 4.3.5. Percentage of the participants who used any form of contraceptives

Table 3 below shows that 60% (24) of the participants did not use any form of contraceptives while 40% (16) used contraceptives.

**Table 3. Use any form of contraceptives**

| Participants | Number | Percentage |
|---|---|---|
| Used contraceptives | 16 | 40% |
| Did not use contraceptives | 24 | 60% |
| Total | 40 | 100% |

### 4.3.6. The number of responses to the following question: How did you deliver?

Figure 3 below shows that 47.5% (19) of the teenage mothers less than 16 years old delivered normally while 25% (10) delivered by caesarean section. Fifteen percent (6) of those over 16 years delivered by normal vertex delivery while 12.5% (5) delivered by caesarean section.

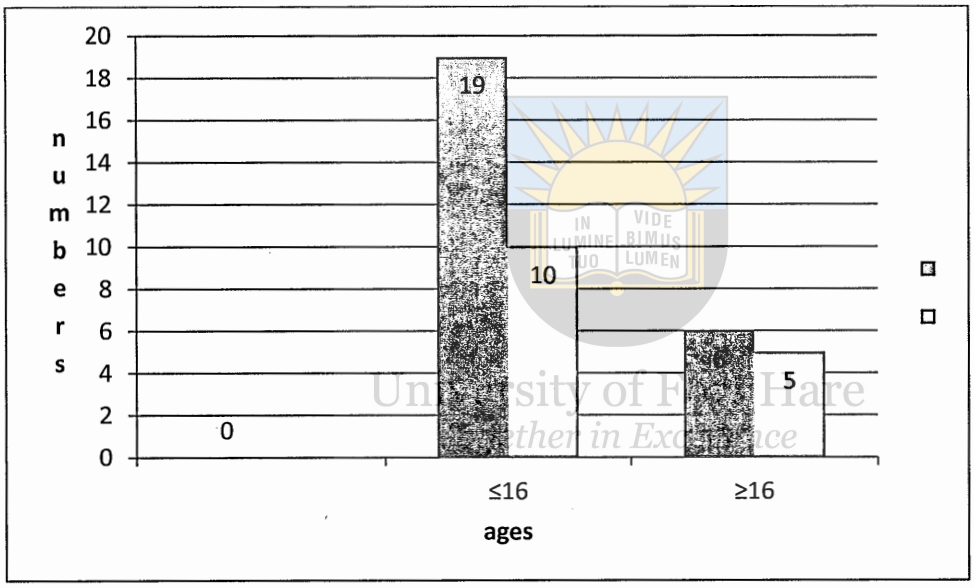


**Figure 3. Method of delivery**

### 4.3.7.Response of the participants on whether the pregnancy was intentional or not.

Out of 29 participants whose age was below 16, 51.7% (15) indicated that the pregnancy was intentional while 48.3% (14) participants indicated that it was not intentional. Out of 11 participants whose age was above 16, 45.5% (5) indicated that the was intentionally while 54.5% (6) indicated that pregnancy was not intentionally. The study showed that 51.7% from participants below the age of 16 had intentions to become pregnant (see table 4 below).

**Table 4. Participants whose preganancy was intentionally or not intentionally.**

| Age category | % | Pregnancy intentionally | % | Pregnancy not intentionally | Total |
|---|---|---|---|---|---|
| ≤ 16 | 51.7% | 15 | 48.3% | 14 | 29 (100%) |
| ≥16 | 45.5% | 5 | 54.5% | 6 | 11 (100%) |
| Total | 50% | 20 | 50% | 20 | 40 (100%) |



### 4.3.8. Percentage of participants who suffered complications during pregnancy

Some of the participants indicated that they suffered complications during their pregnancy namely: 17% (7) reported that they suffered form aneamia,12.5 % (5) reported that they suffered from hypertention, 15.0% (6) developed pre-eclamplsia and 20% ( 8 ) suffered from depression. Few of the participants did not know whether they suffered from this complications (see table below). The results showed that depression was the most complication suffered by the group study

**Table 5. Complications during pregnancy**

| Complications during pregnancy | Had complications | Did not have complications | Did not know | Total |
|---|---|---|---|---|
| Aneamia | 7 (17.5%) | 31(77.5%) | 2(5.0%) | 40 |
| Hypertension | 5 (12.5%) | 34(85.0%) | 1(2.5%) | 40 |
| Pre- eclampsia | 6 (15%) | 33(82.5%) | 1(2.5%) | 40 |
| Depression | 8 (20%) | 31(77.5) | 1(2.5%) | 40 |



### 4.3.8. Percentage of the participants who receive treatment during the time of illness



The results on table 5 indicated that all participants who had complication received treatment during illness. The study illustrated that the participants were properly managed as all suffered the illness received treatment.

**Table 6.Treatment received that time of illness**

| | Received treatment | Percentage |
|---|---|---|
| Anaemia | 7 | 17.5% |
| Hypertension | 5 | 12.5% |
| Pre-eclampsia | 6 | 15% |
| Depression | 8 | 20% |

### 4.3.9. Percentages of participants who encountered problems during child care

Figure 4 below shows that 71.8% of the participants had financial problem, 33.3% of the participants experienced social support problem, 38,5% experienced lack of father support problems and 69.2% of the participants had problem in caring for their children. The study shows it clearly that most of the participant had financial problem and looking after their children.

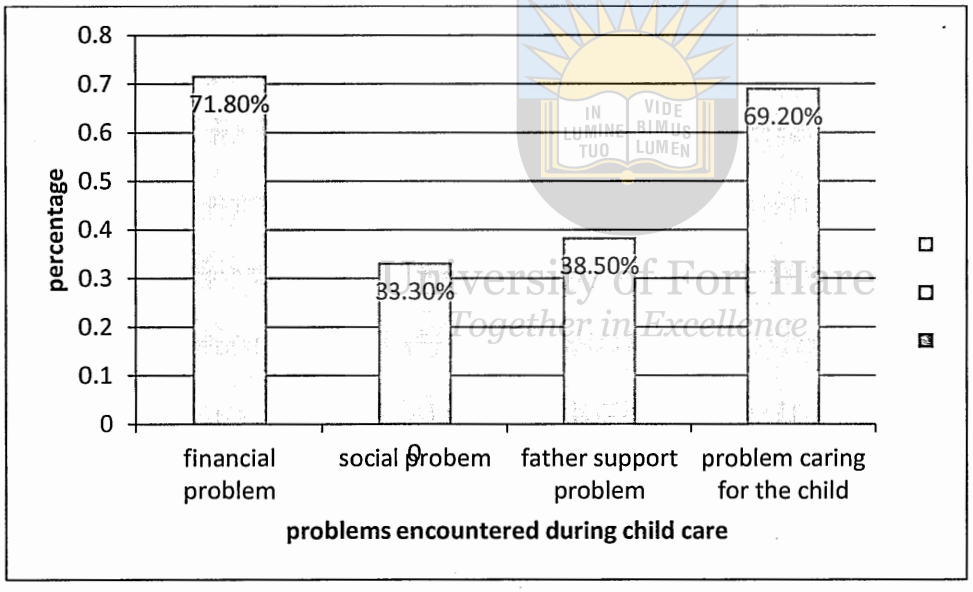


**Figure 4. Problem encountered during child care**

### 4.4. SUMMARY

The study endeavoured to answer the following:-

- What are the demographic characteristics of teenage mothers?
- What are the health related risks associated with teenage motherhood among the group?
- What are the social and financial problems encountered by teenage mothers regarding child care?

In an attempt to answer these questions the researcher made use of a descriptive study .This methodology, based on a convenient sample of the population, set out to achieve the following objectives:

- To document demographic characteristic of teenage mothers.
- To identify the health risks regarding to teenage motherhood.
- To describe the social and financial problems with regard to child care by teenage mothers.

# CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

## 5.1. INTRODUCTION

From the perspective of a descriptive study, the experiences by teenage mothers with regard to child care have been described. Chapter Two highlighted research by other authors, chapter 3 outlined the methodology and chapter 4 presented the data gathered from teenage mothers themselves. The discussion will focus on the objectives of this study, in the light of the data collected on personal characteristics of teenage mothers, health risks with regard to motherhood, and social and financial problems.Discussion, conclusion, and recommendations will also be provided.

## 5.2. DISCUSSION

### 5.2.1. DEMOGRAPHIC CHARACTERISTICS OF THE STUDY GROUP



The personal characteristics were addressed by asking questions such as "How old were you during pregnancy?" "What grade were you studying?" and "Did you have any knowledge about contraceptives?"

#### 5.2.1. (a). AGE

The researcher was interested to know whether age is a contributory factor to pregnancy, and it has been identified that the decrease in age relates to an increase in pregnancy as 72.5% of the participants were less than 16 years of age. The researcher believes that early ages at adolescence are especially vulnerable to fall pregnant. Woods and Jewkes (2006: 111) mention that a third of teenagers in South Africa become pregnant before the age of twenty. Reasons include influence either from peers and partners. Another factor is wanting to "proof their womanhood". The study concurs with Lefrancois (2001: 5) and WHO (2000) state that teenagers are marked by a crisis of identity as they seek acceptance in the adult world and their peers by experimenting with behaviours that lead their lives into early sexual activity which result to pregnancy.

### 5.2.1. (b). LEVEL OF EDUCATION

Teenage mothers who participated in this study were still at school and most (74.3%) were in Grade 9-10. Some teenage mothers left school whilst they were pregnant. The participants stated that once they found out that they were pregnant, they felt bad and could not disclose their pregnancy to their friends and parents. They informed the fathers to be who in turn deserted them as they could not afford responsibility. Some of the participants decided to abscond from school as they felt that they will not pass for that year and were concerned that their parents were paying school fees. According to Grant and Hallmark (2006: 7), teenage pregnancy changes teenager' lives forever and in most cases, in a negative way. The birth of their children marks the end of their schooling and they leave school and never return because of greater responsibilities to their children.

### 5.2.1. (c). KNOWLEDGE ABOUT CONTRACEPTIVES

It has been noted by the researcher that knowledge about sexual reproduction is not enough as it is very important that teenagers also understand themselves. The study showed that 60% of the participants did not use any form of contraception. The researcher concur with Wikipedia, 2010: 3 that teenagers lack knowledge in accessing conventional methods of preventing pregnancy. Contraceptives are available, but teenagers do not have sufficient knowledge about how to use them and rely on the information from peers instead. According to Kirby (2001: 28) mentioned that many teenagers do not consistently use contraceptives properly, thereby exposing themselves to the risk of pregnancy.

### 5.2.2.HEALTH RELATED RISK PROBLEMS WITH REGARD TO MOTHERHOOD

To investigate health risks associated with adolescent motherhood, questions such as, "Was the pregnancy intentional", "Did you suffer any complication such as anaemia, hypertension, pre-eclampsia, depressive disorders and others were posed. These questions were based on identification of any complications suffered by these teenage mothers during pregnancy. The study illustrates that 51.7% of the participants below the age of 16 became pregnant intentional and another 45.5% of the participants above the age of 16.Out of study group 48.3% of the participants below the age of16 became pregnant unintentional and 54.5% of the participants of the age above 16. It was interesting to find that young teenagers from the age

below the 16 planned to be pregnant and an individual could ask herself that teenagers how can you plan for other responsibility as you are not matured enough for such responsibility (Cronin, 2003: 5).

### 5.2.2. (a). COMPLICATIONS DIAGNOSED DURING PREGNANCY

The study shows that 17.5% suffered anaemia, 12.5% suffered hypertension, 15.0% suffered pre- eclampsia and 20.0% suffered depression during their pregnancy. Gilbert et al (2007: 3) indicated a number of health problems that teenagers are at risk for during pregnancy, including anaemia, hypertension, renal disease, pre-eclampsia and depression disorders. The study showed that depression as the most suffered complication by the group study. Mwale (unpublished: 129) highlights that early pregnancy results in a number of complications that can be harmful to the mother and the baby. The study concurs with Clemmens (2002: 559) who stated that depression is common after birth and possibly even more so in teenage mothers as feelings of frustration are experienced. In most cases teen mothers cannot afford children – care facilities and their families do not offer much help in taking care of their babies. Martenal depression during postpartum period has an impact on the development of the child as well as mother's own health and ability to act as mother (Najman, Anderson, Bor, O'Callaghan and Williams, 2000:23). Clemmens (2002: 556) agrees that lack of social support from family or friends during other's pregnancy has a negative effect on the mother's mental health. This is one factor that lead to depression.



### 5.2.2. (b) METHOD OF DELIVERY

Questions such as "How did you deliver?" were asked. Response indicated that both caesarean and normal vertex delivery were experienced .The researcher was interested to identify which of these methods were performed the most and what could be the result of undergoing them. The study showed 50% of the participants had delivered normally and 50% of the participants had undergone caesarean section. The researcher could not identify the mostly used methods as participants in this study had utilised equally both method, but according to Raatikaan et al (2005: 164), teenage mothers had many instrumented deliveries but fewer caesarean sections.

## 5.3. SOCIAL AND FINANCIAL PROBLEMS

The researcher had questions based on problems pertaining to child care, such as finance, social support, support from the father, and caring for the child. The researcher was interested in finding out the experiences that the teenage mothers undergo in raising the child. It has been clearly identified that the majority of teenage mothers experienced financial problems as the study indicated 71.8% of the participants experienced financial difficulties, 33.3% of them had problems with social support and 38.5% of the participants had the problems with support from the father. The result on the study indicated that 69.2% of the participants had problem looking after their children. Schultz (2001: 584) states that, however that young mothers made ambitious plans for their future as they were worried about their children, hence some teenagers look for some jobs to meet financial demands of their children, thus result some teenagers drop out of school. The study supported Makiwane et al (2006:4) who underline that the child support grant is not only contributory factor to teenage pregnancy but there are other factors that need to be clearly identified. The data has shown that there is little financial support from families because the family members are committed to other personal challenges such as paying for loans and other responsibilities. The researcher believed that they receive support only because it was imperative as the child could not cope without money. Cost include taking the teenage mother to the clinic or hospital for delivery, and after birth, taking the child to the clinic or doctor and to buy food to feed the baby. Teenage mothers clearly need much support during pregnancy and child care. The results show that there is a great need for parents and health care workers to equip teenagers with life skills which enable them to handle with their problems (Olivier, 2000: 215).



Early motherhood affects the psychosocial development of the infant as development disabilities and behavioural issues increased in children born to teen mothers. The researcher has identified teens who live with their grandparents and parents increase the chances of enrolling in school after giving birth, which suggest that the availability of child care may be an important factor in school continuance (Bunting and McAulley, 2004: 211). The participants mentioned that they were deserted by their partners and some had to confide in neighbours, as no relative was available to help them. They therefore ended up leaving school

to take care of their children. Family support is particularly important to teenage mothers and has been found to have a positive influences on parenting behaviour and practices (Bunting and McAulley,2004: 211) Cronin (2003: 7) believes that families, partners and peers tend to provide different but complementary form of support to teenage mothers which appears to contribute to more positive outcomes. Those who reported to having been deserted by their partners, expressed feeling of depression and frustration. It was interested to learn that all the respondents now have nothing to do with their partners. The pattern of increasing relationship breakdown over time is related to decreasing partenal contact with children (Bunting, 2004: 296). According to teenage mothers, during pregnancy and after, was the time when they desperately needed support (Bunting and McAulley, 2004: 209). Lentournean et al (2004: 511) mention that social support can promote successful adaptation for adolescent mothers and their children. According to Richter et al (2007: 9), lack of social support was a risk factor for the adjustment and development of both young mothers and their children.

## 5.5. CONCLUSION



There are numerous problems facing teenage mothers. Some challenges of teenage motherhood are medical complications for the mother and the baby; others are social problems where the responsibility of parenthood is assumed despite immaturity (Cronin, 2003: 4). The researcher can concur with other researchers such as Cronin, (2003:5) and Bunting (2001: 297) that teenage mothers lack parenting skills as they are not socially and personally mature enough to assume the new roles imposed on them by parenthood. It is less likely that a pregnant teenager will finish high school. She often has financial problems, as many are reported to not be receiving government support. This study showed 10% of the participants who dropped out of school. According to Pillay (2008: 1) identified that teenage mothers leave school and may never return because of the need to take care for their children. These teenage mothers receive very little support or no support from the father of their children, parents and peers as support. Kaufman et al (2001: 149), find that returning to school is a function of support from the girl's family of residence, and paternal recognition of the child.

It has to be mentioned that children at present are exposed to a more sexual environment at a very young age. Children are also subjected to advertisements, film, literature, music and

other stimuli with a strong sexual connotation and this often happens without proper parental supervision or any guidance from other responsible people. It is not surprising to see the increase in teenage pregnancy (Chandra, 2008: 11).The incidence of teenage pregnancies is recorded as high. This research explored the experiences of these teenagers with regard to child care. The researcher believes that is a challenge and responsibility of all professionals, parents, and the wider community to give support in any form to these mothers and children. Unsupported teenage motherhood carries a high risk of adverse consequences in both the short and long term for the mother, child and family (Cronin, 2003:7).

## 5.6. RECOMMENDATIONS

1. Ineffective utilization of contraceptives and ignorance of contraceptives methods are contributing factors to teenage pregnancy. The researcher recommends that emphasis should be placed on providing contraceptive services for teenagers and adopting a more purposeful and holistic approach. Proper health education by health care workers to teenagers about contraceptive such as how contraceptives work in the body; when to start using them; how to use them and to be made available to all primary health care centres



2. Health care workers should take a different approach when working with teenager mothers to help with the negative impacts of poor parenting. Policy makers should design programs that may equip teenagers with the kind of education and skills they need. For instance, the programs should be available on the media.

3. Children born to teenage mothers are one of the groups at greatest risk of living in poverty. Teenagers who become pregnant have high rates of termination of pregnancy. Many of those who carry their pregnancies to term regret having done so. It is clear that strategies to address child poverty should try to reduce teenage birth through:

    - Sex education
    - Making contraceptive services and abortion more accessible
    - Providing financial and other support throughout pregnancy
    - Encouraging and supporting young mothers to remain in education.

4. Health, education and community authorities should pursue strategies that reach Teenagers *before* they become sexually active. Strategies that can be directed to young school girls at primary and secondary level should be designed, with a view to empower them to postpone their sexual debut.

5. Parent–child relationship:

   Health worker should equip parents of teenage mother to be role models for their children, by conducting workshops to discuss issues related to motherhood.

6. Better support of teenage mother is needed including help to return to education, advice and support work with young fathers, better childcare and increasing the availability of supported housing.

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## 7.1. APPENDIX A

## Permission letter to conduct the study

**Eastern Cape Department of Health**


| | | | |
|---|---|---|---|
| Enquiries: | Zonwabele Merile | Tel No: | 040 608 0830 |
| Date: | 06th July 2009 | Fax No: | 043 642 1409 |
| e-mail address: | zonwabele.merile@impilo.ecprov.gov.za | | |


Dear Ms NA Qambata

**Re: Study on experiences of teenage mothers with regard to pregnancy and child care at Nontyatyambo Health Care Center, Mdantsane**

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants. You will not impose or force individuals or possible research participants to participate in you study. Research participants have a right to withdraw anytime they want to.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

PGDP EASTERN CAPE 2004 - 2014

*Ikamva eliqaqambileyo!*

**Province of the Eastern Cape**

**Isebe LeZempilo • Department of Health**
**Office of the Sub-district Manager**
**Buffalo City Sub-District**

Ingxowa Eyodwa
Private Bag x 9015
East London 5200

Tel: (043) 7222 194
Fax: (043) 7430 032

Reference:
Enquiries: Mr Zamxaka
Date: 2009/07/27

To: The CHC Manager ( Nontyatyambo CHC)

Subject: Re: Study on experiences of teenage mothers with regard to pregnancy and child care at Nontyatyambo CHC, Mdantsane.

Ms N.A Qambata is a second year Master of advanced community student at the University of Fort Hare. She would like to do the above mentioned research in your institution. The Buffalo City LSA manager has approved this research. Nontyatyambo CHC is requested to give her all sources of information she may need in this research. An approval letter from the Province is attached together with her research protocol.



Your co-operation will be highly appreciated in this regard.

Yours faithfully

Mr T.T Zamxaka
Buffalo City Sub-District Manager

Date: 27/07/2009

OFFICE OF THE DEPUTY VICE-CHANCELLOR:
ACADEMIC AFFAIRS AND RESEARCH
Private Bag X1314, Alice 5700
Tel: 04060 22403
Fax: 0866282944
tsnyders@ufh.ac.za

University of Fort Hare
*Together in Excellence*

**Application for clearance from the University of Fort Hare's Ethics Committee**

**Project Title:** **Experiences of teenage mothers with regards to pregnancy and child care.**

Chief Researcher: Nolitha Albah Qambata

Supervisor/co-supervisor: Prof Rautenbach/ BF Mayeye

Date of application: 29 May 2009



Having consulted the Dean of Research, I hereby grant permission to conduct the research.

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

6 April 2010

## 7.2. APPENDIX B

**Permission letter to access the participants**

From: N.A.Qambata, 56 Morrison Road, Cambrigde West,East London

To: Research Directorate, Department of Health, Bisho.

**RE: Study on experiences of teenage mothers with regard to pregnancy and child care at Nontyatyambo Health Care Centre, Mdatsane.**

**Dear Madam/ Sir**

I am a second year Master of advanced community student at the University of Fort Hare. As part of my studies I am required to undertake a research study. For my study I would like to assess experiences of teenage mothers with regard to pregnancy and child care at Nontyatyambo Health Care Centre in Mdatsane. I am employed as a lecturer at Lilitha College of Nursing, East London and involved in lecturing Community health science to diploma student.



An increase in teenage pregnancy has been observed in Eastern Cape, thus has prompted me to investigate about experiences of teenage mothers with regard to pregnancy and child care.

The study aims to assess teenage sexual responsibility and to make aware of other teenagers about challenges of being a mother and raising the child.

Data will consist of the number of teenage mothers between the ages of 13-19 years attending family planning at Nontyatyambo Health Care Centre from the period of June to July 2009.

The result and recommendations from the study will in turn contribute towards reducing teenage pregnancy to your local community and other communities in future.

The study will be conducted during June and July 2009.

The study will involve questionnare during clinic hours to teenage mothers attending family planning at Nontyatyambo Health Care Centre in Mdatsane.

I will be pleased if my request receive your favourable consideration.

Yours sincerely,

N.A.Qambata

Tel no: 043-7611802, Cell no: 072 728 9030, E mail 200803150@ufh.ac.za.

## 7.3. APPENDIX C

**Consent form**

56 Morrison Road

Cambrigde West

East London

**Request your consent to participate in a research study**

**Dear participant**

My name is Nolitha Qambata and I am interested in your opinions about experiences of teenage mothers with regard to pregnancy and child care.



**Purpose of the study**

It is to assess challenges of teenage mothers with regard to pregnancy and child care. The results and recommedations from the study will contribute towards awareness of other teenagers about these challenges.

**Procedure**

You will be interviewed in a form of answering questions. An answer will be written in answering questionnaire form. Explanation will be needed when there is a suggestion to do so.

**Duration**

It will take 15 minutes to answer the questions.

**Logistical detail**

You will be interviewed as an individual. The researcher will take 15 minutes of your time. The interview will be conducted in a separate consulting room. You don't need to come back again.

**Electronic recording**

No tape recording will be used.

**Potential risks and discomfort**

You will not experience any discomfort and the research has no risks to your health or image.

**Study activities that exceed the definition of minimal risks**

None

**Potential benefits to subjects and/or society**

The participants will not benefit directly from participating.

**Payment for participation**

No payment will be done for participating.



**Confidentiality**

Your participation will be confidential and only be disclosed with your approval or required by law. Your name and the data will be kept completely separated. The data will be locked in a safe cupboard and only the researcher has access to it.

**Participation and withdrawal from the study**

You may refuse to answer any question that you choose not to answer. There will be no penalties from withdrawal from the study.

**Contact details**

If you have any question relating to this study, you should contact, Nolitha Qambata at 043 7611802 or 0727289030.

**Consent form**

I have read the content of this form, understand, and agree to participate in this study

I understand that I am free to refuse to answer any questions and that I can end my participation at any time without this affecting my care now or in future.

Participant's signature..... Date.....

Parent's signature.....Date.....

Witness' signature.....Date.....

I have explained this study to the above participant and have sought her understanding for informed consent.

Researcher's signature.....Date.....

**Uluhlu lwesithathu-Isicelomvume- isixhosa**

56 Morrison Road

Cambridge Road

East London

**Isicelo mvume sokwenza uphando**

**Nkosazana ebalulekileyo**

Ndingu Nolitha Qambata, ndinomdla ngezimvo namava akho malunga nobumama uselula nokukhulisa umntwana.

**Injongo zoluphando**

Kukujonga imiceli mingeni malunga namava akho ngobumama uselula, nokukhulisa umntwana. Iziphumo zoluphando zizakunceda nabanye abaselula ngezimvo zakho.

**Inkqubo**

Uzakubuzwa imibuzo. Impendulo yakho izakubhalwa ngokuphendula kwakho. Uzakucelwa unike ingcaciso xana kuyimfuneko.

**Ixesha**

Ukuphendula imibuzo kuyakuthatha imizuzu elishumi elinesihlanu.

**Inkcukacha eziphangaleleyo**

Uzakubuzwa imibuzo uwedwa. Umphandi uyakuthatha ixesha elingangemizuzu elishumi elinesihlanu. Uvavanyo liyakuqhutywa kwigumbi elilodwa. Akukho mfuneko yakubuya kwakhona.

**Ushicilelo**

Akukho lushicilelo luzakwenziwa.

**Ubungozi nokuphatheka kakubi ngexesha lophando**

Akukho bungozi nakuphatheka kakubi ngexesha lophando kwaye uphando alunabungozi empilweni yakho okanye kwinkangeleko yakho.

**Inzuzo kubathathi nxaxheba nasemphakathini**

Akukho nzuzo ethe ngqo elindelekileyo ngokuthatha inxanxheba.

**Imfihlelo**

Inxaxheba yakho iyakuba yimfihlelo kwaye iyakupapashwa ngokwemvume yakho okanye ngokwasemthethweni. Igama lakho lizakugcinwa endaweni eyahlukeneyo kwinkcazelo yakho.Yonke lenkcazelo iyakubaselugcinweni olukhuselekileyo kwaye iyakuba ngumphandi onelungelo lokufikelela.



**Ukuthatha inxaxheba nokurhoxa koluphando**

Ungangayiphenduli imibuzo ofuna ukungayiphenduli. Akusayi kubakho sohlwayo ngokurhoxa kwakho koluphando.

**Inkcunkacha ngonxibelelwano**

Ukuba unemibuzo malunga noluphando, qhagamshelana noNolitha Qambata kwezinombolo zilandelayo-043 7611802 okanye 072 728 9030.

**Imphepha mvume**

Ndiyifundile inkcazelo yalembalelwano,ndaqonda, ndaneliseka, ndavuma ukuthatha inxaxheba koluphando.

Ndiyaqonda ukuba ndinakho ukungayiphenduli eminye imibuzo kwaye ndinakho ukurhoxa nangalo naliphina ixesha ngaphandle kokuphazamisana nempilo yam ngoku nakwixesha elizayo.

Mthathi nxaxheba……umhla……

Umzali……umhla……

Ingqina……umhla……..



Ndimchazele umthathi nxaxheba malunga noluphando kwaye waqonda wanika nemvume.

Mphandi……umhla……..

## 7.4. APPENDIX D

**Questionnaire**

1. How old were you during your first pregnancy ? ☐

2. Were you still at school? ☐ Y ☐ N

3. If yes, what grade? ☐

4. Did you use any form of contraceptives before that pregnancy? ☐ Y ☐ N

5. Was your pregnancy intentional or not? ☐ Y ☐ N



6. How did you deliver?

| | |
|---|---|
| Normal vertex delivery | ☐ |
| Caesarian section | ☐ |

7. Did you suffer from any of the following complications during pregnancy?

| | Y | N | Don't know |
|---|---|---|---|
| Anemia | | | |
| Hypertension | | | |
| Pre- Eclampsia | | | |
| Depressive disorders | | | |
| Other | | | |

8. What happened during that time of illness ?

.....

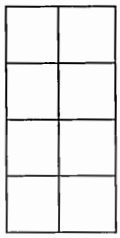
9. Have you had any problem on the following: Y/N

Finance:

Social support:

Support from the father:

Caring for the child:



10. If yes, explain the answer to the above:

.....



11. What can you advise other teenagers about being a young mother?

.....

.....

12. Anything you want to say?

.....

.....

**THANK YOU VERY MUCH FOR PARTICIPATING IN THIS QUESTIONARE**