

**Exploring the mental health experiences of young mothers affected by HIV in South  
Africa**

Chuma Busakhwe  
BSKCHU001

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Faculty of Humanities  
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**COMPULSORY DECLARATION**

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## **Abstract**

The mental health of young women living in adversity, including those at risk of HIV exposure and early pregnancy, remains understudied. This study contributed to this research gap by exploring the mental health experiences of young mothers affected by HIV in South Africa. Seventeen semi-structured interviews were conducted with 18-24-year-old young mothers in the Eastern Cape, South Africa, twelve of whom were living with HIV. Interviews were recorded, transcribed, and analysed using thematic approaches. The study found that psychological research's framing of mental health does not always align with young mothers' understanding and articulation of their day-to-day experiences of their wellbeing. Furthermore, young mothers experienced multiple stressors and challenges which affected their mental health, including school disruptions, coming to terms with their HIV status and unintended pregnancy, and experiences of violence. Adjusting to their new realities and transitioning into their roles as mothers was overwhelming as they were not prepared for such sudden changes in their lives. Additionally, young mothers living with HIV are more vulnerable to poor mental health experiences, particularly at the intersection of early motherhood and HIV syndemic. Young mothers living with HIV employed different techniques to negotiate and navigate living with HIV. The majority experienced profound levels of HIV-related stigma within their social environments. As a result, young mothers chose not to disclose their HIV status due to fear of being exposed to further discrimination and rejection. To design supportive interventions, research must understand young mothers' emotional challenges and mental health experiences over time including different life stages from pregnancy to motherhood, because their mental health burden is affected by exposure to multiple overlapping or simultaneous stressors.

**Key words:** mental health, HIV, young women, early motherhood, syndemic, stigma and South Africa

## Chapter 1: Introduction

Sub-Saharan Africa continues to be the centre of the human immunodeficiency virus (HIV) epidemic, with over 20 million people living with HIV (UNAIDS, 2018). In South Africa, about a third of all new HIV infections occur amongst young women under the age of 25 (Jonas et al., 2016; UNAIDS, 2018; Zuma et al., 2016). Additionally, adolescent girls and young women in South Africa experience high rates of unintended pregnancies, increasing the likelihood that pregnancy and motherhood co-occur with HIV (UNAIDS, 2018). In South Africa, various factors contribute to HIV and unintended pregnancies, including structural factors linked to gendered power relations, poverty, and financial insecurity (Adeagbo, 2019; Jonas et al., 2016; Zuma et al., 2016). Furthermore, young mothers living in resource-limited settings are also more likely to experience premature delivery, low birth weight and infant mortality (Hill et al., 2015). However, little is known about the lived experiences of young mothers affected by HIV and how factors such as poverty and risk of violence intersect with mental health to impact the psychosocial wellbeing of these young women.

These factors may also persist throughout young women's pregnancies or experiences of living with HIV. For example, HIV status disclosure places young women at risk of violence within intimate relationships, and accessing HIV treatment may be difficult, particularly for those who have not yet disclosed their status to their partners (Joska et al., 2020; Willan et al., 2020). Additionally, being subjected to violence may restrict a woman's agency to negotiate safe sexual practices in intimate relationships, and this increases the chances of complex and multiple problems; both physical and mental health issues (Campbell & Mannell, 2016; Hossain et al., 2021; Laurenzi et al., 2021).

Moreover, living with HIV and becoming pregnant entails major transitions from one's present reality to an unplanned and unknown reality with multiple new dimensions—HIV diagnosis, motherhood, and the familial and social changes linked to both (Adeagbo, 2019; Jochim et al., 2021). When unintended pregnancy and HIV co-occur, young women may experience dual stigma, and typically have limited access to social and healthcare support services (Toska et al., 2020). In such contexts, motherhood often becomes stressful because of the increased emotional and psychological stress of having a child while young, struggling financially, and experiencing societal stigma—while managing unfulfilled educational and career aspirations, and, in some cases, postnatal depression (Adeagbo, 2019; Jochim et al., 2021; Laurenzi et al., 2021).

Additionally, an unintended pregnancy may intensify existing social and contextual factors, creating additional stressors that result in poor mental health outcomes (Jochim et al.,

2021). However, despite the extent of these challenges, the mental health of young women remains under-explored, especially in the context of syndemic factors – factors that may exacerbate the effect of one another when they co-occur – such as HIV and early motherhood (Roberts et al., 2021; Singer et al., 2017; Toska et al., 2020).

The complex challenges that young women affected by HIV encounter, such as being a young mother without adequate support, are not experienced as single events, but rather as continuous and inter-related experiences. It is therefore important to explore their mental health experiences in the face of ongoing and multiple stressors such as HIV and motherhood, to understand potential risks for their mental health and opportunities for prevention and response to mental health problems. This study aims to investigate mental health experiences of young mothers affected by HIV living in South Africa.

## **Chapter 2: Literature review**

### **2.1 Introduction**

This chapter presents a review of the literature on many facets of this study, such as early motherhood and the features of living with HIV as a young woman. These aspects include: 1) the mental health of young mothers affected by HIV, 2) early motherhood and HIV, 3) HIV stigma and disclosure, and 4) resilience and agency.

### **2.2 Mental health of young mothers affected by HIV**

Poor mental health is a major contributor to the disease burden in South Africa and other parts of sub-Saharan Africa, and it is also associated with unintended pregnancy and HIV (Kuo et al., 2019; Hill et al., 2015; Vreeman et al., 2017). However, the mental health of vulnerable groups such as young women remains a neglected research and intervention gap, particularly in the context of syndemic factors such as HIV and early pregnancy (Roberts et al., 2021; Singer et al., 2017).

Adolescence and young adulthood are critical phases where significant changes occur, such as the onset of puberty, exploration of identity and sexuality (Barry et al., 2013). Global data show that many mental health conditions begin between the ages of 18-25 years (Solmi et al., 2022). Additionally, poor mental health may present unique difficulties for young people, particularly in the context of other health challenges or risks (Barry et al., 2013; Field et al., 2020; Roberts et al., 2021).

Furthermore, studies have shown that risk factors such as violence, HIV, poverty, and alcohol use can cause stress and have a detrimental impact on young women's mental health (Campbell & Mannell, 2016; Willan et al., 2020). Consequently, exposure to these intersecting stressors not only causes negative mental health experiences, but also has compounding effects for those individuals experiencing multiple stressors.

For instance, for young people living with HIV, adolescence comes with other responsibilities, including taking accountability for managing their antiretroviral therapy (ART) and navigating risks that may affect their physical and mental wellbeing (Field et al., 2020; Laurenzi et al., 2021). Poor mental health can negatively affect adherence to HIV treatment among young women living with HIV (Vreeman et al., 2017). However, very few studies have explored mental health experiences among young women living with HIV in communities where they are exposed to multiple forms of stressors and challenges.

Girls and young women maybe at heightened risk of mental problems as a result of unintended pregnancies and HIV. Firstly, young women experience physical changes in their hormones and bodies which can cause emotional distress (Madlala & Kassier, 2018; Tuthill et al., 2021). These physical changes become exacerbated by contextual factors such as poverty and food insecurity. Young women living with chronic illnesses such as HIV are often at risk of experiencing pregnancy-related complications such as preterm labour, low birth weight infants and pre-eclampsia (Duby et al., 2021). In addition to the stress of having a child while young, pregnancy-related complications contribute to poorer mental health and other emotional challenges (Duby et al., 2021; Tuthill et al., 2021).

Secondly, postpartum depression is the most commonly recognised mental health condition following childbirth, and often goes underdiagnosed and untreated (Govender et al., 2020). A recent quantitative study in South Africa amongst adolescent mothers between the ages of 13-19 found that 15.9% had antenatal depression and 8.8% had postpartum depression (Govender et al., 2020). These findings highlight the complexity and impact of early motherhood on young women's mental health.

Thirdly, young women in South Africa, particularly those from resource-constrained communities, encounter a number of personal and societal challenges related to marginalisation such as intimate partner violence and socioeconomic inequalities (Adeagbo, 2019). An unintended pregnancy can therefore exacerbate pre-existing social and economic stressors, resulting in increased stress, unhappiness, and hopelessness (Duby et al., 2021).

Due to the social stigma associated with unintended pregnancies, young women often receive minimal support from their families, leading to feelings of guilt and poor mental health outcomes (Damulira et al., 2019). Consequently, young women's abilities to cope with the stressors associated with HIV and motherhood may be constrained by a lack of financial and social support (Damulira et al., 2019; Duby et al., 2021). However, there is limited research specifically focused on exploring how young women cope with motherhood, its multiple responsibilities and other challenges in their lives (Duby et al., 2021).

Since 2020, the HIV epidemic became interwoven with the COVID-19 pandemic, thus exacerbating mental health issues globally (Cluver et al., 2022). The pandemic resulted in shifts in all aspects of life including the health system, making daily life harder for the average person (Cluver et al., 2022; Gittings et al., 2021). This was particularly the case for young women living with HIV in South Africa, who faced additional challenges such as ART adherence, risk of violence, increased poverty, and stigma (Gittings et al., 2021). These

challenges have intensified mental health issues among young people, particularly those who are mothers and living with HIV especially since the COVID-19 pandemic.

### **2.3 Early motherhood and HIV**

A large body of research has investigated the factors influencing the high rates of unintended pregnancies among young women in South Africa. According to one study, young women may become pregnant because of limited knowledge about the consequences of having unsafe sex. Additionally, in that study, young women identified barriers to receiving sexual and reproductive health care, such as being stigmatised and shamed by parents and nurses for engaging in sexual behaviours at a young age (Mchunu et al., 2012). Similar findings were observed in another study, whereby young women reported experiencing judgement or harsh treatment from healthcare providers when they access contraception (Christofides et al., 2014). These findings highlight two issues; firstly, young women have inadequate knowledge about safe sexual behaviours. Secondly, young women face stigma and shame associated with sexual activity, which discourages them from accessing services and information, even when these are available in their communities (Christofides et al., 2014; Mchunu et al., 2012).

Other studies have identified associations between unintended pregnancies and structural factors such as poverty and financial insecurity. The current youth unemployment rate in South Africa stands at 42.4 percent, highlighting the severity of unemployment as a significant socioeconomic problem in the country (Statistics South Africa, 2023; Yu, 2013). However, within the context of youth unemployment, there are gender disparities that disproportionately affect women, making them the most affected group by unemployment (Mlatsheni & Leibbrandt, 2014; Yu, 2013). The high rates of unemployment, which often translates into poverty, can lead young women to seek intimate relationships or engage in transactional sex in order to meet their basic needs for money and food (Adeagbo, 2019). Consequently, being financially dependent on a man reduces a woman's agency and choice to negotiate safe sexual practices, putting her at risk of becoming pregnant and experiencing violence (Field et al., 2020). Studies that support these findings highlight the complex and interconnected factors that contribute to unintended pregnancies.

Many of the factors that result in unintended pregnancies among young women in South Africa are similar to drivers of new HIV cases among them, spanning biological and behavioural issues (Seeley et al., 2012). Additionally, for young mothers who are already

living with HIV, contextual issues such as poverty and food insecurity are some of the factors which have been found to be associated with poor ART adherence (Callahan et al., 2017; Mchunu et al., 2012). The children of young mothers with poor adherence are not only at risk for HIV, but they are also likelier to have poorer health outcomes than infants of older mothers or of young women living without HIV (Callahan et al., 2017; Mchunu et al., 2012). This body of evidence highlights that early motherhood and HIV can have adverse effects on both young mothers and their children (Adeagbo, 2019; Callahan et al., 2017; Mchunu et al., 2012).

## **2.4 HIV stigma and disclosure**

Research has shown that HIV stigma is a risk factor for mental health issues among individuals living with HIV. HIV stigma remains a global health concern and a significant barrier to HIV preventative measures (Armstrong-Mensah et al., 2019; Brittain et al., 2023; MacLean & Wetherall, 2021). HIV stigma refers to an enduring process where individuals living with HIV are seen to have a lesser social worth compared to others. Consequently, they face unfair treatment due to this perception (Turan et al., 2017). This type of stigma occurs or is experienced in different ways which includes enacted stigma (actual experiences of stigma and discrimination), perceived stigma (an individual's perception of stigmatising attitudes in their society) anticipated stigma (fear of experiencing stigma in the future), and internalised stigma or the adoption of negative beliefs (Turan et al., 2017). HIV stigma is caused by multiple factors, one of which is the spread of misinformation about the disease. As a result, limited knowledge about HIV creates significant challenges with HIV status disclosure (Armstrong-Mensah et al., 2019; Turan et al., 2017).

Furthermore, gender has been identified as an essential aspect of social and structural inequalities that intersect with stigma (Turan et al., 2017). Young women account for approximately 56 percent of all new HIV infections in Sub-Saharan Africa, with South Africa experiencing the highest burden of new infections (UNAIDS, 2018). Other studies have also shown that men and women perceive and experience HIV stigma differently, with women experiencing higher levels of HIV stigma (Brittain et al., 2023; MacLean & Wetherall, 2021). Consequently, women are more likely than men to experience moral judgments about their HIV status and sexual engagements with beliefs that they could have avoided HIV (Turan et al., 2017).

In the South African context, women are routinely tested for HIV when they enter antenatal care, and an HIV diagnosis during pregnancy may result in increased vulnerability (Brittain et al., 2019). In such situations, women are faced with a new reality of having to adapt to their HIV diagnosis as well as transitioning into pregnancy (Duby et al., 2021). Further, during pregnancy, many young women have to manage the disclosure of both the unintended pregnancy and HIV diagnosis to their families as well as their intimate partners (Crankshaw et al., 2014; Duby et al., 2021).

Dual disclosure can be complex for two major reasons. Firstly, young women delay disclosing their pregnancies to families because of the anticipation of negative reactions (Crankshaw et al., 2014; Hill et al., 2015). Consequently, the delay in disclosing the pregnancy to family has an impact on young women's health care and wellbeing (Crankshaw et al., 2014; Hill et al., 2015). Secondly, the experience of internalised and externalised HIV stigma can prevent disclosure, especially in intimate relationships, which causes stress and thus affects young women's mental health (MacLean & Wetherall, 2021).

Studies have shown that HIV disclosure is influenced by many factors including fear of anticipated stigma, rejection, and power imbalances particularly within intimate relationships (Turan et al., 2017; Willan et al., 2020). Young women are often at risk of violence when they disclose the pregnancy and HIV status, as they are often blamed by their partners for falling pregnant and accused of infecting the male partner (Peltzer & Mlambo, 2013). As a result, many young women living with HIV choose not to disclose their HIV status. Non-disclosure and stigma have a significant effect not only on HIV prevention and ART adherence, but also on the emotional and mental wellbeing of young women (Armstrong-Mensah et al., 2019). It is therefore important to consider experiences and risks of potential stigma when doing research on the mental health of young women living with HIV and contextualising it in their experiences of early motherhood.

## **2.5 Resilience and agency**

The long-term effects of motherhood and living with HIV might be stressful as well as traumatic for young women. However, other research has emerged that speaks to the agency that young women undergoing these experiences might be able to exercise (Campbell & Mannell, 2016), thus indicating their potential for mental wellbeing in terms of coping, resilience, and hope (Kuo et al., 2019). In the context of multiple concurrent or simultaneous adversities, motherhood might provide opportunities for growth, a sense of purpose, and thus

foster resilience (Adeagbo, 2019; Campbell & Mannell, 2016; Masten, 2014). Some young mothers might have positive emotional and mental experiences, for example, when parenting increases maturity as well as improves their self-esteem, or when motherhood provides them with a new sense of meaning in life (Adeagbo, 2019; Mjwara & Maharaj, 2018; Mkhwanazi, 2014).

Additionally, existing research suggests that not all young women affected by HIV are affected negatively by motherhood, and in some cases, parenting might be an opportunity to build resilience (Masten, 2014). Mapping these complex psychosocial experiences of mental health in the context of HIV and early motherhood is needed to better understand pathways to positive and negative mental health outcomes for this vulnerable cohort of adolescent girls and young women.

## **2.6 Study rationale**

The majority of research on motherhood and mental health is quantitative and focuses on a certain stage of their life course—for example, the first six months after giving birth (Roberts et al., 2021). These studies have provided significant knowledge regarding this topic. However, they may offer a limited understanding of the young women's adjustment processes over time. Current research among young mothers emphasises depressive symptoms rather than other aspects of mental health and wellbeing. It is thus important to expand the knowledge base of mental health in the context of motherhood and HIV to determine the implications for young women and their children such as intergenerational mental health issues (Roberts et al., 2021) and inform future programming for young mothers and their children. This study anchored mental health and wellbeing by investigating the experiences of motherhood in adolescence and young adulthood. Additionally, the study included young women who had been experiencing motherhood over the course of up to three years, to allow them to reflect on the process throughout pregnancy and the transition to motherhood as well as how they navigated those challenges.

## **2.7 Significance of the study**

As indicated above, being a young mother living with HIV can be a major formative experience for young women. This lived experience has serious implications for both the mother's and the child's health as well as their future life trajectories (Adeagbo, 2019; Roberts et al., 2021; Toska et al., 2019). Additionally, young women and their children are two main

groups of vulnerable people, as they are both in critical stages of their lives (Adeagbo, 2019). Young mothers often face multiple challenges that can hinder their ability to achieve stability, including limited educational and employment opportunities, and inadequate access to healthcare and support services (Adeagbo, 2019). Consequently, children born to young mothers also face increased vulnerability due to the circumstances in which they are born (Callahan et al., 2017). Additionally, the overlap between unintended pregnancy and HIV has been a major issue in South Africa in recent decades, requiring a more nuanced understanding of how early motherhood in the context of HIV shapes the wellbeing of adolescent mothers and their children.

## **Chapter 3: Research Methods**

### **3.1 Introduction**

This chapter outlines the study's research questions and aims, its theoretical framework, and the research methodology and study design. This chapter also describes the study setting, sampling strategy used, and participant recruitment process. Additionally, a step-by-step process of how data were collected and analysed using thematic analysis is described. Finally, the chapter concludes by discussing ethical considerations and a section on researcher reflexivity.

### **3.2 Research question and aims of the study**

The current study aimed to explore the mental health experiences of young mothers affected by HIV. The study had three research questions:

- 3.2.1 What are the mental health experiences of young women during early motherhood?
- 3.2.2 How do young women experience stigma related to HIV and early motherhood?
- 3.2.3 What factors contribute to the mental wellbeing of young mothers?

### **3.3 Theoretical framework**

To guide the research in exploring the mental health experiences of young mothers affected by HIV, this study applied syndemic theory to understand these issues and how they co-exist, overlap, and combine to inform the overarching research questions. Syndemic theory focuses on the overlap between social and environmental factors, which combine in various ways to impact the health of a population (Singer et al., 2017; Sullivan et al., 2015). HIV was one of the earliest applications of syndemic theory due to HIV being significantly influenced by a range of structural and societal factors, such as stigma, gender inequality, poverty, and violence (Singer et al., 2017). As a result, in HIV-related syndemics, women have been identified as the most vulnerable because of biological factors and societal inequalities (Singer et al., 2017; Sullivan et al., 2015). Syndemic theory has been used to study motherhood and HIV.

Additionally, syndemic theory has also been used to describe the confluence of mental health and HIV in several studies and settings; however, almost all of these studies take place in the Global North (Solmi et al., 2022; Tsuyuki et al., 2016; WHO, 2012), with only a few studies having applied the concept of syndemics to the Global South where context and environment may interact with HIV very differently.

For these reasons, the current study enhances existing research on syndemic theory on HIV and mental health among women by focusing on young mothers affected by HIV in South Africa. Additionally, experiencing the syndemic of both living with HIV and being a young mother may further exacerbate poor mental health experiences (Roberts et al., 2021; Toska et al., 2020). Consequently, considering these overlapping issues such as HIV, unintended pregnancies, and mental health, syndemic theory may provide a deeper understanding of these complex issues.

### **3.4 Study design**

Qualitative research is a valued method used to generate knowledge grounded in lived experiences (Nowell et al., 2017). Consequently, a qualitative design was employed to explore the mental health experiences of young mothers affected by HIV. This study utilised a qualitative approach for several reasons. Firstly, the majority of studies on mental health and HIV have been conducted using quantitative research (either cross-sectional or longitudinal methods) in South Africa (Manyema et al., 2018; Roberts et al., 2021; Waldron et al., 2021). These quantitative methods have yielded a growing body of data, which provides a valuable overview of this topic. However, they may have not effectively deconstructed the context and processes that are important for understanding the syndemic of HIV and motherhood, nor mental health amongst young women in South Africa (Kabeer, 2019).

Qualitative research therefore explains more of the “how” that is often not observed in quantitative research (Willan et al., 2020). Additionally, in order to gain the most comprehensive insight into this syndemic as it occurs in the South African context, qualitative research is required, which will explore the study topic in depth.

Secondly, both HIV and motherhood, particularly in relation to mental health, are very sensitive topics with significant stigma attributed to them. Consequently, when exploring such topics, the researcher must be empathetic to the participants’ experiences and be mindful of the manner in which they ask questions. Qualitative research is thus a suitable approach to employ when conducting such studies, as it provides the space and tools to engage in depth with participants and their experiences such as interviews (Terre Blanche et al., 2006; Willan et al., 2020).

### **3.5 Study setting**

Study participants were recruited from a research site that engages with young mothers affected by HIV in the Buffalo City Municipality, Eastern Cape Province, South Africa. This research site is home to an ongoing longitudinal mixed methods study called HEY BABY (Helping Empower Youth Brought up in Adversity and their Babies and Young children) which conducts research with young mothers and their children living in HIV-affected communities (Toska et al., 2020). Associate Professor Elona Toska, one of my supervisors, is the co-Principal Investigator of this study.

Buffalo City Municipality has one of the highest HIV prevalence rates (30 percent) among pregnant women in antenatal care (Adeniyi et al., 2017), which suggests that young women in this region are at higher risk of HIV than the average young woman in South Africa. Additionally, another study conducted in the same region found that 71 percent of pregnancies among young women under the age of 21 were unplanned (Adeniyi et al., 2018). Cross-sectional analyses of the baseline data of the HEY BABY quantitative cohort (n=1,045) found that a majority of young mothers (approximately 55.9 percent of the cohort), experienced delays in their education, and 15 percent ultimately dropped out of school as a result of their pregnancies (Jochim et al., 2021). Overall, these studies outline the context of HIV and early motherhood in the Eastern Cape region.

### **3.6 Recruitment**

Recruitment for this study was conducted both in person and telephonically by the researcher and two research assistants who were part of the HEY BABY study team. All the participants had previously participated in HEY BABY studies, therefore they had an existing relationship with the study team. Firstly, participants were called or visited to introduce the study and assess their interest. Secondly, those who had shown interest in participating in the study were asked for verbal consent to share their demographic information (see Appendix A for demographic form) for screening purposes. Additionally, responses to the demographic form were the first data source (see Table 1). After screening and determining eligibility interviews were arranged with the participants, only those who were screened were then interviewed.

The purpose of this demographic form was to determine the eligibility of potential participants for inclusion in the study. The demographic form asked for simple and non-sensitive information such as their age, if the participant had a child or not, the age of the

child, employment status, and perceived mental health status (well, coping, or stressed) to identify ahead of time if there was variability within the self-reported mental health of eligible participants.

Recruitment of young women living with HIV is complex, particularly at the intersection of HIV disclosure and stigma attached to HIV (Loutfy et al., 2014). As a result, the demographic form did not ask about HIV status in order to avoid unintentional stigma of potential participants. Thus, the study included participants living with and without HIV. These pre-screening measures were useful tools to consider and employ, particularly when recruiting participants for a sensitive study. Additionally, during the screening process the researcher and/or research assistant informally engaged with participants to build rapport and create an environment of mutual respect before conducting the interviews. Research assistants from HEY BABY have an existing relationship with the participants.

### **3.7 Sampling and participants**

A total of 17 young women between the ages of 18-24 were purposively recruited through the networks of HEY BABY. Seventeen participants were thus considered sufficient for this study since they represented a diverse range of experiences within the sample. Of the 17 participants, 12 were living with HIV and 5 were living without HIV. All the participants had a single child between the ages of 1-3 years.

Participants with two or more children, those who were currently pregnant, or those who had children over the age of 3 years were excluded from the study. This eligibility criteria enabled the researcher to engage with a narrower scope of participants in exploring the questions of interest—young women’s experiences of pregnancy and motherhood with their first children. A summary of participants’ self-reported demographic information is shown below in Table 1. Pseudonyms were used in all study records to protect the identity of participants.

**Table 1: Self-reported demographic details of the participants**

Pseudonym	Age (year)	HIV status	Child age (year)	Employment/Educational Status
Nontombi	21	Living without HIV	2	Unemployed
Zanele	18	Living with HIV	1	Looking for work
Amanda	22	Living with HIV	1	Unemployed
Sihle	18	Living with HIV	2	In high school
Zethu	18	Living with HIV	1	Looking for work
Nande	21	Living without HIV	2	Looking for work
Nosipho	22	Living with HIV	2	Unemployed
Sinovuyo	23	Living with HIV	1	Looking for work
Thando	24	Living with HIV	2	In high school
Athule	23	Living without HIV	1	Unemployed
Emihle	21	Living with HIV	2	Looking for work
Zintle	21	Living without HIV	1	Unemployed
Ezile	24	Living with HIV	2	Looking for work
Ziyanda	21	Living with HIV	2	In university
Khanya	18	Living with HIV	1	In high school
Babalwa	20	Living without HIV	3	In high school
Anda	18	Living with HIV	1	In high school

### 3.8 Fieldwork preparations

Prior to recruitment and data collection, the researcher connected with senior researchers from the HEY BABY team, who have experience working with young mothers living with HIV, to review the interview guide and receive training on how to recruit and conduct qualitative interviews particularly for a sensitive study. The HEY BABY team in the research site supported with fieldwork management and provided the researcher with additional training to ensure that she was fully equipped on how to make proper referrals using the HEY BABY research protocol.

Due to time constraints and the geographical distance between UCT and the research site, the researcher could not be in the field for the whole data collection period. The researcher was in the field for two weeks during the recruitment and piloting phase. Two research assistants who are part of the HEY BABY team supported with the rest of data collection. The research assistants have experienced in conducting qualitative research. Additionally, he researcher also closely engaged with the research assistants and took responsibility for leading daily planning and supervision of the whole data collection process.

The researcher and research assistants held weekly virtual debriefs to discuss each interview process in depth, and to clarify any nonverbal cues that may be difficult to detect by listening to an audio recording, to problem-solve, and to address referral cases that emerged.

Furthermore, the study used HEY BABY's qualitative reflection forms as an opportunity for the research assistants to reflect on the content and overall experience of each of the interviews. Reflection forms were completed immediately after an interview and were uploaded to a secure server where all the study data has been stored. The researcher would read reflection forms and listen to interview audio recordings daily. In addition to discussing each interview in depth, these reflection forms were used as discussion points for the weekly virtual debrief meetings and informed the research team of referrals.

The current study utilised the referral partnership that the HEY BABY has with Masithethe Counselling Services to ensure that counselling services were available to all participants. Masithethe Counselling Services, formerly known as Lifeline, is a free counselling support service based in East London, Eastern Cape. HEY BABY has a partnership with Masithethe, and the study has its own counsellor/social worker who works directly with participants requiring support.

Following recruitment and fieldwork preparations, interviews were then scheduled at times convenient for the participants. Voluntary informed consent was obtained from all participants before interviews began (see Appendix B for informed consent form). The interview guide was piloted with three participants to check the quality and appropriateness of the questions. Minor adjustments were made after piloting, such as removing and rephrasing some of the questions. Thereafter, data collection proceeded until data saturation was reached (see Appendix C for the full interview guide).

### **3.9 Data collection**

In-person interviews were conducted between September and December 2022 with individuals who met the eligibility criteria, gave full consent (verbal and written) and were willing to share their lived experiences. Individual face-to-face interviews have the benefit of allowing the researcher to establish rapport and capture both verbal and nonverbal data while considering factors such as privacy and comfort of the participant (Terre Blanche et al., 2006), making this method a good fit for this study.

Interviews were semi-structured and open-ended questions were used to allow for flexibility and enable the participants to drive the conversation into areas that the researcher

might have not expected. Consequently, in depth interviews were utilised because of their usefulness in actively involving marginalised individuals, maintaining privacy, and facilitating a thorough understanding of young women's experiences (Willan et al., 2020).

Interviews were the primary source of data collection, and they were designed to be approximately 30-45 minutes long. Each interview focused on three broad areas: 1) thoughts and feelings about pregnancy and motherhood, 2) experiences of living with HIV, and 3) mental health experiences in relation to motherhood and HIV. Additional probing questions were asked in order to gain more detail on the participants' responses (see Appendix C for the full interview guide).

Due to the sensitive nature of study, vignettes related to the study topics were used as opening questions to engage with the young women. Vignettes are short stories used in qualitative research to elicit experiences and responses from participants (Törrönen, 2018). Additionally, interviews were conducted in private spaces such as in and around participants' homes to maintain confidentiality and to protect them from the stigma associated with HIV as well as other personal topics. Participants were offered food and soft drinks during the interview.

Interviews were mostly conducted in a mixture of English and isiXhosa, and only one interview was conducted fully in English. The language used during the interview was based on the participants' preference. Qualitative research allows participants to use their home language to enable open expression (Terre Blanche et al., 2006). All interviews were audio recorded and recordings were stored on a secured cloud-based server. The data collected were used for research purposes only.

### **3.10 Referrals**

Given the sensitive nature of the study topics, interviews had the potential to cause participants to recall painful experiences or memories that could make them feel uncomfortable or emotional. Questions were combined with vignettes to introduce topics in a sensitive way and thus, minimising the risk of participants being triggered. Participants who had emotional reactions during the study were comforted and asked if they wanted to continue or not with the interview. Additionally, they were referred to counselling and/or psychosocial support services at Masithethe Counselling Services, a local non-government organisation that provides psychosocial support for referred participants from the HEY BABY study using pre-existing protocols developed with the overall research team. These

participants were flagged for referrals based on their emotional reactions and responses to the interview questions.

### **3.11 Transcription and translation**

Transcripts were produced by attentively listening to all the audio-recorded interviews. Interviews conducted in a mixture of isiXhosa and English were translated into English and transcribed verbatim to include all verbal and non-verbal cues such as tone and pauses. The researcher simultaneously translated and transcribed all audio recordings, as she is fluent in both isiXhosa and English. Furthermore, to ensure rigour, the researcher re-listened to the audio recordings, double-checked the transcripts, and reviewed texts for errors. In addition to these quality checks, the two research assistants selected six transcripts and listened to the audio recordings to ensure the quality of the isiXhosa to English translations, as well as meanings expressed in the transcripts both verbally and non-verbally.

### **3.12 Reflexive thematic analysis**

Data were analysed using the reflexive thematic analysis approach, a data-driven method for identifying, analysing, and presenting themes from the dataset (Joy et al., 2023). The concept “theme” refers to a distinctive pattern of meaning discovered in the data (Joffe, 2012). Reflexive thematic analysis emphasises the importance of finding themes without losing the depth of investigation dataset (Joy et al., 2023). As a result, it not only serves as the implicit foundation for qualitative research, but also aims to give a more structured and clearer version of it.

Additionally, reflexive thematic analysis method is flexible as it can be employed within different theoretical frameworks and research questions (Joy et al., 2023). This approach is often quite subjective: the researcher becomes the tool for analysis, making judgements about coding and contextualising the data (Joy et al., 2023). Thus, as a researcher it is important to reflect on one’s own biases and how they might influence the research to ensure rigour and trustworthiness of the study. Additionally, at each stage of the data analysis the researcher consulted with her supervisors and research assistants to ensure the study credibility.

The current study chose a reflexive thematic data analysis approach because it aligned with the aims and research questions as well as the study design. The study design was exploratory: the aim was to investigate and understand young mothers' lived experiences as

well as the meanings they attach to those experiences. As a result, thematic analysis was a suitable method to complement this research as it fit into the theoretical framework and data collection methods. Further, thematic analysis better enabled the researcher to understand how factors may influence the syndemic of HIV and early motherhood among young women.

The current stud followed the six step of thematic analysis framework proposed by Joy and colleagues (2023). These steps included:

1. Familiarisation of all transcripts
2. Generation of codes
3. Search and identification of themes
4. Review of themes identified
5. Definition of identified themes
6. Write up of the study

The following paragraphs provide a detailed explanation of how the six steps of thematic analysis were employed in the current study.

### ***3.12.1 Data familiarisation***

The first step of the data analysis was to become familiar with the data and get an overview of the data collected before starting to analyse individual transcripts (Joy et al., 2023). The researcher immersed herself in the data in order to get familiar with the depth of the data in its entirety (Joy et al., 2023). Immersion with data entails reading the content repeatedly in an active manner in search of meanings and patterns. The data familiarisation step involved transcribing the interviews and reading and re-reading the transcripts before coding. During the familiarisation process, the researcher manually took brief notes searching for meanings and patterns within the dataset.

### ***3.12.2 Coding***

Following data familiarisation, transcripts were uploaded on Dedoose to be coded. Dedoose is a software programme for organising and analysing qualitative data as well as mixed methods data (Lieber et al., 2021). Coding is separating data into analytically relevant pieces (Terre Blanche et al., 2006). The coding process involved highlighting interesting sections of a transcript, usually phrases, sentences or paragraphs and naming them to describe their content (Joy et al., 2023; Terre Blanche et al., 2006).

Furthermore, texts were highlighted in different colours to differentiate codes. Each code represented a concept or meaning conveyed in that section of the text, and codes were then compared across all transcripts. Coding was conducted by the researcher and research assistants. As the transcripts were double-checked additional codes were added, and codes which overlapped with existing codes were removed. Additionally, coding enabled the researcher to gain a richer and more in depth understanding of the patterns and meanings that occurred within the dataset.

### ***3.12.3 Generating themes***

The third stage began by first creating a list of different codes across the data. The researcher exported all codes into a Word document and manually grouped them according to their relevance in relation to their meaning. Following the grouping of codes, the research team began identifying more patterns within the data and considered how different codes may be combined to formulate a theme based on their relevance. The patterns of codes were then generated into main themes and subthemes from each transcript with the aim of capturing a nuanced meaning of the data (Terre Blanche et al., 2006).

### ***3.12.4 Reviewing themes***

The review of themes started when they were initially generated and required refinement (Joy et al., 2023). The research team reviewed all themes in relation to the coded transcripts to ensure that they formed a coherent pattern. The validity of individual themes was determined by whether the themes were an accurate representation of the data, and they captured the meanings conveyed in the dataset (Joy et al., 2023). During this review step, the research team went back to the coded data extracts and compared themes against extracts to check coherence.

### ***3.12.5 Defining and naming themes***

During this step the researcher refined and defined the themes identified. Defining themes involved identifying the essence of what each theme meant as well as the overall meaning of themes and the analysis (Joy et al., 2023). Additionally, the researcher identified what aspects of the data each theme captured and how each theme fit into overall data set in relation to the study research questions.

Furthermore, to reduce possible bias and increase credibility, the researcher ensured that the themes developed were based on the experiences and narratives of participants rather

than on her own biases. This process involved reviewing and defining identified themes and subthemes with her supervisors and the two research assistants who conducted the interviews. Identified themes were evaluated in relation to the codes.

### ***3.12.6 Write up***

The last step of the data analysis was writing this dissertation, which was the final step of the phenomenon studied – the mental health experiences of young mothers affected by HIV. It is recommended that a reflexive thematic analysis report should give a clear, cohesive, and logical description of the data. (Joy et al., 2023). The writing process consisted of selecting coded data (extracts) and interweaving it within existing literature to highlight the complexity of the data, going beyond a description of the data, and instead convincing the reader of the analysis's validity and usefulness (Joy et al., 2023). The aim of the analysis was to investigate how early motherhood and experience of living with HIV affects the mental health of young mothers.

## **3.13 Ethical considerations**

Before data collection commenced, the study proposal was presented to the Ethics Review Committee of the Department of Psychology at the University of Cape Town. The study was critically examined and thereafter ethics approval was granted (PSY2022-035). Ethical considerations are crucial in research, particularly when it involves human participants (Willig, 2008). These ethical considerations are designed to protect the rights, welfare, and dignity of research participants. It is important for researchers to adhere to these principles throughout the research process, from the initial planning stage to the reporting and dissemination of findings (Willig, 2008). Additionally, upholding these ethical considerations, researchers can maintain the integrity and trustworthiness of their research and safeguard the well-being of participants.

Some of the fundamental ethical issues that are related to dealing with of participants are as follows: informed consent, anonymity and confidentiality, risks, benefits, voluntary participation and withdrawal.

### ***3.13.1 Informed consent***

Participants were provided with a copy of the informed consent form, to ensure comprehension and understanding of the study purpose and aims. The researcher or research

assistant conducting the interview read out the content of the consent form including participants rights. The consent form was explained and written in simple language. Participants could ask questions before signing the consent form. Given that the majority of participants were isiXhosa-speaking, the consent forms were made available in both English and isiXhosa to ensure that participants fully understood the study and that they were able to use a language of their preference. The consent process was conducted in either language, or a combination of languages as appropriate. All physical copies of the signed consent forms as well as screening information have been kept in locked cabinets at UCT separate from other data. Additionally, electronic versions of the consent, demographic forms and interview recordings have been stored in a secured cloud-based server where all the data has been backed up.

### ***3.13.2 Anonymity and confidentiality***

The current study ensured that participants' rights, anonymity, and confidentiality were upheld at all times. To protect the confidentiality of the participants, the researcher used pseudonyms in all research documents. Each participant was assigned a unique code name to protect their identity (as shown in Table 1). Participants were also advised that their responses and information will be kept confidential. However, participants were also made aware from the beginning that there are some exceptions to confidentiality, such as if they were to reveal information that they might be at risk of harm. In such circumstances, confidentiality would be breached, and participants would be referred to relevant support, including counselling.

### ***3.13.3 Risks***

To prepare for the possibility that some participants might intentionally disclose traumatic experiences such as suicidality, and may thus need immediate assistance, the study utilised a strengthened emergency referral system building from existing HEY BABY protocols. Masithethe Counselling Services, which was identified and contracted to provide support to the ongoing HEY BABY cohort study, offered each participant three counselling sessions. Following an interview with participants who were flagged for referrals, the research assistant would send non-identifying information (full name and contact details) about the participant to the HEY BABY project manager who deals with referral cases. The project manager would then forward the participants' information to the counsellor/social worker, who would contact the participant directly. All referrals made in this study were non-

emergency and participation in these counselling sessions was voluntary. Additionally, except for the sensitive nature of the research topics, there was no harm that participants experienced as a result of their involvement in the current study.

#### ***3.13.4 Benefits***

There were no direct benefits for participating in the study. However, all the participants were thanked for their time through personal care packs containing sanitary towels, toothpaste, soap, body lotion and a toothbrush. No financial remuneration was provided. Additionally, through the study, participants had the opportunity to share their narratives and had access to referral services where necessary. All participants expressed that the interviews had a positive therapeutic impact on them, because they were able to talk to someone about their feelings and experiences without being judged and stigmatised. They were given a space where they felt heard and understood.

#### ***3.13.5 Voluntary participation and withdrawal***

Participants were made aware that their participation was entirely voluntary and that they had the right to withdraw at any time during the study without any consequences.

### **3.14 Researcher reflexivity**

Qualitative researchers are a critical part of generating data during the research process as they are deeply embedded in the world where data collection happens. (Dodgson, 2019). Researchers are thus advised to keep a self-critical journal of their research process (Nowell et al., 2017).

Recognising the researcher's social identities and biases and how they may shape the relationships throughout data collection is necessary to understand results and interpretation (Temple & Edwards, 2002). Additionally, reflection on the researcher's individual social identities and perceived biases is crucial in understanding how they influence the interpersonal dynamics of fieldwork (Dodgson, 2019; Temple & Edwards, 2002). The rest of this section are my reflections as "the researcher."

In the population I studied, I was both an outsider and insider. I am a young woman who does not have children. In addition to that, I came from an institution of higher education, while the majority of the participants were either in high school or had dropped out. These attributes of my life made me an outsider in the participants' lives. This might

have influenced the research as there was a limited shared understanding on these aspects of lived experiences. However, we did share similar social identities such as being young African women, of similar ages, and other shared understandings of culture such as clan names and speaking the same home language (isiXhosa).

Furthermore, conducting research on sensitive topics and working with vulnerable populations necessitates ongoing reflexivity and critical awareness. This is essential to ensure ethical practices and manage power dynamics between the researcher and the participants (Dodgson, 2019). In an attempt to counter these power imbalances, I was mindful of my social identities, and I kept a journal to reflect on my emotions and experiences in relation to the research process. Additionally, I acknowledged that my personal opinions, values, and biases may have impacted data collection. I ensured that I never assumed to know what participants meant, particularly when listening to audio recordings. As a result, the context in which participants responded had to correspond to the context in which I comprehended and interpreted their responses. Conducting the weekly debriefs and reading the research assistants' reflection forms enabled me to get a comprehensive understanding of what took place in the field. Additionally, the research assistants' reflections were considered both during fieldwork as well as in the writing of this dissertation given that they assisted with data collection.

Finally, while writing this dissertation, I was conflicted about how I should write about my role. You may have noticed that I used the term "the researcher" to refer to myself throughout the dissertation, and that I used first person pronoun "I" in this section. As a qualitative researcher, I felt it was appropriate for me to use first person pronoun in this section to demonstrate my personal reflections on the study, however throughout the dissertation I chose to use "the researcher."

## Chapter 4: Findings and insights

### 4.1 Introduction

This chapter presents the study’s qualitative analysis exploring the mental health experiences of young mothers affected by HIV in South Africa in four main themes which emerged from the data: 1) Mental health shaped by distinct stressors during pregnancy, 2) Navigating critical life events, 3) Imagined futures and pathways to mental wellbeing. Table 2 shows a summary of themes and sub-themes identified during the analysis.

**Table 2: Identification of each themes and subthemes**

Main themes	Sub-theme	Thematic definition and description
Mental health shaped by distinct stressors during pregnancy	<ol style="list-style-type: none"> <li>1. Diverse understandings and experiences of mental health</li> <li>2. Stressors affecting young mothers’ mental health               <ol style="list-style-type: none"> <li>2.1 Stressors linked to material and psychosocial support</li> <li>2.2 Stigma linked to HIV and pregnancy</li> <li>2.3 Violence as a risk factor for poor mental health</li> <li>2.4 Healthcare experiences as stressors for mental health</li> </ol> </li> </ol>	Exploring how young mothers understand mental health and experience unique challenges and stressors related to limited forms of support, stigma
Navigating critical life events	<ol style="list-style-type: none"> <li>1. Coming to terms with HIV status from a young age</li> <li>2. Emotional and psychological transitions</li> <li>3. Structural changes: disruption of schooling</li> </ol>	Exploring how young mothers experienced emotional, psychological, and structural changes during their transitions to motherhood and accepting their HIV status
Imagined futures and pathways to mental wellbeing	<ol style="list-style-type: none"> <li>1. External dimensions of early motherhood: emotional support</li> <li>2. Future goals and outlook</li> <li>3. Agency and resilience</li> </ol>	Exploring how young mothers demonstrated agency and had positive future outlooks.

### 4.2 Mental health shaped by distinct stressors during pregnancy

Based on the themes which emerged during the analysis, this section will discuss how the mental health of young mothers is shaped by unique and interrelated stressors during pregnancy and early parenthood. This section elaborates on the following sub-themes: diverse

understandings and experiences of mental and stressors affecting young mothers' mental health: material and psychosocial support, stigma linked to HIV and pregnancy, experiences of violence and healthcare experiences.

#### **4.2.1 Diverse understandings and experiences of mental health**

Participants were asked about their understandings of the concept of mental health, and how they would describe their own mental health using their own terms. Young women described diverse and different understandings of mental health, which were related to lived experiences and social interactions. Participants described that their understanding of mental health was influenced by various factors, including cultural background, personal beliefs, societal norms, and personal experiences. Generally, these understandings were very personal and removed from more technical or clinical psychological language. Consequently, participants described intense and stressful emotions related to their lives, including early motherhood and HIV-related challenges. Nosipho explained her understanding of mental health in the following way:

*“Like mental health... like when your brain is tired.” (Nosipho, 22 years, living with HIV)*

Nontombi described her mental health in relation to complex emotions she experienced as a young mother. These emotions resulted from the guilt she experienced after she became pregnant and due to a lack of support from both her family and her child's father.

*“You are facing challenges and you are blaming yourself, you feel guilty because no one supports you.” (Nontombi, 21 years, living with HIV)*

Another young woman described her mental health based on her experience of living with HIV. According to Sinovuyo, accepting her HIV status and adhering to ART translated into positive mental health:

*“It means I must continue taking my treatment so that I can be healthy...Like not thinking too much or be emotional about the fact that I am living with HIV.” (Sinovuyo, 23 years, living with HIV)*

The study findings suggest that young women understood mental health as emotions or experiences as translated into their day-to-day lives. Few participants explained mental health as a scientific or clinical phenomenon by using terms that are common in how research writes about mental health such as depression, anxiety and suicide. Additionally, young mothers had their own unique understandings and language around mental health, shaped by many factors including relationships, family dynamics, education and societal expectations. Some of the participants viewed mental health in terms of emotional wellbeing, self-esteem, and stress management, while others associated it with feelings of happiness, or their ability to cope with challenges.

Consequently, instead of mental health, participants articulated positive and negative feelings as well as emotions in relation to their lived experiences. However, most of the emotions described were conflicting emotions such as regret, guilt and disappointment and stressors which affected their overall mental health. The next sub-theme highlights some of the main stressors shared by the young mothers.

#### **4.2.2 Stressors affecting young mothers' mental health**

##### **4.2.2.1 Stressors linked to material and psychosocial support**

For several young mothers, there was a close connection between tangible, material stressors and their mental health. The connection between material stress and mental health emerged particularly from conversations around finances and resources available to them. As a result, young mothers described financial challenges – being unable to afford essentials for the baby such as food, nappies, and clothes – as one of the main stressors affecting their mental health.

There were two ways in which financial challenges were experienced and linked to mental health. The first aspect was individual stress and worry of being unable to afford the child's basic needs, as well as concerns about where to acquire such support. The second aspect of financial challenges was related to how financial stressors strained relationships young women had with their parents or caregivers and the father of the child—notably, in the event that they were unable to assist them financially fully or partly. Participants described the stress they experienced when they did not have financial means to provide for the child's needs, particularly when the father of the child was also unemployed:

*“It's stressful sometimes because I do run out of nappies when the father of the baby doesn't have money, so I end up stressing.” (Sinovuyo, 23 years, living with HIV)*

*“I am unemployed, and father of the baby is also unemployed so we would struggle sometimes with baby stuff.” (Nosipho, 22 years, living with HIV)*

For Nosipho, the father of her child was not actively involved in their child’s life and therefore did not provide any form of support. Nontombi’s family was also unable to assist financially, as they were dependent on social support grants:

*“We are really struggling, and this baby doesn’t have a father, he ran away.... So being a mother is not entirely okay, there should be someone assisting you. Yes, I’m a mother but I need support cause I’m unemployed, I’m just sitting in this township.” (Nontombi, 21 years, living without HIV)*

Furthermore, for most of the young women, though not all, the father of the child either denied paternity, or was largely absent in the child’s life even if they did acknowledge their paternity. Young women described the shame, blame and stress they faced when their partner denied paternity of the child:

*“So, let me talk about myself, my baby’s father decided not to be a part of our child’s life. So, I raised my child by myself with the help of my grandmother...What would I do, cause his father denied him, so what would I do?” (Amanda, 22 years, living with HIV)*

However, some of the young women had difficulties with accepting that they would be single parents. Despite his initial denial, Zintle hoped that the father of her baby would eventually acknowledge the paternity after birth:

*“He denied the pregnancy and I said okay if you say so, but you will see when the baby is born.” (Zintle, 21 years, living without HIV)*

With the father absent, the young woman and her family had to shoulder the financial and primary caregiving responsibilities for the child. This includes tasks such as feeding, bathing, and nurturing the child’s emotional wellbeing. The increased caregiving demands can be overwhelming, especially if the young woman has limited support networks.

Additionally, young women experienced feelings of stress and emotional exhaustion as they navigated the challenges of being a single parent.

In summary, these findings suggest that having a child while young puts emotional and psychological pressure on young women as individuals and their relationships with family as well as partners. Additionally, having limited financial resources to take care of the child was a material stress which affected these young women's mental health, especially considering that none of them were employed, and that the majority of their children's fathers were largely absent and did not provide any form of support. The inability to meet the financial needs of the child, the stress of not having adequate money to care for the child can result in increased stress and pressure which in turn affect their overall wellbeing and mental health.

#### **4.2.2.2 Stigma linked to HIV and pregnancy**

The experience of HIV and pregnancy stigma was described as another stressor which negatively affected young mothers' mental health. However, for most of the participants, this was not experienced as dual stigma: some experienced either pregnancy stigma or HIV stigma, with only a few having described experiencing both HIV and pregnancy stigma. Athule described experiencing pregnancy-related stigma; as a result of this stigma, she decided to socially isolate herself in order to protect herself from further judgments within the community:

*“There were a lot of people that were looking at me. So, I actually stayed at home during my pregnancy and there were also people that were gossiping about me.” (Athule, 23 years, living without HIV)*

Additionally, some of the young mothers described experiencing pregnancy-related stigma from their friends' mothers and other elderly people within the community. These parents stigmatised pregnant girls and young women; they also had concerns that these young women would encourage or influence their own children into becoming pregnant at a young age. Zanele described how this experience made her feel:

*“Some mothers used to say so and so's child is not educated, she loves men, and she is now pregnant. So, things like that used to hurt me a lot.” (Zanele, 18 years, living with HIV)*

Furthermore, for young mothers living with HIV, the dual experience of HIV- and pregnancy-related stigma was overwhelming, irrespective of whether HIV stigma was experienced in the past or it was ongoing. For young women who experienced both ongoing HIV-related stigma and pregnancy their stories suggested that they developed internalised and perceived stigma.

This was the case for Ziyanda: her experience of externalised stigma triggered internalised stigma. Due to the stigma surrounding HIV, the participant had not fully come to terms with her HIV status. Consequently, she experienced low self-esteem and struggled with trust issues when it came to revealing her status to those close to her. In addition to these thoughts, she was concerned about how people in the community talked about her, considering that her own family stigmatises her and discriminates against other people living with HIV.

*“I do live around people who talk negatively about HIV and things like that. For example, at home I do hear them... and I feel bad when they gossip about someone living with HIV and then I think for sure, in other households this is how they talk about me. They do talk badly even in my presence, and they know about it, so I don't know how they think I feel when they talk about someone else like that, who is in the same situation as me.” (Ziyanda, 21 years, living with HIV).*

Similar to Ziyanda's experience, another young woman, Anda, expressed how one of her peers at school told her that they would never associate themselves with someone living with HIV. This made Anda think about how her classmate would respond and treat her if they were to discover her HIV status:

*“One of them said they would never be friends with someone living with HIV and I was shocked cause here I am, and they talk to me, but I was wondering how they would react if they were to find out.” (Anda, 18 years, living with HIV)*

Furthermore, fear of HIV stigma was also expressed by young women living without HIV. One of the young women, Babalwa, was concerned about how people in her community might perceive her if she were to acquire HIV.

*“Let’s say maybe I have HIV like, how will people treat me if ever I told them my status? How will they treat me, how will they look at me?” (Babalwa, 20 years, living without HIV).*

Social isolation was a protective technique utilised by these young women to protect themselves from further stigma, particularly pregnancy-related stigma. During this isolation period, young women described feeling lonely, sad, and emotionally distressed. Despite the fact that the majority of participants did not outrightly describe mental health in clinical language, some of them expressed experiencing symptoms of depression, anxiety, and suicidality. Suicidality, in particular, was expressed with reference to HIV-related stigma. One of the participants, Amanda described having suicidal thoughts and attempting suicide due to stigma she experienced within her social environment from her friends and people in the community:

*“I once attempted suicide because of such things... People disclosed my private issues and I wanted to kill myself.” (Amanda, 22 years, living with HIV)*

Ziyanda discussed the psychological impact of HIV stigma she experienced as a child from her caregiver and extended family members. The experience of HIV stigma can cause emotional distress, including feelings of sadness, negative self-image, and self-stigmatising thoughts:

*“It made me feel less at home because I was not treated like other children, of which I understood what the problem was... I used to cry every day, I was so close to having depression otherwise what helped me was deciding to leave that house.” (Ziyanda, 21 years, living with HIV).*

In summary, the findings highlight the psychological impact of stigma on young mothers. HIV-related stigma can have long-term consequences that affect an individual emotionally and mentally. However, beyond HIV stigma, there were other challenges and stressors that were described as affecting their mental health.

#### **4.2.2.3 Violence experienced by young mothers as a risk factor for poor mental health**

For some young mothers, unplanned and unintended pregnancies were associated with extra risk factors and stressors, such as emotional, physical, and sexual violence, and

thus taking a significant toll on the young women's mental health. Ezile was blamed for becoming pregnant by her child's father, and as a result, he would verbally and physically abuse her:

*"He would come here to insult me, and he would beat me sometimes." (Ezile, 24 years, living with HIV)*

Another young woman, Sihle, experienced physical violence from her child's father. She shared that he began being abusive towards her after she had informed him of her pregnancy. Additionally, for Nontombi, the pregnancy was a result of sexual assault.

*"It was not nice at all cause the baby father started being abusive...He was abusive.....He started laying hands on me, while I was pregnant." (Sihle, 18 years, living with HIV)*

*"I was so stressed and hurt because my story is almost rape when I fell pregnant...Uhm so I used to smoke drugs at the streets and that person used me because of the drugs." (Nontombi, 21 years, living without HIV)*

These findings highlight that young mothers experience multiple and intersecting risk factors including emotional, physical, and sexual violence. Violence adds to already complex and overwhelming experiences these young mothers were facing and thus affects their mental health and wellbeing.

#### **4.2.2.4 Healthcare experiences as stressors for mental health**

Young women faced additional stressors that affected their mental health prior to and during their pregnancies, such as difficulties in accessing family planning services and the need to make decisions regarding pregnancy termination. The majority of participants noted that contraception was freely accessible in healthcare services within their communities, and a number of participants, though not all, had adequate access to and knowledge about contraceptives. Some of the young women expressed that they had never used contraceptives before, while others had used them, but stopped due to side effects such as disrupted

menstrual cycles. Only one young woman was unaware of contraception and had never used it.

*“I don’t know why but I was not using contraceptives. I was sexually active, but I didn’t think I would fall pregnant.” (Thando, 24 years, living with HIV)*

*“No, I have never used them... The thing is I didn’t know about them, I didn’t know anything at the time... I was still young and dumb.” (Nontombi, 21 years, living without HIV)*

Despite contraceptives being freely accessible, some of the young women did not make use of the services out of choice, whereas some had challenges with accessing such services. The first major challenge was that most of the participants were still in high school when they became pregnant. Consequently, young women stated that they were unable to access family planning services since they spent most of their time in school, and the clinic would have been closed by the time they left school.

*“On the day of my date I was writing exams and I was writing in the afternoon so by the time I left school it was already closed on the contraceptives side.” (Babalwa, 20 years old, living without HIV)*

*“When we were in Grade 12, we spent most of our time at school. We would be at school from 8am until 4pm, and at that time the clinic is also closing.” (Ziyanda, 21 years, living with HIV)*

Another challenge for not accessing family planning was young women being afraid of or anticipating the nurses’ reactions if they were to go to the clinic. This fear and anticipation of negative reactions was based on previous personal experience or peers’ experience:

*“I was scared to go to the clinic. The nurses are not polite, so I thought... I was just scared... They were talking about how nurses are not polite, they make you feel down.” (Nande, 21 years, living without HIV)*

Furthermore, most of the young women described their pregnancies as unintended, which created mental health stressors, especially given the lack of control over bodily

autonomy (control over their own situations and major life transitions). As a result of their pregnancies being unplanned and unintended, most of the participants shared that they were stressed upon discovering their pregnancy and had thoughts of terminating it. Additionally, the desire to terminate the pregnancy emerged out of anticipated burdens of caring for a child, concerns about their educational goals and prospects for the future.

However, due to various reasons, none of them continued with the termination, as this was a difficult decision to make. Some of the two main reasons stated by the young women were stigma associated with pregnancy termination and a lack of information about where to access such services in their communities. One of the participants went to her nearest clinic to seek information and assistance, but she did not receive the help she needed.

*“When I asked at the clinic about what to do when I want to have an abortion, they told me that I must go to [hospital]. If you are 18 years and below, you must go there with a parent so I was like no, I would never, I would rather not do it.” (Ziyanda, 21 years, living with HIV)*

Another young woman described how she considered terminating her pregnancy, but was unable to do so due to the anticipation of moral judgments and the stigma associated with abortion in her community:

*“Like I will be honest, when I found out that I’m pregnant I wanted to do an abortion because I was thinking my life will be stagnant, there is nothing else I would be able to do. But then I told myself that what I’m about to do [abortion] is wrong, let me keep the pregnancy and raise my baby by myself. Like I was thinking there are people who judge others like they would see that I’m pregnant and suddenly the belly will disappear. They might say a lot of things, people talk a lot.” (Zintle, 21 years, living without HIV).*

In summary, these findings reflect challenges with engagement with care – young women desire to safely terminate their pregnancies but are prevented by barriers such as the stigma attached to termination including moral judgements, lack of information about the legality of termination of pregnancy and poor service provision. These barriers can have serious consequences for the health and wellbeing of young women. Additionally, the lack of

awareness can contribute to confusion and fear, making it difficult for young women to navigate the healthcare system and find safe as well as reliable options for termination.

### **4.3. Navigating critical life transitions**

This theme will discuss the main critical life transitions experienced by the young women: 1) coming to terms with HIV status at a young age, 2) emotional and psychological transition from girlhood into motherhood, 3) disruption of schooling. The first sub-theme will discuss findings from young women living with HIV, and the rest of the sub-themes will discuss findings from all participants.

#### **4.3.1 Coming to terms with HIV status from a young age**

For participants living with HIV, learning about their HIV statuses at a young age was a life-changing event. The young women in this study disclosed that they all acquired HIV perinatally, and they learnt about their HIV statuses at different phases of their lives. For the majority, the age range when they learned their HIV status was between 7-13 years. Their HIV status was kept a secret from them by their parents or adult caregivers to protect them from stigma. However, upon learning about their statuses, they were confused, hurt, and felt betrayed.

*“I was hurt but I was still young, I didn’t know that this is something you live your entire life with.” (Amanda, 22 years, living with HIV)*

Additionally, one participant discovered her HIV status when she went to the clinic to test for pregnancy at the age of 16. She was taking medication prior to learning about her HIV status, however she believed she was taking diabetes medication. Khanya’s caregiver encouraged her to take her medication, but she never disclosed to her the reasons as to why she was taking it.

*“They asked if I knew my status and I said yes but I was not aware. I said sugar diabetes then they said, you don’t have sugar diabetes, you have HIV...” (Khanya, 18 years old, living with HIV)*

*“But my aunt was not telling me that I have HIV... Yes, I was told that I must take medication and I was asking myself, what are these pills for? then I was told at the clinic that I have this problem like this HIV, that’s when I found out.” (Khanya, 18 years old, living with HIV)*

Although concealment of HIV status was a form of protection, these young women nonetheless experienced profound levels of stigma, particularly those who lived with relatives and in HIV-affected communities.

*“They gossiped about me and laughed at me, some didn’t want to use a cup I drank with, they thought it would infect them and I would see they were scared when I approached them.” (Zanele, 18 years, living with HIV)*

In summary, these findings highlight the negative impact of secrecy and non-disclosure around HIV on the wellbeing of individuals affected by the virus. Additionally, secrecy and non-disclosure can not only harm the mental and emotional wellbeing of those living with HIV but also perpetuate stigma and discrimination. When young women experience stigma, they may develop trust concerns and subsequent challenges in disclosing their HIV status, particularly within intimate relationships. The fear of negative reactions, rejection, or potential harm can make disclosure of their HIV status a challenging and complex decision. Being young and navigating an unintended pregnancy can complicate the process of disclosure further. In addition to the fear of negative reactions, there may be concerns about the potential implications for the individual's relationships, support networks, and future plans. This can include worries about the acceptance and support of the child's father, and the potential social and economic consequences of disclosing the HIV status.

#### **4.3.2 Emotional and psychological transitions**

Pregnancy and motherhood are complex life changes, especially among young women affected by HIV who may experience a transition into motherhood which is unplanned and for which they are unprepared. This was the case for the participants in this study: young mothers reported experiencing challenges with adjusting to their new and unplanned realities. Thus, navigating this adjustment was seen as stressful and overwhelming.

*“It was actually hard to accept it, it took me a long time to deal with the fact that I am a mother.” (Athule, 23 years, living without HIV)*

*“I felt stuck and like my life is going to change, I won’t be able to go out with my friends anymore.” (Anda, 18 years, living with HIV)*

Furthermore, young women described experiencing conflicting emotions about their new realities of having to balance individuality (taking care of their own needs as young women) and parenting (taking care for the physical and emotional needs of the child). These conflicting emotions emerged as a result of unpreparedness for motherhood in addition to other challenges. Additionally, given that the majority of these young women's pregnancies were unplanned, they were concerned about becoming inadequate parents to their children. Nontombi and Nande described these feelings of uncertainty and doubt in the following way:

*“I’m doubting myself because I’m not supposed to be a mother, I didn’t plan to be a mother.” (Nontombi, 21 years, living without HIV)*

*“What has changed is that I am full of self-doubt. I’m doubting myself and sometimes I feel like I’m not good enough. So sometimes it’s difficult.” (Nande, 21 years, living without HIV)*

Moreover, some participants expressed feelings of regret, frustration, and self-blame. Feelings of regret were specifically related to how these young women’s lives had changed from the onset of their pregnancies to parenting. Additionally, feelings of frustration and self-blame emerged from missed opportunities as a result of parenting – having to take care of a child made accessing opportunities such as employment even more complicated for these young women.

*“I mean everything didn’t go well like I was looking for a job, but I had to stop and take care of the baby...I don’t feel okay. I mean if I didn’t have a baby, I would’ve found a job by now” (Sinovuyo, 23 years, living with HIV).*

Parenting responsibilities, such as childcare can consume a significant amount of time and energy. As a result, this can make it difficult for young women to pursue employment opportunities that may require flexibility in terms of working hours or travel.

#### **4.3.3 Structural changes: disruption of schooling**

For all participants, the transition to motherhood was not only internal but structural as well. Given that the majority of the participants were still in school when they became pregnant, and only a few of them were out of school and/or looking for employment, they reported missed opportunities (as discussed above) and school delays as stressors which affected them both during and after pregnancy. Young women described having to pause either looking for employment or attending school in order to take care of their infants. Some of the young women who took a break from school had difficulties returning due to financial issues and the challenges of having no one to care for the child while the young mother attends school.

*“I decided to quit....and when you are pregnant you can’t go to school so I just quit, I think for about 2 years. I quit because I wouldn’t have been able to raise the baby while I’m still in school.” (Nande, 21 years, living without HIV)*

*“After I gave birth, I tried to return to school but the situation didn’t allow me...cause the aunt I currently live with, was telling me that I’m the one who decided to have a child and things like that.” (Zintle, 21 years, living without HIV).*

In summary, the unplanned transition to motherhood triggered the stressors and challenges experienced by young mothers from varying levels; being a young woman, living with or affected by HIV, at risk of violence, and having limited resources. These stressors are not experienced as single events, but rather as multiple events which together affect young women’s mental health and wellbeing. Young women also carry the shame and guilt of becoming pregnant at a young age. Additionally, the findings suggest that unintended pregnancies have an emotional, psychological, and economic toll on both young women and their families.

#### **4.4 Imagined futures and pathways to mental wellbeing**

This final theme presents findings on how young mothers imagine pathways to mental wellbeing and stability. Young mothers described the different types of support they received from people in their social environments, as well as how that support enabled them to pursue their educational ambitions.

##### **4.4.1 External dimensions of early motherhood: Emotional support**

Having a support system contributed to the wellbeing of the young mothers who participated in the study. As a result, some of the young mothers described positive experiences of early motherhood, despite admitting that their pregnancies were unplanned. In contrast, young mothers without adequate support experienced conflicting emotions with assuming their parenting roles at a young age. The support of family members, the child's father, and friends was reported to play a crucial role in helping young mothers navigate conflicting emotions. However, in the event that there was a lack of or limited support from these individuals, young mothers described how their challenges were exacerbated and thus felt over-whelmed.

Most participants received support from their families in the form of caregiving and financial support: there was little to no emotional support from family members. A minority of those who described having emotional support received it from their friends. In this context, maintaining friendships and receiving emotional support throughout pregnancy promoted young mothers' mental wellbeing. One of the participants, Babalwa, isolated herself during pregnancy to protect herself from anticipated shame and judgments. However, her friends would visit her at home and spend time with her so she would not overthink the fact that she was pregnant and feeling lonely at that time. She said:

*“My friends were very supportive because they used to come see me at home, I barely went outside during that time.” (Babalwa, 20 years, living without HIV)*

Anda described the moral and emotional support she received from her friends when she had to drop out of school during her pregnancy, sharing:

*“So, all along I was not alone, my friends were supportive and if I didn't go to school they would come and update me on schoolwork. If I go to the clinic, one of them*

*would go with me. So, they were supportive, they were not judgemental at all.” (Anda, 18 years, living with HIV)*

For another participant, Nande, her only friend was not physically present; however, this friend provided her with telephonic emotional support during stressful times of her pregnancy and early motherhood.

*“No, but they did support me, and I don’t have a lot of friends. I only have one friend and she was not around while I was pregnant, but we used to communicate through the phone, supporting me when I was stressed.” (Nande, 21 years old, living without HIV)*

Sihle described how her friends supported her not only emotionally, but also financially in some instances:

*“My friends stay at [name of place] so they would visit me and chill with me the whole day and if there was no food at home, they would give me money to buy something to eat or I would go and eat at their homes. So, they did support me a lot.” (Sihle, 18 years old, living with HIV)*

Conversely, losing friends during pregnancy translated into a loss of emotional support for many of these young women, as they mostly relied on their friends for this form of support.

*“So, I stayed at home, and I didn’t have any friends or anyone to talk to...” (Zanele, 18 years, living with HIV)*

#### **4.4.2 Future outlook and goals**

Young women who received full support such as emotional, financial and caregiving support from their families stated that they did not experience many challenges with either parenting or individual stressors. Having a supportive family enabled these young women to continue with their lives – return to school, seek employment, and/or pursue further education – which had a positive impact on their overall wellbeing.

*“It [motherhood] wasn’t too difficult for me because I had a supportive family.”  
(Thando, 24 years, living with HIV)*

*“Okay the kind of support that I get at home.... Like if they were different people, they would expect me look for someone that will take care of the baby when I’m at school. So, my grandmother looks after the baby when I’m at school.” (Sihle, 18 years old, living with HIV)*

*“I think I’m better just because there is someone taking care of her while I’m here at school.” (Ziyanda, 21 years old, living with HIV)*

Despite the challenges they faced, many young women remained optimistic about their future and aspired to pursue further studies. These young mothers saw education as an opportunity to regain control over their lives and create a better future, not only for themselves, but also for their children. Consequently, the pursuit of education was seen as a means to empower themselves, break the cycle of adversity, and build a brighter future for their families.

*“I want to study law and build a house for my family and have a nice life somewhere.” (Sihle, 18 years, living with HIV)*

*“I think I’m mature enough, unlike before, I think she is the reason why I’m motivated to study. I have a responsibility now and that’s why I’m more worried about my future.” (Ziyanda, 21 years, living with HIV)*

#### **4.4.3 Agency and resilience**

Despite the stressors and conflicting emotions which emerged from the challenges of early motherhood without sufficient resources and support, most young women expressed feelings of happiness and fulfilment about their parenting experiences. Additionally, the young women also shared their positive experiences of motherhood and celebrated their positions as mothers which demonstrated their agency.

*“I’m happy about my life. Now I know that I have a someone to live for.” (Ezile, 24 years, living with HIV)*

*“It [motherhood] has a positive impact because you get to experience a lot of things, things you didn’t know...” (Anda, 18 years, living with HIV)*

Furthermore, young women in this study demonstrated a sense of agency, perspective-taking, and resilience in various ways. While early motherhood may have delayed short-term and long-term plans, for some it also provided an opportunity for self-growth and maturity. Young women embraced their role as mothers and saw it as a chance to develop their nurturing skills, gain a sense of purpose, and become more responsible individuals.

*“I feel good because I am able to support another person. I don’t regret anything about being a mother.” (Thando, 24 years, living with HIV)*

*“It has changed because I stopped doing what I used to do before, like smoking so now I stay at home and take care of my baby.” (Nontombi, 21 years old, living without HIV)*

In summary, these findings suggest that in the context of unintended pregnancy having a support structure such as family and friends plays an important role in young mothers’ lives. Consequently, support not only assisted them with raising their children, but also enabled them to process and deal with their internal emotions as they transitioned into motherhood. Additionally, young women were able to demonstrate resilience and agency by taking charge of their lives following early motherhood. The study findings have demonstrated that the ability to move beyond the transition of motherhood is fostered by not only individual factors such as agency, but also the support and resources one has access to in their social environments.

#### **4.5 Reflections on referrals**

Of the 17 young women who participated in the study, six were referred to counselling including one participant who also received a food voucher (see Table 3). With some degree of confidence, this study demonstrated research as an intervention. Young women were able to not only share their stories but also had access to counselling resources,

which they needed for other experiences in their lives, including violence. Participants expressed that the interview had a therapeutic impact on them, because they were able to talk to someone who they could relate to about their stressors. As a result, they disclosed experiences of violence, and shared other daily challenges that had been bothering them. The reflections from these referrals highlight the importance of having appropriate support systems in place when conducting research with vulnerable populations, such as young mothers affected by HIV. It is also crucial to consider the emotional and psychological wellbeing of participants and provide access to counselling referrals and other necessary resources. This referral process ensured that participants had the support they needed during and after the research process.

**Table 3: Participants who were referred for counselling**

<b>Pseudonym</b>	<b>Age (year)</b>	<b>HIV status</b>	<b>Referral</b>
Nontombi	21	Living without HIV	Counselling and food
Amanda	22	Living with HIV	Counselling
Nosipho	22	Living with HIV	Counselling
Athule	23	Living without HIV	Counselling
Khanya	18	Living with HIV	Counselling
Anda	18	Living with HIV	Counselling

## **Chapter 5: Discussion**

### **5.1 Introduction**

This chapter discusses the findings of the study by engaging the themes which emerged from the analysis and integrating them with literature related to the mental health experiences of young mothers affected by HIV. The following themes will be discussed: 1) Mental health shaped by distinct stressors, 2) Emotional and psychological transitions to early motherhood, 3) Stigma linked to HIV and pregnancy, and 4) Social support and resilience. Additionally, this chapter will explore the implications of these findings on the syndemic of HIV and motherhood.

### **5.2 Mental health shaped by distinct stressors**

Psychological research has a specific way of describing mental health, however, this does not align with the young women's understanding of the concept and how it translates to their day-to-day experiences. These descriptions were grounded in personal experience rather than scientific or clinical language. Furthermore, young women, regardless of their HIV status, described stressors which negatively affected their mental health—such as limited financial and psychosocial support, experiences of stigma, having to discontinue school following pregnancy, and other challenges of early motherhood.

Quantitative data from a cohort of adolescent mothers and young women in the same catchment area conducted 3 years before this qualitative study showed that symptoms of common mental health disorders, such as depressive symptomology, were higher among mothers compared to participants who were not mothers, regardless of HIV status (Roberts et al., 2021).

The findings of the current study illuminate the complexities of mental health challenges experienced by young women affected by or living with HIV which are shaped by intersecting and syndemic factors, including the double burden of HIV-related stigma and the stigma associated with being a young mother. Additionally, these findings highlight the need for a more nuanced understanding of the mental health issues faced by this population. It is evident that young women affected by or living with HIV have diverse and unique experiences when it comes to their mental health.

Pregnancy and childbirth involve a transition and the need to adapt to new a reality for every woman (Adeagbo & Naidoo, 2021). However, the study findings have shown that young women experience additional challenges such as lack of adequate support, financial

instabilities, and education as well as career disruptions. Young women experience a transition from girlhood into motherhood as they are undergoing critical developmental changes. Consequently, they struggle to cope with their new roles and responsibilities as young mothers. Similar findings were demonstrated in previous research which explored young women's experiences of early motherhood (Adeagbo, 2019; Mjwara & Maharaj, 2018). These studies have also shown that young mothers experience challenges with managing their own personal needs and the demands of raising a child (Adeagbo, 2019; Mjwara & Maharaj, 2018).

Furthermore, young women in this study described experiencing intense and complex emotions regarding early motherhood such as fear, regret, and guilt. Feelings of guilt and uncertainty were specifically linked to structural changes and material challenges. Most of the participants either had to drop out of school or pause looking for employment and furthering their studies. As a result, these young women viewed pregnancy and motherhood as a burden which would negatively change the rest of their lives. Mental health was therefore shaped by multiple forces and potentially worsened when all these factors exist together at the same time.

Several studies in South Africa have shown that young mothers are often concerned about the impact of early motherhood on future plans, especially unfulfilled educational and career aspirations (Jochim et al., 2021; Mjwara & Maharaj, 2018). Additionally, beyond the early post-partum period, young mothers experience several stressors such as financial burden of raising a child and plans on future prospects that have a negative impact on their quality of life and mental health (Waldron et al., 2021). These findings emphasise how mental health is a dynamic process which changes over time.

Young mothers described various stressors that significantly affected their mental health. However, much of their worry emerged from financial struggles because an unintended pregnancy adds to the financial burden of the household. These findings are in line with previous research which has shown that young women are not only disappointed with their unintended pregnancies, but also more concerned about the impact of additional financial costs for an already-constrained household income (Mjwara & Maharaj, 2018). Additionally, these findings demonstrate that unintended pregnancies may exacerbate existing contextual factors such as poverty and food insecurity, creating additional stressors that result in poor mental health outcomes (Jochim et al., 2021).

Furthermore, young mothers who received financial support from their families had a decreased chance of having poor mental health outcomes, a finding consistent with another

qualitative study exploring HIV infections among young mothers (Horwood et al., 2013). This finding highlights the importance of financial support in providing stability for young mothers and their children in the context of unintended pregnancy. Additionally, financial support could be a protective factor enabling better mental health outcomes (Willan et al., 2020).

### **5.3 Emotional and psychological transitions to early motherhood**

This study's findings show that young women's experiences of motherhood are not only limited to their unplanned pregnancy and a new reality with additional stressors, but they are interwoven with complex emotions of transitioning into motherhood while faced with numerous doubts and insecurities. This finding was reflected in another study (Adeagbo & Naidoo, 2021), which explored the emotional state of young mothers living with HIV and found that young mothers experience intense emotions which are often silenced and seen as negative when it comes to motherhood, particularly feelings of regret. The current study findings highlight the syndemic of HIV and motherhood, particularly with regards to experiences of stigma and complexities of early motherhood.

The study further argues that young women experience changing emotions and their ability to manage such emotions is important, as it largely shapes their future relationships and plans (Adeagbo & Naidoo, 2021). Additionally, examining emotions can also help determine the experiences and feelings of this group of young mothers as they navigate unintended motherhood, a finding the current study supports. Consequently, investigating the emotional burden and mental health of young mothers may provide a lens through which researchers may be able to investigate the relationship more accurately between unanticipated reality, agency, and subjectivity.

Furthermore, becoming a young mother while living with HIV places a young woman and her child in a vulnerable position. Both mother and child become vulnerable to a range of challenges such as poverty, mental health issues, stigma, discrimination, and lack of support, this finding is similar to other studies (Adeagbo, 2019; Mjwara & Maharaj, 2018; Roberts et al., 2021). The current study finding demonstrates that mental health and social consequences of unintended pregnancies may be far-reaching, and that disadvantage and risk can be transferred to the next generation. Unintended pregnancies can also result in social consequences, particularly since young women may face societal stigma, judgment, and

discrimination. These social consequences can further exacerbate the mental health challenges they may already be experiencing, leading to feelings of isolation and shame.

#### **5.4 Stigma linked to HIV and pregnancy**

Young women living with HIV who become pregnant may face multiple layers of stigma. They may experience stigma related to their HIV status, as well as stigma associated with being a young mother. This can have detrimental effects on their mental health and wellbeing. In the current study, all participants but one admitted to their pregnancies being unplanned. The unexpected nature of their pregnancies added an additional layer of emotional burden and uncertainty to their already challenging circumstances. Being young, and financially insecure, complicated these experiences. As a result, a number of young women desired to terminate their pregnancies upon finding out about their pregnancy. However, none of them continued with the termination due to lack of information regarding the legality of abortion and the stigma attached to it. One of the participants was told false information about termination at a clinic.

According to the South African Act No. 92 of 1996, “girls and women of all ages have a right to terminate a pregnancy and should never be denied the service because of their age” (Staatskoerant, 1996, p3). However, despite this legal provision, the lived realities of young women often do not align with these policies. Many young women are unaware of their sexual and reproductive health rights, a finding consistent with previous research exploring factors which influence access and utilisation to sexual and reproductive health services (Ninsiima et al., 2021; Pillay et al., 2020). Overall, the current study findings demonstrate that young women faced barriers including limited access to information and services on sexual and reproductive health, resulting in under-utilisation of these services. It is thus important to address these barriers in order to ensure that young women have access to and can effectively utilise reproductive health services within their communities.

The majority of the participants described experiencing HIV-related stigma and pregnancy stigma. Given the intensity of stigma attached to both early motherhood and HIV, it was not surprising that the majority of the participants experienced intense feelings of fear, guilt, and uncertainty in negotiating parenthood and living with HIV.

Similar findings were demonstrated in previous studies (Adeagbo, 2019; Mjwara & Maharaj, 2018). These findings highlight the societal judgment and stigma faced by girls and young women who become pregnant at an early age in South Africa. Despite the common

occurrence of unintended pregnancies, adolescent girls and young women who become pregnant still face judgement and stigma from their communities and society at large. These stigmas can have significant negative impacts on their mental health and wellbeing, exacerbating the challenges they already face.

Moreover, living with HIV as a young woman presents with several emotional, social, and psychological challenges. Young women in this study described different ways in which they negotiated and navigated living with HIV. The findings indicate that young women living with HIV face various challenges in accepting their status and navigating disclosure due to the experience of HIV stigma. While some young women were able to accept their HIV status, many participants in the study found this process to be challenging and detrimental to their mental health.

Young women reported experiencing substantial levels of HIV stigma in their communities, experiences of stigma were the most impactful in the challenges of HIV status non-acceptance and navigating disclosure within their intimate relationships. The current study findings are consistent with other qualitative studies which found that levels of HIV stigma remain high in South Africa particularly among young women living with HIV (Brittain et al., 2023; Waldron et al., 2021). As a result of HIV stigma, some of the young women described feeling unworthy, depressed and suicidal.

These findings demonstrate that HIV stigma can pose considerable challenges to acceptance and disclosure, resulting in feelings of shame, fear, and isolation. These negative experiences can have a significant impact on the mental wellbeing of young women living with HIV. These findings also highlight how stigma remains a major issue and aspect of HIV among young people in South Africa. Additionally, it is important to recognise that the impact of stigma can extend far beyond a single incident or experience. The memories and emotions associated with stigmatising incidents can resurface in various ways, potentially triggering anxiety, depression, or suicide ideation at later stages.

Overall, the findings have shown that despite efforts to raise awareness and minimise HIV-related stigma, many young people still face discrimination, prejudice, and unfavourable attitudes due to their HIV status, and the findings of this study reinforce this. This stigma can have serious consequences for their mental health, self-esteem, and general wellbeing (Waldron et al., 2021).

## 5.5 Social support and resilience

Due to having a support structure, some of the young women in this study had positive experiences of motherhood. For some, early motherhood was an opportunity for self-growth, motivation, and maturity. Similar findings have been demonstrated in previous studies (Adeagbo, 2019; Mjwara & Maharaj, 2018).

Studies have shown that young women encounter challenges and conflicting emotions as they negotiate parenting. However, positive experiences of early motherhood are also of significance, and merit further discussion. These perspectives are particularly important in contexts such as South Africa's, where becoming a mother at a young age is assumed to be unplanned and young mothers are deemed to be inherently deficient (Mkhwanazi, 2014).

Indeed, a young woman's present and future life changes when she becomes pregnant, and in many cases, it does not change for the better. However, despite multiple challenges, young women in this study were able to continue with their lives, they had plans and future aspirations, and were adamant on achieving their goals. Previous research has shown that young mothers are not without agency, and they do not fall into motherhood without exercising some degree of control and decision-making (Campbell & Mannell, 2016; Mkhwanazi, 2014).

Additionally, young women are not powerless victims in how they respond to their positions as mothers and negotiating their future (Mjwara & Maharaj, 2018; Mkhwanazi, 2014). Despite the many challenges they face, young mothers have the agency and ability to make decisions which will positively shape their lives, as well as those of their children.

Researchers have often emphasised the significance of individual resources in understanding resilience. However, the current study findings have shown that resilience is also fostered through resources accessible within one's broader social environment, including resources within one's network as well as other structural resources, a finding consistent with other studies and theories of resilience (Groves et al., 2022; van Breda & Theron, 2018).

Additionally, this perspective recognises that individual resources and hope alone may not have the same influence on resilience and subsequent results as resources accessible within one's larger social environment (Kuo et al., 2019). While individual resources, such as personal strengths, skills, and coping strategies, are important for resilience, social resources play a critical role in shaping one's adaptive capacity. Thus, it is important to address the broader social context and individual level of resilience, such as agency, hopefulness, and self-esteem, as an included factor for mental health outcomes (Groves et al., 2022).

## **Chapter 6: Conclusion**

### **6.1 Introduction**

This concluding chapter summarises the main findings of the study, highlighting the contributions this study makes to research on the mental health of young mothers affected by HIV in South Africa. It also presents some of the study limitations and proposes possible recommendations for future research on this topic.

### **6.2 Overall contributions to research**

This study contributes to the body of literature on how early parenthood, HIV stigma, and the social changes that precede these experiences affect young women's mental health. The aim of the study was to explore the mental health experiences of young mothers affected by HIV.

The study has shown that young mothers affected by HIV have unique mental health understandings, as well as experiences shaped by HIV, stigma, social support, and early motherhood more broadly. Furthermore, these young mothers experience multiple and overlapping challenges including financial challenges, experience of dual stigma, and disruption of schooling, while faced with the responsibility of caring for their children's needs as well as their own needs. These stressors are not isolated, but rather a series of events that may have a cumulative impact on the mental health and overall wellbeing of young women. The ongoing nature of these stressors can intensify their effects, making it even more challenging for these individuals to maintain their mental health and cope with the various challenges they face.

There was a disconnect between scientific understandings of mental health and how it translates into the day-to-day lives of young women. The study findings suggest that, to some extent, mental health concepts are not relatable and applicable to the lived experiences of young women. The reason for this disconnect may be the limited representation of diverse voices and experiences in scientific research and mental health discourses.

Additionally, the language and terminology used in scientific research may not always relate to young women's experiences in certain contexts. It is therefore important to communicate mental health concepts in accessible and relatable ways using a language and examples young women can relate with. It is also crucial to consider the diverse perspectives and lived experiences when exploring mental health issues. By exploring young women's

unique perspectives, researchers can gain invaluable insights into how mental health is perceived and experienced by youth.

Young women used social isolation as a protective method to avoid the shame of being publicly seen pregnant while they are still young. During this period, they described feeling lonely, sad, and distressed. The experience of young women feeling the need to isolate themselves during pregnancy reflects the societal pressures and stigma associated with unintended pregnancies. The fear of judgment and negative reactions from others can lead them to withdraw from social interactions, limiting their exposure and vulnerability to public scrutiny. Social isolation can thus have detrimental effects on mental health and emotional wellbeing of young women.

For most young mothers, there was a link between material stressors and their experiences and descriptions of their mental health. Young women experienced feelings of guilt which emerged from bringing another member into a family that was already struggling financially. As a result, financial challenges strained the relationships young women had with their partners and family members, whom they mostly relied on for material and financial support.

Young women living with HIV had different ways in which they negotiated and navigated their experience of living with HIV. Some of them had accepted their HIV status, while others had not. Accepting one's HIV status was largely shaped by HIV-related stigma. As a result, most of the participants could not disclose their HIV status to close people due to trust issues and fear of rejection or abandonment, particularly within intimate relationships.

These findings have shown that despite the openness and efforts made thus far to eliminate HIV stigma, young women living with HIV continue to face discrimination, prejudice, and negative attitudes due to their HIV status. Stigma creates barriers to HIV disclosure, treatment adherence, and access to support services. To address this issue, it is essential to continue raising awareness about HIV, challenging misconceptions, and promoting empathy and understanding. Additionally, providing education, promoting inclusive environments, and fostering supportive communities can help reduce HIV-related stigma among young people and improve their overall wellbeing.

Despite the challenges they faced, young mother's stories reflected agency and the ability to make informed decisions that shape their lives and the lives of their children. They can actively seek support and resources to ensure their wellbeing and that of their children. These involved pursuing further education, seeking employment opportunities, and building support networks. By empowering young mothers and providing them with the necessary

tools and resources, we can support them in navigating their futures and achieving their goals. It is therefore important to recognise and respect the agency and autonomy of young women in making decisions about their lives and the lives of their children, and to provide them with the support and resources they need to thrive.

In conclusion, early motherhood is a complicated issue with significant and multiple repercussions. The complex challenges that these young women affected by HIV encountered, such as being a young mother without adequate support, are not experienced as single events but rather as long-term realities. Young mothers' mental health is influenced by diverse, yet overlapping factors such as social support, financial support, resilience as well as other lived experiences. Additionally, the study findings highlighted that experiencing the syndemic of both living with HIV and early motherhood can exacerbate poor mental health experiences. It is therefore important to explore the range of perspectives and mental health experiences in the face of ongoing and multiple stressors such as HIV and motherhood, as potential risks for their mental health, and opportunities for response and prevention. It is equally critical to include young people in these initiatives to ensure that their views are heard, and their needs are appropriately met.

### **6.3 Limitations of the study**

Qualitative research allows for the exploration of meaningful insights and a deeper understanding of the research topic. However, it is important to acknowledge that the interpretation of qualitative data is subjective. Due to the nature of this research, the results of the study cannot necessarily be generalised or transferred to other settings within the South Africa region. However, similar research could be conducted in other regions. Additionally, the study focused on young mothers from a small sample of geographical location(s) within one province. As part of the researcher's reflection, some of the participants' responses could have been probed more to clarify some of the ideas they presented. Probing could have helped to improve the data and potentially result in a more in-depth understanding in some of the themes as well as analysis of the study. Furthermore, the study did not include any participant who had been recently diagnosed with HIV; all study participants vertically acquired HIV.

Despite these limitations, this research offered rich and insightful narratives of young mothers' experiences of mental health which could be used to inform future research, mental health support programmes, and interventions. Additionally, this study also adds to the

emerging body of research which qualitatively explores young women's mental health and emotions.

#### **6.4 Recommendations**

This section presents a number of important considerations for future research. Firstly, future research should use a longitudinal approach to investigate how young women transition into motherhood and how they experience mental health over a certain time period. Mental health is not a static state, but rather a dynamic process that can change and evolve over time. Thus, it is important to explore young mothers' mental health trajectories over a long period of time in order to understand their adjustment processes. Additionally, by studying the adjustment processes of young women affected by or living with HIV over an extended period, researchers can gain a deeper understanding of how their mental health fluctuates and how they adapt to various challenges and life transitions. This longitudinal approach will allow for a more comprehensive understanding of the factors that contribute to mental health outcomes along the life course and coping mechanisms of young mothers as well as understand the challenges faced during this period. This approach would also inform the development of interventions and support services that are tailored to the unique needs of these individuals at different stages of their lives. Furthermore, this tailoring can help young women to receive the appropriate care and interventions at different stages of their lives.

Secondly, the study sample included young women living with HIV and young women living without HIV. This aspect of the study, in addition to its qualitative nature, limits the scope by which overarching conclusions can be made about the mental health of young mothers more broadly. Further research could narrow their scope by focusing on either young women living with HIV or young women living without HIV, instead of having both sub-groups in the same sample. Additionally, the current study and other research has shown that majority of adolescent girls and young women living with HIV in South Africa acquired HIV vertically; however, there is a growing cohort of those who have acquired HIV recently. It is therefore important for future studies to recruit more of them in order to understand the experiences of young women who acquire HIV during pregnancy or breastfeeding. In this way, future studies may be able to take a deeper dive into the unique mental health experiences of these two different groups of women.

Thirdly, in the current study there was limited overlap between HIV and early motherhood stigma. However, there was a connection between stressors of early motherhood

and mental health. The study therefore provides a new way of considering the syndemic of HIV, early motherhood and mental health. Syndemic theory is important in understanding how these factors co-exist and combine to inform the mental health of young mothers affected by HIV. Syndemic theory seems relevant to explain the phenomenon observed in our study, however intersectionality theory and decolonial feminist approaches may provide alternative and rich insights and should be considered for future studies. Future studies should also consider how different sequencing or intensity of life experiences, such as longer-term experiences of living with HIV and repeat pregnancies, may reinforce negative impacts of mental health on young mothers in South Africa.

Furthermore, there is limited research that explores the emotional state of young mothers within the South African context. Thus, health facilities are unable to meet the emotional needs of this population. To prevent young women from adopting negative coping mechanisms, researching the emotional state of young mothers is critical (Adeagbo & Naidoo, 2021). Additionally, the emotional needs of young mothers are significant and should be addressed as these needs influence their mental health, self-esteem, and general wellbeing. By addressing the mental health and social consequences of unintended pregnancies, research and interventions can work towards creating a more supportive and inclusive environment for young women and their children, ensuring that they have the resources and opportunities they need to thrive in future.

Lastly, there is limited research that explores the mental health of young men in South Africa. Future studies could include both young women and men in their sample in order to understand the mental health of youth regardless of gender. By including both genders in future studies, researchers can gain a more comprehensive understanding of the mental health challenges faced by youth as a whole. This approach can help identify any gender-specific patterns or differences in mental health experiences, as well as common mental health issues that affect both genders. This can inform the development of targeted interventions and support services that address the specific needs of young people.

Despite the fact that the study findings are qualitative in nature and thus cannot be generalised, they provide a rich understanding of the mental health experiences of young mothers affected by HIV in South Africa – from their transition of early motherhood, living with HIV, experience of HIV stigma, and the challenges which come with the overlap of these life events. The study findings point to the need for psychosocial interventions focused on the mental health of young women living with HIV exposed to multiple risk factors and

stressors: early motherhood, experiencing HIV-related stigma, with limited support and exposed to violence.

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## Appendices

### Appendix A: Demographic Information/In-person Screening

Thank you for making time to talk to me. I am doing a study on mental health experiences of young mothers affected by HIV. I would like to ask you a few questions, this is for screening purposes and to check if you are eligible for the study. **Do you agree to being asked questions?**

1. What is your full name?
  2. When is your date of birth?
  3. Do you have any children? (Yes/No)
    - If yes, how many children do you have?
    - Are you currently pregnant?
  4. How old is your child?
  5. What is your current status?
    - In school/studies of some type
    - Employed formally (full time or part-time)
    - Employed informally (casual or temporal)
    - Looking for work
    - None of the above
  6. Are you currently in a relationship? (Yes/No)
  7. Who do you live with?
  8. Over the last two weeks how have you been?
    - Well
    - Coping
    - Stressed
  9. Would like to participate in the study (Yes/No)
    - If yes, please provide your contact details, so that we can schedule an interview
- 

*Thank you very much for your time.*

## Appendix B: Informed Consent Form and Information Sheet



**Title of study:** Exploring the mental health experiences of young mothers affected by HIV in South Africa

**Researcher:** Chuma Busakhwe  
Department of Psychology  
University of Cape Town

**Supervisors:** Associate Professor Elona Toska and Dr Christina Laurenzi

**Dear Participant,**

You are kindly invited to participate in a research study conducted by a Master's level researcher, Chuma Busakhwe, from the Department of Psychology at the University of Cape Town. The purpose of this study is to explore the mental health experiences of young mothers affected by HIV: this relates to both individuals who may be living with HIV and those who are living in communities with high rates of HIV. We would love to hear your experiences of being a young mother. Before you decide to participate in this study, it is important that you understand what the research is about, why is it done and what will your involvement be in the study. Please take time to read the following sheet carefully. Please ask the researcher/research assistant if there is anything that is not clear to you or if you need to more information. You will be given a copy of this information sheet to keep in case you want to contact us. Please remember participation is voluntary.

## **Information Sheet**

### **Study Procedures**

If you decide to participate in this study, you will be asked to sign the consent form and then make time for an interview with the researcher and/or research assistant. The interview will take about 45 minutes to complete, and it will be done in a comfortable, safe, and private place. During the interview you will be asked questions about pregnancy, HIV, and mental health as well as how you adapt to the challenges you encounter in relation to these topics. We can pause and take breaks if we need to. The interview will be audio recorded in order to ensure that we have correctly recorded your answers. Your participation in the study and all the information you share with us will be kept strictly confidential. As the participant, you are allowed to withdraw from the study at any point without any questions asked. This is even if you have already given your consent or have already started with the interview. We will offer you snacks and juice during the interview.

### **Confidentiality**

All of your personal information will be kept strictly confidential. It will only be used by our research team. The study team will make every attempt to maintain your confidentiality, including the following:

- Your information will be kept in a password protected device that will only be accessible to the research team.
- Any reports or publications about the study will not identify you or any other study participant. Information shared will be anonymized. A pseudonym (which you are welcome to choose for yourself) will be used on all research notes and documents to protect your identity, and you will be given a unique code number.

However, there are a few exceptions to confidentiality. When you reveal incidents of abuse or if you share that you are at risk of harming yourself or someone else, the research team is obligated to report the information to relevant authorities. However, we will discuss this with you in case it happens.

### **Privacy**

Protecting your privacy is very important to us. All of your information will be stored in a password protected device and backed up in a secure server. In addition, hard copies of your

consent forms as well as other information will be kept in locked cabinets at the University of Cape Town. There are limited chances that your information might get lost or be accessed by someone outside of our research team. We have a strong back-up and security system.

### **Voluntary Participation**

Participation in this study is completely voluntary, you may choose not to participate. You are free to refuse to provide responses to any questions. If you decide to participate, you are free to change your mind and discontinue participation at any time without any consequences. If you decide to withdraw from the study before the data is anonymized or publish, we will remove your answers.

### **Possible Benefits**

There are no direct benefits to you in participating in this study, although the sharing of experiences to another young woman might have a therapeutic impact on you. In overall, your experiences will help us understand how young women affected by HIV cope and how they respond to the challenges of being a young mother. We hope to develop a specific South African theory that captures young women's realities and use that theory inform interventions which will assist young women in future. We will give you a 'thank you' personal product care pack at the end of the interview.

### **Possible Risks**

The questions in the interview guide are of a sensitive nature and may be cause emotional responses, especially questions around HIV and mental health. It is possible that some of the topics we will discuss will make you recall past traumatic experiences. If you feel discomfort during our conversation, please feel free to let the researcher and/or research assist know, and we can stop the interview at any time. If this happens, we will explain to you, in private, the option of connecting you with our counsellor at Masithethe Counselling Services. In addition, here are contact details of other support services you can contact:

- South African Depression and Anxiety Group (SADAG): 0800 12 13 14 or send a WhatsApp to 076 882 2775
- Mental Health Support Group - East London: 078 5677 5060
- Family & Marriage Society of SA (FAMSA) – East London: 043 743 8277

## Questions

Any study-related questions, problems or emergencies should be directed to the following research team:

Chuma Busakhwe	0740362423	bskchu001@myuct.ac.za
A/Prof. Elona Toska	0818629611	elona.toska@uct.ac.za
Dr Christina Laurenzi	0767595716	christinalaurenzi@sun.ac.za

Questions about your rights as a study participant, comments or complaints about the study also may be presented to the ethics board: **Department of Psychology at the University of Cape Town** by telephone: **021 650 3417** or by email: Rosalind.Adams@uct.ac.za/  
mia.karriem@uct.ac.za

I agree to participate in the study

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Name of participant

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Date

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Signature of the participant

## Consent Form

**In this section we will be asking for your consent to participate in the study.**

**By ticking 'Yes' to this form, you are consenting to:**

	YES	NO
I have read the information sheet and I am satisfied with my understanding of the study, its possible benefits, and risks.		
My questions about the study have been answered.		
I understand that I have chosen to take part in this study and that I am free to discontinue at any time without giving any reason.		
I am aware of who will have access to my information. I understand how personal data will be used and protected.		
I agree to my responses being used for education and research purposes on the condition that my privacy is always respected.		
I understand that the interview will be audio recorded.		
I understand how to contact the research team to raise a concern or make complaint, and if I want to remove my answers and withdraw from the study.		
I voluntarily agree to participate in this research study.		

## **Appendix C: Interview guide**

As I have mentioned in the information sheet and consent form, this study is about understanding the mental health experiences of young mothers affected by HIV. This can mean young people living with HIV or living in homes with people living with HIV or in communities where HIV has affected many households and people.

### **Please tell me a bit about yourself?**

- What do you do on a normal day, what are your hobbies?
- Who do you currently live with?

### **Vignette:**

Before we continue with the rest of the questions, I want to tell you a story about a young mother who experienced some challenges in her life, and she is currently navigating her way through life. Nomsa is a young mother living in Mdantsane. She found out that she was pregnant, and she also tested positive for HIV during her second antenatal visit. Nomsa did not take this news very well, it was difficult for her to accept the pregnancy and her HIV status. She did not want people to know especially about her HIV status, because she was afraid that people might judge her and say bad things about her. Nomsa feels ashamed, and she struggles to feel good about herself because people sometimes say negative things about young women living with HIV. **She** decided to wait until she is ready to tell people close to her about her HIV status. Nomsa is now currently living with her boyfriend, and they are raising their child, a little boy named Dumisile. Nomsa plans on looking for a job so that she can take care of herself and the child without depending only on the boyfriend.

**I would like to ask a little bit about your experiences as a mother. Being a young mother comes with changes in your life. Some of these changes can be exciting while others can be difficult to handle. I want to better understand what is like to be a young mother. There are no right or wrong answers. I would like to hear things from your perspective.**

#### **1. Pregnancy**

- Do you relate to the story of Nomsa in terms of accepting your pregnancy?

*Probe: If you do, how do you relate?*

- If you are comfortable, please tell me about your first pregnancy resulting in birth?  
*Probe: How was your pregnancy? Did you experience any challenges?*
- How old were you when you fell pregnant?  
*Probe: Were you still in school when you fell pregnant? If yes, were you able to continue with school or you had to drop out?*
- When you fell pregnant were you trying to have a baby? If not, please explain what happened?  
*Probe: Did you know of ways to prevent pregnancy such as contraceptives? Could you easily access such services?*
- Could you please tell me about your feelings and thoughts when you found out you were pregnant, and you were going to become a mother?  
*Probe: Did those feelings and thoughts change over time, or they remained the same throughout pregnancy?*
- How did you tell your family about your pregnancy?  
*Probe: At what point did you tell them? How did they react?*
- How did you tell the father of your child about your pregnancy?  
*Probe: At what point did you tell him? How did he react?*
- Were you treated differently by your friends, family, or people in your community? For example, whereby they tease, insult or gossip about you because you were pregnant at a young age?  
*Probe: How did that make you feel? What made you feel better?*
- Thinking back to the time you were pregnant did you feel supported by your friends? What about your family? What about the father of the child?  
*Probe: How did your friends, family, and father of your child support you?*
- Is there anything else you wish they could have done differently to support you? If so, please elaborate

## 2. **Motherhood**

- How do you feel about being a mother?  
*Probe: What do you enjoy about it?*
- How has your life changed since becoming a mother?  
*Probe: How do you feel about those changes?*

- What are the main challenges you experience as a young mother that you believe have an impact on your overall well-being?

*Probe: How do you resolve those challenges? Are you still experiencing such challenges?*

- How has becoming a mother made you feel about yourself and your life?

*Probe: Would you say motherhood had a positive or negative impact in your life? Please elaborate*

- Did your experience of motherhood change at all between when your child was very young (a few months old) and now?

- What kind of support do you receive from your family/friends/father of your child with taking care of the child?

*Probe: Is it financial, emotional, or caregiving support?*

- How does the support you receive make you feel?

*Probe: Does it makes the experience of being a mother a bit easier?*

**The next questions will ask you about HIV. We know that we have asked you before about being treated differently because of being pregnant or a young mother, but we would like to ask you about your thoughts and experiences linked to HIV. We would like to understand how people around you talk about HIV - and how do these experiences impact your life. Remember that everything is confidential, no one will know about what you have shared during this interview.**

### **3. HIV stigma and disclosure**

- Do you remember testing for HIV during pregnancy just like Nomsa?

*Probe: If you are comfortable with sharing, what were the results of your test?*

- How did you feel when you learned about your HIV status?

### **For participants who have disclosed that they are living with HIV only:**

- Some people say negative things about Nomsa, and as a result she struggles to feel good about herself, how much do you relate to this?

*Probe: Do people's attitudes about HIV make you feel ashamed of your status?*

- How do you feel about living with HIV?  
*Probe: Do you have any positive or negative feelings?*
- Have you disclosed your status to anyone? If so, how was the process of disclosing your status?  
*Probe: Who did you disclose to? How did they respond?*
- What are your reasons for disclosing to someone?  
*Probe: What are your reasons for not disclosing to someone?*
- Have you ever experienced any stigma or rejection because of your HIV status?  
*Probe: What happened?*
- Could you please tell me about your feelings when you experienced the stigma and how it has affected you?  
*Probe: How did this experience affect you mentally and emotionally?*

**For participants who are not living with HIV:**

- Do you fear that you could contract HIV and that people would say bad things about you just like Nomsa?  
*Probe: How does this make you feel?*
- What do you do to protect yourself from contracting HIV?  
*Probe: Have you ever taken Prep?*
- What do you think about HIV?  
*Probe: Do you think it's a disease for certain people? Do you ever judge or shame someone living with HIV? If so, why, and what do you say?*
- Do you openly talk about HIV with your friends, family, or partner?  
*Probe: How do you talk about it?*
- Could you tell me a little bit about how people in your community and home think as well as talk about HIV?  
*Probe: Do they use any specific words? Or think that HIV is a punishment from God/Ancestors?*
- Do you ever witness or experience stigma and discrimination against people living with HIV in your home?  
*Probe: How has this impacted you? Can you tell me about a specific occasion this has affected you?*

### 3. Mental health:

**Now I would like to ask you some questions to better understand your feelings. Mental health includes our emotional and social well-being. Our mental health affects how we handle stress and relationships as well as how we make decisions. Sometimes as people, just like Nomsa we feel sad, stressed, down, and worry about our lives.**

*[Start with mood chart – explain the different faces/moods and ask participant which one they relate to or describes their current mood and why]*

- Do you relate to Nomsa and ever find yourself feeling down, stressed, and hopeless recently? If yes, in what way do you relate?  
*Probe: How often do you feel that way? What makes you feel like that?*
- Can you tell me a little bit about these experiences?  
*Prompt: What made you feel better? How long do those experiences last?*
- Could you please tell me about a time you recently felt happy and motivated?  
*Probe: What caused those feelings? What do you think you should do to maintain them?*
- What do you understand about mental health?  
*Probe: What does good/positive mental health mean to you? What does bad/negative mental health mean to you?*
- How would you describe your own mental health?  
*Probe: How often do you feel like this?*
- What helps you maintain good mental health?
- Where or from whom do you seek support from when you are going through difficult times?  
*Probe: What kind of support do they provide?*
- Have you ever attended counselling or talked to someone about how you feel before?  
*Probe: If so, where did you attend it? How was that experience like for you?*
- How do you feel about the future?  
*Probe: What are your dreams?*

We have now come to the end of the interview, thank you for making time to speak to me.

- Is there anything else you would like to share with us before we finish?
- How has talking about your experiences made you feel?

*Probe: Why did you find it easy/upsetting/stressful/ to answer these questions?*

- Please remember we have Masithethe Counselling Services available. Would you like us to refer you to our counsellor?