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Student Name: Thandiwe Msipu Phiri

Student Number: 214582135

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Supervisor: Dr. Olagoke Akintola

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Declaration

I hereby declare that this dissertation, unless otherwise indicated, is my own original work. All citations, references and borrowed ideas have been duly acknowledged. This thesis has not been submitted for any degree or examination at any other university.

THANDIWE MSIPU PHIRI Sign……

Student No. 214582135

Dedication

To my daughter Lushomo, who was born during the course of my studies and was always my greatest inspiration for this work.

Abstract

The improvement of maternal and child health (MCH) outcomes has been an important part of the millennium development goals (MDGs). Although the world is at end of the MDG era, MCH remains an important issue globally as the MDGs have not been achieved in most countries. Maternal physical and psychological wellbeing is crucial because poor health during pregnancy does not only affect mothers but their unborn infants as well hence the integration of maternal, newborn and child health (MNCH). Young women in universities are likely to experience pregnancy due to the risky sexual behavior in tertiary institutions which is characterized by lack of condom and/or contraceptive use and coercion. Therefore, most of these pregnancies are unintended. Unintended pregnancy can be a traumatic experience for students and has been associated with negative maternal and child health outcomes. In addition, pregnant young women in an academic environment are susceptible to stressors such as meeting academic demands, lack of financial resources, unstable relationships with their partners and social stigma. This is a problem because stress in pregnancy has been associated with anxiety, depressive symptoms and is a risk factor for postpartum depression. Therefore, it has potential negative effects on MNCH outcomes. One way to cope with stress in pregnancy is receiving social support because of its role in mediating psychological wellbeing in stressful situations. The role of male partners in giving social support was the main area of interest in this study. Therefore, this study explores the support needs of pregnant students at the University of KwaZulu Natal in Durban, South Africa. Participants were purposively selected among pregnant students at the university. The findings show that pregnant students experience challenges in their environment which is a source of stress in pregnancy. To cope with these challenges, they seek different types of support such as emotional, instrumental, informational and financial support. Male partners are considered to be an important source of support in mediating stress and fostering physical and psychological wellbeing. The types of support received from male partners are mainly emotional and instrumental support. There is need for greater social support at different levels ranging from interpersonal, community and policy and male partner support should be encouraged by the health system for better MNCH outcomes.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
EST	Ecological Systems Theory
HIV	Human Immune Virus
MCH	Maternal and Child Health
MDGs	Millenium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
PMTCT	Prevention of Mother to Child Transmission of HIV
STI	Sexual Transmitted Infection
UKZN	University of KwaZulu Natal
UNAIDS	Joint United Nation Programme for HIV/AIDS
UNICEF	United Nations Childrens Fund
WHO	World Health Organisation

Contents

CHAPTER ONE
INTRODUCTION

1.1 Introduction and background of study

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While pregnancy may often be a period of anticipation accompanied by feelings of maternal love and nurturing for a lot of women, it can also be a period of suffering, ill health and even death (Fortney & Smith, 1996; Say, 2014). Maternal mortality is one of the leading causes of death among women. The World Health Organization (WHO) estimates that in 2013, 289 000 women died from pregnancy related causes worldwide. In spite of this being an improvement as compared to the 523 000 maternal deaths in 1990, maternal mortality still remains a huge health problem as this means that globally, 800 women still die every day- that is 33 per hour due to pregnancy and childbirth complications. The majority of maternal deaths occur in LMICs mostly in Africa (WHO, 2013).

LMICs account for 99 percent (286 000) of the global maternal deaths with the sub-Saharan African region alone accounting for 62 percent (179 000) (WHO, 2014). Most maternal and infant deaths occur in the puerperium which refers to the time period from childbirth to six weeks or post abortion (Guyon *et al*, 2014). Therefore, the need for quality skilled care during pregnancy and childbirth cannot be overemphasized as key for the health of both the mother and baby (WHO, 2009). Among the biggest challenges for maternal, newborn, and child health in sub-Saharan Africa are pregnancy and childbirth complications (Kinney *et al*, 2010). The United Nations set targets called the Millennium development goals (MDGs) in 1990 and among them are the goal to reduce by two-thirds, the mortality rate of children under five and to reduce by three quarters the maternal mortality ratio, between 1990 and 2015 (WHO, 2013). However in 2009, the United Nations estimated that most African countries are unlikely to meet their targets for maternal and child health by 2015.

There is need for health services worldwide to improve on service delivery with regards to maternal and child health if the mortality rates are to be reduced as stated in the MDGs. This is because pregnancy and the transition to motherhood is a period of biological and psychological changes that can sometimes cause severe stress for women. Among the stressors new mothers often experience are decreased financial resources, physical exhaustion, task overload, confusion, social isolation and depressive symptoms (Uno *et al*, 1998). According to Lazarus (1966), stress arises when an individual identifies a situation as

taxing and a threat to their wellbeing that they are unable to cope with. A first step to dealing with this stress is for pregnant women to recognize their situation as stressful (Folkman & Lazarus, 1984a).

Given the statistics in maternal morbidity and mortality and the various stressors that come with pregnancy, it would seem that it is a period when women are vulnerable. One way of coping with stress is receiving social support. This argument is supported by studies which have shown that social support during pregnancy has a positive effect on maternal and child health outcomes (Feldman *et al*, 2000; Voight *et al*, 1996). Feldman and colleagues (2000) found that women who received multiple types of support from different sources during pregnancy gave birth to infants with higher birth weights. It has also been shown that larger support networks are associated with better maternal adjustment. According to Voight *et al* (1996), support networks act as a buffering system against the normal stresses associated with motherhood and may help women to perceive pregnancy-related changes as less stressful. Mulder and colleagues (2002) also showed that pregnant women with high stress and anxiety levels have an increased risk of spontaneous abortion and preterm labour and have babies who are retarded in growth. This shows that psychological factors contribute to negative pregnancy outcomes. The transition into motherhood requires emotional, instrumental and material support and it has also been shown that recipients of this support have lower risks of developing postpartum depression (O'Hara & Swain, 1996; Seguin *et al*, 1999).

While it has been shown that social support, particularly from mothers and male partners, appears to play an important role in mitigating the postpartum adjustment difficulties (Gee & Rhodes, 2003; Bunting & McAuley, 2004), some studies argue that family support is not as beneficial to the health and psychological well-being of pregnant women as compared to support from husbands or partners (Dunkel-Schetter *et al*, 2000). Studies in different parts of Africa have also demonstrated that partner support is critical for the success of maternal and child health programmes such as PMTCT (Farquhar *et al*, 2004; Alusio *et al*, 2011; Peltzer *et al*, 2011; Msuya *et al*, 2008).

An important group that has received less attention in the literature on maternal and child health is young post-adolescent women due to their risk of unintended pregnancy. Research has shown that this group is more likely to engage in risky sexual behaviors. Akintola *et al* (2012) found that young people entering university for the first time are at risk of engaging in unprotected sex. This puts them at risk of unintended pregnancy (El-Adas, 2007; Lewis *et al*,

2009, Ma, 2008). Among the reasons for risky sex which leads to a high rate of unintended pregnancies among young women at university are peer pressure, the university social context, lack of contraceptive knowledge and power relations which don‟t promote condom use (Akintola *et al*, 2012; El-Adas, 2007; MacPhail & Campbell, 2001; Tschann *et al*, 2002).

Literature on pregnancy and sexual behavior among young people has linked unplanned motherhood to a plethora of negative prenatal and postpartum consequences such as alcohol abuse, heavy smoking and prenatal and postpartum depression. It has also been shown that women who get pregnant unintentionally are less likely to initiate prenatal care in the first trimester, postnatal care after birth and have less optimal parenting practices (Cheng *et al*, 2009; Goto *et al*, 2006). Other studies have shown that births reported as unwanted by one or neither parent experience significantly higher risks of infant mortality (Chalasani *et al*, 2007). Due to these reasons, unintended pregnancy is a concern from a public health perspective and has been associated with the mothers‟ mental health which could be a potential risk to infant and child health (Gipson *et al*, 2008; Joyce *et al*, 2000). For students, unintended pregnancy can lead to emotional, social, or financial difficulties that may inhibit higher educational progress (Buhi *et al*, 2010).

The risky sexual behavior that students engage in also predisposes them to HIV infection which a mother can pass on to her unborn child. Pregnant students have to attend antenatal clinics as well as deal with other issues related to their pregnancy and this can result in poor attendance of classes. Having birth complications can further extend the period that a new mother has to stay away from school (Jewkes *et al*, 2001; Aviram *et al*, 2013; Sriprasert *et al,* 2014).

1.2 Problem statement

The current literature on young people in tertiary institutions has looked at alcohol and drug use, sexual behavior, abortion, contraceptives and condom use/negotiation and HIV/AIDS (Cooper, 2002, Akintola *et al*, 2012; El-Adas, 2007; Petersen et al, 2001). Furthermore, studies that have been conducted in South African tertiary institutions have focused on sexual debut and/or coercion, intimate partner violence and HIV (Akintola *et al*, 2012; Mokgatle & Menoe, 2014; Petersen *et al*, 2001). However, very little is known about young people in tertiary institutions who get pregnant during the course of their studies and choose to keep the pregnancy. In low- and middle - income (LMICs) countries ensuring safe motherhood and child survival are challenging even among married couples who become pregnant

intentionally. These challenges are heightened in the case of unintended pregnancies. In addition to focus on their studies, pregnant students have to prepare for the birth of their unborn babies by attending clinic activities. After childbirth, they require help with childcare as they continue with their studies. Further, having a child means there should be financial resources available in spite of being unemployed and unmarried. They therefore appear to be a group that is both physically and emotionally vulnerable during pregnancy and the puerperium.

Significance of the study

Social support, which has been described as the availability of interpersonal resources causing one to feel loved and cared for, has been linked to positive maternal health outcomes during and after pregnancy (Turner et al, 1990; Collins *et al*, 1993; Feldman *et al*, 2000; Tanner-Stapleton *et al,* 2012).The focus on young people is motivated by the high rate of pregnancies among young women in tertiary institutions as a result of the risky sexual practices on campus (Ma *et al*, 2008; Adam & Mutungi, 2007; Petersen *et al*, 2001). This study will add to the body of knowledge on unplanned pregnancies with emphasis on social support from male partners among young people. It will also provide insight into the support needs of unmarried pregnant students and the role that their partners play (or do not play) in providing support during pregnancy and the puerperium. That being said, the aim of this study is to explore the perceptions of pregnant students at the University of KwaZulu-Natal on the type of male partner support that they need during pregnancy.

The study will also explore other types and sources of support, if any, that pregnant students feel are important for them to receive during pregnancy and the puerperium, the period from childbirth until 6 weeks postpartum. Considering the statistics on maternal morbidity and mortality, the findings of this study could be useful for policy makers in maternal and child health programs at the department of health to improve maternal health outcomes. They could also be useful in planning antenatal clinic programs for pregnant women as well as improving the facilities at the campus clinics, counseling centers and the university at large for pregnant students.

1.3 The study objectives

The main objectives of the study were as follows;

1. To describe the support needs of young women during pregnancy up to 6 weeks post partum
2. To explore the kind(s) of support and sources of support pregnant students perceive as the most important.
3. To document the kind(s) of support given to pregnant students by their male partners and its impact on maternal and child health.

1.4 Research questions

The study attempts to answer the following questions;

1. How do young women describe their support needs during pregnancy and the puerperium (6 weeks after birth)?
2. What are the sources of support for students and what kind (s) of support do they perceive to be the most important?
3. What kind(s) of support do pregnant students receive from their male partners?

1.5 Structure of the dissertation

Chapter one

This chapter introduces the topic of the dissertation as well as motivation and background of the study. It also outlines the research problem and summarises the significance of the study to give an overview of what the study is about. The objectives of the study as well as the main research questions are also stated in this chapter.

Chapter two: Literature review

This section covers the empirical literature relevant to this study. It gives an overview on the literature on maternal health and the current global trends on the topic. Other areas included that are relevant to this study include the relationship between maternal and newborn health; youth sexual behavior and the rate of unintended pregnancy among young people in tertiary institutions; the relationship between unintended pregnancy and maternal and child health; stress among young women with unintended pregnancy and the benefits of social support, particularly male partner support.

Chapter three: Methodology

The third chapter outlines the research methodology of the study. The aims, objectives, research questions and the research design will be presented in detail here. It also includes information on the study site, the participants of the study and the method of sampling employed in the study. This section also outlines the data collection and analysis methods in detail. The reflexivity of the researcher, the trustworthiness of the study and the ethical considerations are also included in this chapter.

Chapter four: Theoretical framework

The theoretical framework that informs this study is introduced in this section. This is the Ecological Systems Theory (EST). The origins of the EST, its principles and applications in different fields will be discussed. This will be followed by outlining the different levels of the theory and how they apply in the context of social support for unmarried pregnant students.

Chapter five: Findings: Challenges faced by pregnant students

Here, the first part of the findings of the study will be presented and interpreted in relation to previous work that is relevant to the study. These will mainly be the challenges faced by pregnant students.

Chapter six: Findings: Support needs of pregnant students and male partner support

The second part of the findings, the support needs of pregnant students and the type of support received from male partners, are presented and compared with previous studies.

Chapter seven: Discussion and conclusion

The findings of the study are discussed in this final chapter using the ecological systems theory as the theoretical framework. The meanings and implications of the findings at individual, relationship, family, community and policy level are discussed in detail. The limitations of this study are also discussed in this chapter.

CHAPTER TWO
LITERATURE REVIEW

Maternal and child health: Male Partner Support

2.1 Maternal and child health: The global perspective

Pregnancy is a time of joy and anticipation for most women but in most parts of the world, having a child remains one of the greatest health risks. According to the 2008 United Nations Children‟s Fund (UNICEF) report, almost 800 women die every day during pregnancy or childbirth and each year, 2.8 million babies die in the first 28 days of life, the neonatal period. Further, of the more than half a million women who die each year from pregnancy and childbirth related complications worldwide, Africa and Asia account for more than 90 percent of the maternal and neonatal deaths (UNICEF, 2008). This suggests that the developing world has the worst health outcomes in the area of maternal and child health (MCH). This is a cause for worry because developing countries account for 185 million of the more than 211 million pregnancies that occur worldwide each year (WHO, 2013). Sub-Saharan Africa has the worst MCH outcomes with close to six million lives being lost each year and these include 4.4 million children, 1.2 million new-borns and close to 300 000 mothers (WHO, 2013). Forutunately, it is possible to mitigate this gloomy situation through the provision of equitable financial and human resources in maternal and child healthcare.

2.1.1 Inequity in Maternal and Child Health

While the majority of women worldwide survive pregnancy, the risks associated with childbearing remain highest in the least developed countries and are most prevalent among the poorest and marginalized populations (UNICEF, 2008). According to the World Health Organization (WHO), low and middle income countries are responsible for 99 percent of the global maternal deaths, with the sub-Saharan African region accounting for 62 percent of these (WHO, 2014). This means women in poor countries are at a greater risk of death due to childbirth as compared to women in developed countries. More importantly, the widest gap exists between developed countries and low and middle income countries in maternal mortality as compared to any other issue in human development (UNICEF, 2008). This is demonstrated by the Maternal Mortality Ratio (MMR) which was 14 times higher in the low and middle income countries than in the developed regions in 2013 (WHO, 2014). Therefore,

having a child remains a serious risk among women in low and middle income countries. Within-country disparities have also been observed globally. For example, low-income women and children generally experience worse MCH outcomes as compared to high-income women and children. In addition, some countries also experience racial disparities in MCH (Boekholdt & Stroess, 2012). There is need for policy makers to understand the factors contributing to adverse pregnancy outcomes and to allocate resources where they are most needed to reduce within-country disparities. Research shows that these inequities are mostly caused by the location of health facilities. Research shows that interventions that are delivered at community level produce more equitable results (Barros et al, 2005; Barros et al, 2012).

2.1.2 The relationship between maternal and newborn health

In 2009, WHO estimated that 38 percent of deaths of children under the age of five occur in the first 28 days of life - the neonatal period, with three quarters of these occurring in the first seven days. The proportion of neonatal deaths among under-five deaths has been increasing with the latest figure being 44 percent in 2013. Newborn survival cannot be separated from maternal health because preventing the deaths of mothers and newborns requires implementation of the same interventions such as adequate antenatal care, skilled attendance at birth, access to emergency obstetric care when required, essential postpartum and newborn care, proper infant feeding methods and care and proper hygiene practices (WHO, 2009). Hence studies confirm that the high rates of both maternal and newborn mortality are largely as a result of gaps in maternal healthcare (Barros *et al*, 2012; Boekholdt & Stroess, 2012; WHO, 2013).

Maternal health has a direct effect on infant health as studies have shown that harmful behaviours in pregnancy such as cigarette smoking, alcohol use, late initiation of prenatal care and poor nutrition result in poor birth outcomes such as low birth weight and preterm births (Cheng *et al*, 2008; Paul, 2006; Kost *et al*, 1998; Orr *et al*, 2008). Poor mental health in pregnancy also poses health risks to the unborn infant. This is because maternal emotional distress has an effect on prenatal maternal stress hormones which when elevated, results in increased sensitivity of the foetus to stress (Davis *et al*, 2010; O'Donnell *et al*, 2009). This could result in preterm births and low birth weight (Paul, 2006; Lawn *et al*, 2005). In addition, prenatal anxiety and depressive symptoms are risk factors for postpartum depression

which puts infants at risk of morbidity and mortality (Nakku *et al*, 2006; McLearn *et al*, 2006)

Studies have shown that maternal wellbeing during pregnancy, to a great, extent affects infant birth weight with positive prenatal behavior being linked to higher infant birth weight (Dunkel-Schetter *et al*, 1996; Hoffman & Hatch, 1996; Feldman *et al*, 2000). On the other hand, 60-80 percent of neonatal deaths are caused by low birth weight which means it is essential to reduce the number of low birth weight infants (Paul, 2006; Lawn *et al*, 2005). Furthermore, among infants with low birth weight, preterm babies have a higher mortality rate as compared to term babies. (Paul, 2006). In 2013, preterm birth complications accounted for a third of all neonatal deaths (UNICEF, 2014). With this being considered, the importance of preventing preterm births cannot be overemphasized.

The aim of the fifth Millenium Development Goal (MDG 5A) is to reduce the MMR by three quarters between 1990 and 2015. The latest WHO report on maternal health published in 2014 shows that in spite of the 45 percent reduction in maternal deaths globally, most countries had not met their targets. The reduction of maternal deaths now remains a universal goal to make childbearing a less risky experience for women worldwide. A new set of goals known as the sustainable development goals (SDGs) have been put in place and the goal for maternal health is to reduce the global MMR to less than 70 per 100,000 live births as a specific maternal health indicator.

2.1.3 The new push for maternal and child health

At a time when neonatal survival was not given the attention that it required, new support was given to the newborn health agenda with WHO repositioning maternal and child health (MCH) as maternal, newborn and child health (MNCH) (WHO, 2005). A number of organisations have advocated for an increase in resource investment in newborn health programmes in order to increase newborn survival in the developing world (Paul, 2005). Overall, the reduction of neonatal mortality has seen slow progress resulting in more children dying in the first four weeks of life (Requejo et al, 2014). Antenatal interventions have been shown to improve maternal and newborn outcomes through screening and management of infections such as syphilis, HIV and malaria. Other interventions are screening of pre-existing chronic diseases such as diabetes and hypertension, pregnancy-induced disorders and interventions to improve nutritional status and psychosocial health (Requejo, 2014).

The global community has continued to push for the improvement in maternal and child health outcomes post-2015. In 2014, the United States agency for International development (USAID) announced its commitment to saving the lives of the world‟s children by channelling US$2.9 billion of its resources to save up to half a million children from preventable deaths by the end of 2015. Furthermore, USAID embarked on another project called "Acting on the call: Ending preventable child and maternal deaths", aimed at accelerating progress to decrease maternal and child deaths in the 24 countries responsible for 70 percent of maternal and child deaths worldwide (Mastro, 2014). This push is not only aimed at accelerating progress to meet MDGs 4 and 5A but goes beyond the deadline of 2015 and has the potential to save the lives of 15 million children and close to 600 000 by the year 2020. (Requejo & Bhutta, 2014)

International organisations such as the USAID and others like the Presidents Emergency Plan For AIDS Relief (PEPFAR) have also shown commitment to reducing maternal and perinatal mortality in sub-Saharan Africa by providing training for health workers and strengthening the health systems in the remote areas of countries with very few resources but large populations of patients in need of health services (USAID, 2014). Through public-private partnerships, access to skilled health care has improved in some countries. Accessing skilled healthcare at childbirth is crucial to saving the lives of both mothers and babies taking into consideration the number of women who die during childbirth in developing countries. The number of mothers seeking treatment for the Prevention of Mother to Child Transmission (PMTCT) has also increased in some countries further reducing the number of babies who get infected with HIV through mother to child transmission.

The Partnership for Maternal, Newborn and Child Health Partners‟ Forum (PMNCH), a global initiative of health partners including the South African government, WHO‟s countdown to 2015, a promise renewed, and the independent expert review group was held in Johannesburg, South Africa in 2014. The forum‟s goal was to review progress, identify areas for success in MNCH and accelerate progress on MDGs 4 and 5 in the 75 countries that account for more than 95 percent of maternal and child deaths. The disparities between countries had also been raised as a matter of concern and the human resource crisis in poor countries called for urgent action (Roselyn, 2014). The global push for maternal, newborn and child health points to the fact that the world still has not achieved the MDGs and most countries still have a long way to go in improving maternal and child health.

2.1.4 Health systems approach to maternal and child health

The health systems in low- and middle-income countries, particularly in sub-Saharan Africa, face considerable strain when it comes to providing adequate services for maternal and child health as they have rapid population growth rates as a result of the high fertility rates in these countries. This makes it difficult to track intervention coverage to reduce maternal and child mortality ratios amid responding to the growing demand for services (Requejo & Bhutta, 2014). Maternal mortality ratios are a reflection of the overall effectiveness of health systems, the majority of which, in developing countries face a number of technical and financial difficulties and are further marred by lack of skilled personnel (WHO, 2009). Furthermore, most countries in sub-Saharan Africa do not meet the recommended threshold of 23 skilled health professionals per 10 000 population that are required for the high coverage and implementation of essential interventions.

Interventions that are based on community ownership and partnership are well received and achieve fast progress. There have been calls in the past for greater use of non-governmental organizations (NGO‟s) to improve the quality of health services and fill the gaps in health care service delivery especially in HIV/AIDS interventions in Africa (Gill & Carlough, 2008; WHO, 2006). It is also the goal of the WHO to increase community partnerships as the UN global strategy for Women's and Children's Health recommends increased commitment to women and children by governments and donors through effective collaborations with existing and new partners, particularly at the community level (WHO, 2010; Widmer *et al*, 2011).

2.2 Sexual behaviour among young people

Youth sexual behaviour has been extensively researched worldwide. In South Africa, studies on HIV/AIDS prevalence and teenage pregnancy among youths show that most young people initiate sexual activity at an early age (Jewkes *et al*, 2001; Manzini, 2001; Maharaj & Munthree, 2007; Pettifor, 2009). For a lot of young people in South Africa, first sex is uninformed and unprotected and a number of studies show that most young women report their sexual debut as characterized by coercion and sometimes violence and its nature decreases the likelihood that condoms are used (Akintola *et al*, 2012; Maharaj & Munthree, 2007; Manzini, 2001; Mokgatle & Menoe, 2014). This increases the risk of sexually

transmitted infections (STI‟s), including HIV, and unplanned pregnancy among young people (Manzini, 2001).

The initiation of sex is significant in a young person‟s life because it marks the beginning of their exposure to risks of pregnancy and sexually transmitted infections including HIV (Manzini, 2001; Pettifor *et al*, 2004). This means that a lot of young people are exposed to these risks very early in their lives because at least half of adolescents in South Africa have their first sexual intercourse by the age of 16 years and yet almost 60 percent of these report never using condoms at sexual debut (Eaton *et al*, 2003; Manzini, 2001). This body of literature provides insight into the nature of risky the sexual behavior among youths in South Africa. Generally, the lack of condom use among young people has been documented to be the main reason for the high prevalence of HIV and unintended pregnancy (Pettifor *et al*, 2005; Eaton *et al*, 2003). The main reasons for the low condom use among young people are the lack of perceived risk of HIV infection, peer norms, condom availability, gendered power relations, fear of distrust and adult attitudes to condoms and sex (Macphail & Campbell, 2001; Sayles *et al*, 2006; Hendriksen *et al*, 2007)

A number of African studies in relationship dynamics have shown that constructions of male dominance prevail in sexual relationships (Harrison et al, 2001; McPhail & Cambell, 2001; Varga, 2003; Wood et al, 1998). Men are socially constructed to be the initiators of sex and women do not usually exercise sexual agency because they risk being labelled as promiscuous if they are sex-seeking. Women who exhibit sexual agency by carrying condoms are labelled as promiscuous and carrying condoms is tantamount to admitting that they plan to engage in sex (Holland *et al*, 1991; MacPhail & Campbell, 2001). This puts young women in a position where they seek to preserve their reputation hence avoid carrying condoms (MacPhail & Campbell, 2001). Adhering to these social norms not only puts women at risk of unplanned pregnancies, but also HIV infection.

Sexual coercion is also prevalent in relationships among young people (Mokgatle & Menoe, 2014; Wood *et al*, 1998). Sexual coercion refers to the use of “violence, threats, verbal insistence, deception, cultural expectations or economic circumstances” or any circumstances which make a person to feel compelled to have sex against his or her will (Mokgatle & Menoe, 2014, p. 1). Most women in South Africa experience coercion at first sex (Maharaj & Munthree, 2007; Wood *et al*, 1998). A study by Wood and colleagues (1998) among Xhosa-speaking antenatal attendees aged 14-19 years found that most first and subsequent sexual

encounters are characterized by violent behaviours. Coerced sex is usually unprotected hence it is likely to result in unintended pregnancy or HIV infection (Maharaj & Munthree, 2007).

2.2.1 Sexual behavior in tertiary institutions

Sexual activity in universities and tertiary institutions in general is common all over the world (Akintola *et al*, 2012; Adam & Mutungi, 2007; Caetano *et al*, 2010). The majority of students who engage in sexual activity are young people between the ages of 15-24 years. This is a group that has been documented to be involved in risky sexual behaviour and has had a high HIV prevalence rate (Manzini, 2001; Petersen *et al*, 2001; Pettifor *et al*, 2005). In spite of a decline in HIV prevalence among youths in recent years, youth sexual risk behaviour should still be regarded as a serious health concern considering that South Africa still has the highest HIV prevalence in the world (Shisana, 2013). The risk of HIV infection among young people also reflects the risk of unintended pregnancy as they both stem from the same pattern of risky sexual behavior among youths (Jewkes *et al*, 2001).

In spite of the high rate of teenage sex in South Africa, there are still a considerable number of young people who only have their first sexual encounter when they are in tertiary institutions, mostly in the first year of their studies (Akintola *et al*, 2012). While making the transition from home and high school into university, first year students are likely to experience difficulties in adjusting to their new environment. This puts them at risk of making uninformed choices concerning sexual activity (Petersen *et al*, 2001). However, studies in high income countries have also shown that some students delay their sexual debut and as many as half of the students who go into college will experience their sexual debut at any point during their college years (Cooper, 2002; Patrick *et al*, 2007). In a study conducted at a university in South Africa, Akintola *et al* (2012), found that the influence of the university context, friends and male partners were the main factors that influenced sexual debut among first year female students.

The university context plays a role in sexual initiation among students and sexual behavior in general (Akintola *et al*, 2012). The freedom from parental supervision means students are free to explore the university lifestyle and some engage in sex to conform to the university sexual culture while others do it for the excitement (El-Adas, 2007, Petersen *et al*, 2001). Sexually experienced peers also play a role in influencing the sexual behavior of young people. Young people who go to universities without any sexual experience are usually influenced into sexual initiation by their sexually experienced peers and are encouraged to

engage in sexual activity to „fit-in" (Akintola *et al*, 2012; El-Adas, 2007). Some female students get into transactional relationships with older men where they engage in risky sexual behavior. The fear of losing the financial and material gains that characterize such relationships leaves them with very little power for them to negotiate condom use (Akintola *et al*, 2012; El-Adas, 2007).

Sexual behavior in institutions of higher learning is risky as it is usually unplanned and therefore unprotected hence posing serious reproductive health risks (Lewis *et al*, 2009). These risks are sometimes heightened by heavy consumption of alcohol or binge drinking, activities that normally characterize the university environment (Cooper, 2002; Brown & Vanable, 2007). In one study in the United States, 32 percent of students reported alcohol use prior to sexual intercourse and alcohol use was associated with unprotected casual sex (Brown & Vanable, 2007). Furthermore, the findings by Klein *et al* (2007) indicated that first year students are at a higher risk of engaging in unplanned sex as compared to higher level students. This makes them more vulnerable to the consequences of risky sexual behaviour. Sexual activities on campus are also marked by spontaneity and low contraceptive use. The is due to ignorance and unfounded fears of the side effects of contraceptives and this contributes to the levels of unintended pregnancy in universities (Akintola et al, 2012; Cheng *et al*, 2009).

2.3 Unintended pregnancy among students

A pregnancy is classified as unintended if it was unwanted at the time of conception (Goto *et al*, 2002) In addition, an unintended pregnancy may also be referred to as mistimed if it occurred earlier than desired, regardless of contraceptive use (Goto *et al*, 2002; Santelli *et al*, 2003). Globally, half of unintended pregnancies end in induced abortion, a situation which is worrisome because half of all the abortions conducted worldwide are considered unsafe (Singh, 2010). The two million unsafe abortions that are conducted worldwide as a result of unintended pregnancy carry serious health risks and are responsible for one in seven maternal deaths (Orgi *et al*, 2005; WHO, 2009). Nevertheless, the proportion of unintended pregnancies that end in childbirth have also been associated with adverse birth outcomes such as low birth weight and intrauterine growth retardation (Kost *et al*, 1998). Therefore, experiencing an unintended pregnancy is a risk in itself.

Because of the risky sexual behavior among students, young women in institutions of higher learning have a high risk of unintended pregnancy (Brown & Vanable, 2007; Ma *et al*, 2008; El-Adas, 2007). In an Asian study of pregnant women, it was found that 65 percent of the participants reported the pregnancies as being unintended and the odds were greatest among students (Sriprasert *et al*, 2014). This shows that unintended pregnancy is a common problem among students in tertiary institutions and some of the interventions to prevent it should be directed at the student population. Sriprasert and colleagues (2014) also found that pregnancy among students was eight times more likely to be unintended as compared to women who had completed their studies. In the same study, women younger than 20 years of age had double the risk of unintended pregnancy as compared to older women. Unintended pregnancy among young women is not only common, but a serious health issue as well. This is because the literature shows that pregnancy in young women is linked to a number of prenatal risks and adverse birth outcomes such as poor prenatal care compliance, increased risk of maternal anaemia, preterm delivery, low birth weight and newborn admission to intensive care unit (de Vienne *et al*, 2009, Aviram *et al*, 2013). The risks associated with unintended pregnancy, coupled with the risks of young maternal age make young women a group that is in need of specific interventions during and after pregnancy if these maternal and child health outcomes are to be improved.

2.3.1 Unintended pregnancy and poor maternal and child health outcomes

Several studies have linked unintended pregnancy to mothers‟ mental health and prenatal behaviours that put the pregnancy at risk and ultimately leads to increased risk of morbidity and mortality (Cheng *et al*, 2009; Kost *et al*, 1998; Orr *et al*, 2008; Terplan *et al*, 2014). Unintended pregnancy has been associated with late initiation of prenatal care, low intake of prenatal vitamins and insufficient nutrition (Arslan, 2005; Cheng *et al*, 2009; Karacam *et al*, 2011). Late initiation of prenatal care results in increased risk of complications due to late management of diseases such as diabetes, hypertension and HIV/AIDS. According to Kost *et al* (1998), there is a delay when it comes to the recognition of pregnancy hence late initiation of prenatal care. On the other hand, early enrollment into prenatal care has been associated with better pregnancy outcomes (Karacam *et al*, 2011; Singh, 2010).

While late initiation of prenatal care is an antenatal risk in itself, what is more serious is the fact that women with unintended pregnancies are also more likely to engage in risky prenatal behaviours such as alcohol consumption and cigarette smoking (Cheng *et al*, 2009). Terplan

et al (2014) found that more than twice the number of women with unwanted pregnancies engaged in binge drinking in the last trimester of pregnancy as compared to women with intended pregnancies. These behaviours could lead to low infant birth weight and premature births. Indeed, most low birth weight infants have been shown to result from unintended pregnancies (Shah *et al*, 2011). This is a cause for concern because low birth weight is the leading cause of neonatal deaths (Paul, 2006). It has also been found that infants from unwanted births are more likely to be breastfed for very short periods as compared to infants from intended births. This is worrisome because we are in an era where breastfeeding, especially in the first six months of life, has been encouraged with proof of better health outcomes (Taylor & Cabral, 2002).

Unintended pregnancy may also come with increased risk of psychosocial stress, depressive symptoms and may negatively affect a young woman‟s family relationships, romantic relationship, education and finances (Gipson *et al*, 2008; Karacam & Ancel, 2009, Divney *et al*, 2012). It may also result in the disruption of a woman‟s relationship with her partner and elicit feelings of loneliness and hopelessness as a result of social disruption. Social disruption has consequences in pregnancy because it reduces the amount of emotional and instrumental support a woman receives and may lead to depressive symptoms (Orr & Miller, 1997). It has been shown that poor social support has adverse effects on the health of the mother and consequently the wellbeing of her unborn baby (Divney *et al*, 2012; Dudas *et al*, 2012). Depressive symptoms in pregnancy are a risk factor for postpartum depression and these are more common among women with unintended births (Cheng *et al*, 2008; Nakku *et al*, 2006). In addition, women who suffer from postpartum depression have difficulties in creating or maintaining conditions that favour the wellbeing of their child such as breastfeeding, smoking-cessation and general mother-infant interactions and consequently deprive their infants of a range of benefits (Weinberg & Tronick, 1998; McLearn *et al*, 2006). The adverse effects of postpartum depression have been well documented and ultimately, the safety of the mother, her infant and the family as whole can be threatened as a result of depression.

2.3.2 Stress and coping

The stress and coping theory espoused by Folkman and Lazarus (1984a) helps illuminate individuals‟ behaviour when under stress. Stress, according to Lazarus (1966), is a state of health that results from situations in which a person perceives that the demands that s/he is faced with is taxing or exceeding the persons resources or beyond their ability to adequately

cope. Folkman and Lazarus (1990) defined coping as a "person"s constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands, events or experiences that are appraised as stressful (p. 315). Research shows that young women experience a number of stressors during pregnancy due to their age and social context. Stressors such as the academic demands, lack of income and relationship problems with their partners could affect psychological wellbeing. (Atuyambe *et al*, 2009; Belle, 1981; Sriprasert *et al*, 2014). The identification of these stressors is key to the beginning of the coping process. According to Folkman and Lazarus (1984a), individuals experiencing stress carry out cognitive appraisal, a process through which they evaluate their situations and identify any threats to their wellbeing as a result of that situation. This is a mediator of stressful encounters and their outcomes (Folkman *et al*, 1986).

One of the principles of the cognitive theory of psychological stress and coping is the transactional nature of stress and coping (Folkman *et al*, 1986). Young women and their environments are in a mutually reciprocal, bidirectional relationship. Therefore, their coping strategies could involve the use of resources in their environment. Seeking social support is one such coping strategy. It is a form of emotion-focused coping which involves regulating emotion and is considered to be a more subtle way of coping (Folkman *et al*, 1986). Social support for pregnant young women could reduce the negative maternal and child health outcomes associated with unintended pregnancy.

2.4 Social support

According to Perplau (1985), "social support refers to the availability of interpersonal resources" (p. 280). Research has shown that the quality of people"s lives is greatly determined by their social relationships (Collins *et al*, 1993). Therefore, social support has a positive impact on health and plays a buffering role in periods of stress. The stress buffering model of social support proposes that social support has a buffering role when an individual is under stress while another model argues that support leads to increased wellbeing, regardless of the amount of stress that a person is experiencing (Cohen & Wills 1985; Sanderson, 2004). Nevertheless, studies have shown that irrespective of the situation, social support has a positive influence on health (Collins *et al*, 1993). Social support can either be perceived support, which is support that is available for the recipient to use or received support which is the support that is actually transferred to the recipient (Wethington & Kessler, 1986).

2.4.1 Pregnancy and social support

The transition to motherhood is a period of great physical and psychological changes for all women (Deutsch *et al*, 1988). For a lot of women, it is a period of time that is spent in material and psychological preparation for the arrival of a baby, whose presence brings about several changes in the mother‟s life. But for some women, this can cause great amounts of physical and emotional stress. The stressors range from physical exhaustion, overwhelming tasks, decreased financial resources, social isolation and depressive symptoms (Uno *et al*, 1998). Therefore it can be said that pregnancy is a period when women need a support system to help them cope with the changes as well as preparation for their impending role of motherhood.

Social support is a multi-dimensional construct (Flannerry & Wieman, 1989). It has been described as the exchange of social resources and has three dimensions which are emotional support, informational support and instrumental support.

i. ***Emotional support*** includes any actions of caring towards and improvement of esteem in the recipient of the support. Emotional support for pregnant women could decrease the likelihood of psychological stress disorders and depressive symptoms.

ii. ***Informational support*** is generally advice and guidance given and in this case, it could positively influence decisions on issues such as prenatal care, recommended nutritional and healthcare practices and preparation for labour and delivery (Collins *et al*, 1996).

iii. ***Instrumental support*** involves giving help with tasks or providing material or tangible goods to an individual (Collins *et al*, 1993). Instrumental support such as assistance with household chores and childcare could help expectant mothers cope with physical exhaustion and physically taxing demands which could cause strain, particularly in the last trimester of the pregnancy (McDonald *et al*, 1988).

iv. ***Appraisal support*** is the fourth construct of social support which provides people with opportunities for feedback about themselves and for validation of their expectations of others (Caplan, 1974). Therefore, it is information relevant to self evaluation

In the context of maternal and child health, supportive relationships may have a positive effect on pregnant women, giving them a sense of personal control and enhanced feelings of

wellbeing that would help them perceive their pregnancy as less stressful (Norbeck & Anderson, 1989). Decreased stress levels would make stress-related health behaviours such as smoking and alcohol use less probable in pregnancy (Pagel *et al*, 1990).

2.4.2 Stress and social support among young pregnant women

Although social support is of great value for all mothers during pregnancy, certain groups of women are especially vulnerable during pregnancy and these include adolescents, unmarried women, students and women of low socio-economic status. Therefore, they may be in greater need of social support due to their life circumstances (Collins *et al*, 1993).

Students in institutions of higher learning have been left out of studies on pregnancy and social support. This could be because they are considered as „advantaged" as compared to women with low educational attainment (El-Adas, 2007). However, the reality is that students are a vulnerable group considering the circumstances that surround their pregnancy such as their age, pregnancy intention, unstable relationships with their baby"s fathers, risk of HIV infection due to the sexual culture in universities, unemployment/lack of income, family dependency, academic commitments and being pregnant in an academic environment (Petersen *et al* 2001; Pettifor *et al*, 2005; Sriprasert *et al*, 2014). The sexual behavior of students in tertiary institutions puts them at risk of unintended pregnancy (Akintola *et al*, 2012; Petersen *et al*, 2001) However they are unlikely to receive the much needed social support from their partners because the literature shows that a large proportion of women with unintended pregnancies report low support from the father of the baby (Orr & Miller, 1997).

University students, generally, are a group that is susceptible to stress given their academic demands (Chilimanzi, 2013). Most university students are at an age and social context where they are transitioning from adolescence into young adulthood. This can be a difficult period particularly for first year students who struggle with fitting in, maintaining relationships and getting good grades amid the growing demands of life at university (El-Adas, 2007; Bayram & Bilgel, 2008). Overall, university students at various levels of study are exposed to stress (Chilimanzi, 2013). For pregnant students, the stressors are likely to be even much greater. This is because pregnancy may be characterized by poor health, fatigue, and stress due to financial obligations as a result of the pregnancy (Elek *et al*, 1997). Pregnancy among students may also carry social stigma and has been described as a traumatic event for a lot of unmarried young women (Farber, 1991; Wiemann *et al*, 2005). Further, some young women

experience stress due to relationship instability with their partners (Siprasert *et al*, 2014). Facing these challenges in the midst of academic demands may be daunting. While a lot of students choose to terminate their unplanned pregnancies, those that choose not to, remain in need of a supportive environment that favours their psychological wellbeing.

The literature shows that young mothers have less support and face more challenges in terms of adjustment to motherhood as compared to older women (Passion *et al*, 1993; Orr & Miller, 1997). For young mothers in an academic environment, the integration of their roles as students with their new role of motherhood can be confusing and stressful (Birkeland *et al*, 2005). The challenges they face may be exacerbated by lack of social support, putting them at risk of psychological disorders such as postpartum depression. Furthermore, the findings in one study showed that married women received more support from their partners as compared to unmarried women (Feldman *et al*, 2000). This shows that marital status influences the amount of support that pregnant women receive from their partners. However, it is young women who have fewer resources and in need of more support (Passion *et al*, 1993). It is therefore imperative to study the social support needs of pregnant students, particularly the role of their partners in their support system considering their increased risks in pregnancy as a result of the environmental and social-structural stresses they are faced with.

2.4.3 The benefits of social support in pregnancy

It has been shown that support networks have a buffering effect on the stressors associated with pregnancy and motherhood (Collins *et al*, 1993). Support networks have also been proven to positively influence maternal and child health outcomes by encouraging positive prenatal behaviours and mitigating postpartum adjustment for mothers (Collins *et al*, 1993; Feldman *et al*, 2000; Seguin *et al*, 1999). Most of the stressors that young mothers are faced with can be mitigated by the availability of a good support network during pregnancy and after childbirth (Collins *et al*, 1993; Tanner-Stapleton *et al*, 2012). This is because emotional, informational and material resources may have a buffering effect on the physical and psychological stressors associated with pregnancy and early motherhood. A decrease in perceived stress may also have a positive effect on the prenatal behaviours of expectant mothers (Cohen & Wills, 1985; Pagel *et al*, 1990). This ultimately improves their wellbeing and that of their unborn babies (Feldman, 2000). Studies on parenthood have shown that young mothers with good support networks are susceptible to fewer depressive symptoms

and have better interaction with their infants (Turner *et al*, 1990; Seguin *et al*, 1999; Unger & Wandersman, 1988). For students, suffering from prenatal or postpartum depression would not only result in adverse health outcomes but could also have a negative impact on their studies.

The length of gestation and birth weight are primary indicators of newborn health. It has been shown that preterm births and low birth weight are among the common causes of neonatal death (Lawn *et al*, 2005; Paul, 2006). There is epidemiological evidence in the literature that suggests that anxiety, depression and other types of psychosocial stress during pregnancy are all risk factors for preterm birth and low birth weight (Littleton *et al*, 2010). This suggests that anxiety and depressive symptoms need to be avoided during pregnancy because of their negative effects on pregnancy. Given the stress buffering effects of social support, receiving any form of support is likely to give pregnant women who are at risk of depression a sense of control over their resources and ultimately decrease the likelihood of depression (Collins *et al*, 1993). This would have a positive impact on maternal and child health outcomes. Studies in the USA that compared women with good social support networks during pregnancy with those that did not have social support found that social lack of support results in low infant birth weight (Collins *et al*, 1993; Shah *et al*, 2014). Shah *et al* (2014) found that lack of paternal support was also shown to result in increased risks of pregnancy loss, stillbirths and infant deaths among teenage mothers. In studies on pregnancy and social support, it is crucial to identify the risk factors for anxiety and depression because they seem to be the cause of the risky behaviours that are adopted or continued during pregnancy. Improving social support in pregnancy has been proven to mitigate depressive symptoms and ultimately improves health.

Social support for unmarried pregnant women can come from different sources among them family, friends, male partners and their community. Different studies have shown that social support, either received from people closest to a person or offered through organizational interventions have a positive influence on pregnancy experiences (Raman *et al*, 2013; Rogers *et al*, 1996) The more the types of support from different sources that a woman receives, the better the maternal and child health outcomes (Feldman *et al*, 2000). Be that as it may, studies among young women have found that emotional and informational support from mothers and partners has the greatest stress buffering effect (Hildingson *et al*, 2008; Shah *et al*, 2014).

2.5 Male partner support

Studies conducted on male partner support range from paternal pregnancy intention, paternal emotional support, financial support and fathers antenatal clinic attendance to determine the level of male partner support and its effects on maternal and infant wellbeing (Kroelinger & Oths, 2000; Hildingson *et al*, 2008; Collins *et al*, 1993; Feldman *et al*, 2000; Shah *et al*, 2014).

In most of these studies, partner support has been associated with better maternal physical and psychological health. Women who receive support from their partners both during pregnancy and postpartum have been shown to experience less anxiety, emotional distress, depressive symptoms and report greater maternal satisfaction (Tanner-Stapleton *et al*, 2012; Turner *et al*, 1990, Unger & Wandersman, 1988). Barnet *et al* (1996) also found that social support particularly from the father of the baby resulted in decreased risk of postpartum depression in a group of adolescents. This could be due to the stress buffering role of social support which results in increased wellbeing (Cohen & Wills, 1985; Norbeck & Anderson, 1989). For women with unintended pregnancies, a partner‟s attitude towards the pregnancy can determine a mothers feelings about the pregnancy. An increased level of partner support has been shown to result in a woman‟s desire to carry on with the pregnancy (Kroelinger & Oths, 2000). Emotional and instrumental support from a partner are integral parts of received support which elicits positive feelings in the mother (Raman *et al*, 2013).

Apart from its role in the improvement of maternal wellbeing, partner support has also been shown to contribute to improved birth outcomes. Shah *et al* (2014) found that pregnancy loss and low birth weight were lower in teenage mothers with more partner support. Receiving support from a partner encourages healthy prenatal behaviours that ultimately improve birth outcomes. One of these positive prenatal behaviours is early initiation of prenatal care. Women who receive support from their partners have been are more likely to initiate prenatal care earlier than women who do not receive this support. (Martinez *et al*, 2011). Marin *et al* (2007) also found that women whose partners were supportive during pregnancy were more likely to quit smoking as compared to women without partner involvement. Adaptation of these positive prenatal behaviours has a direct positive effect on newborn health (Karacam *et* al, 2011).

Male partner participation has been used to enhance uptake of antenatal clinic programmes for pregnant women as well as programmes that improve newborn care (Peltzer *et al*, 2010).

Involvement of the male partner has been shown to improve the success of health programs such as the prevention of mother to child to child transmission of HIV (PMTCT) in many countries (Peltzer *et al*, 2011). This is particularly true in African settings where men are the key decision makers in relationships. Therefore if men are involved in antenatal and postnatal health programmes, there is enhanced uptake and increased commitment to the medical protocol for better pregnancy and newborn health outcomes.

On the other hand, perceived lack of partner support has negative consequences on MNCH. It has been shown that dissatisfaction with partner support among pregnant women is associated with depressive symptoms, worries, and general emotional distress (Hildingson et al, 2008; Dudas *et al*, 2012). Hildingson *et al* (2008) found that women who reported partner support dissatisfaction early in the pregnancy were more likely to consider abortion. However, it is the quality of a relationship that a woman has with her partner that is also a determinant of the benefits of the relationship and thus the level of support she receives (Fincham & Bradbury, 1990; Stevenson *et al*, 1999) The relationships among young people are usually unstable and their pregnancies unintended which puts them at risk of adverse birth outcomes (Singh *et al*, 2010; Kost *et al*, 1998). Therefore, young people are in need of support during pregnancy.

2.6 Conclusion

While the role of partner support in pregnancy has been extensively studied, the experiences of male partner support among pregnant adolescents and young women in tertiary institutions has not been studied. When it comes to sexual risk behaviour in African tertiary institutions, there are more studies on HIV/AIDS as compared to the risk and consequences of pregnancy among students. The reality that pregnancy is common in universities has often been ignored and the health outcomes of unintended pregnancies in this environment has not been studied. With the extensive research that has been conducted on unintended pregnancy and its risks of adverse maternal and child health outcomes, it is imperative to study the support needs of pregnant students, particularly from their partners, given their social context as unmarried and unemployed women. It is thus important to know the role that male partners play in the support networks and how this might influence maternal and child health outcomes.

CHAPTER THREE
THEORETICAL FRAMEWORK

Bronfenbrenner's Ecological systems theory

3.1 Introduction

This study draws from the theoretical underpinnings of the ecological systems theory which was first developed by Urie Bronfenbrenner in 1977 as a model for human development. The theory was developed in an attempt to understand human development in context of the system of relationships that make up the environment around a person (Johnson, 2008). The ecological systems theory has been used in studies to develop theories on child development, behavioral science, home-based care and educational research. Over the last two decades, there has been an increase in the application of ecological models in research and practice due to their multiple levels of influence in changing health behavior namely intrapersonal, interpersonal, organizational, community and policy. For this reason, ecological models are used to design comprehensive intervention approaches that are able to target changes at each level of influence (Sallis *et al*, 2008). Besides, it was an important goal of the Alma-ata declaration to recognize that the achievement of health for all requires coordinated efforts from various sectors that have an impact on health (Baum, 2007). In view of this, the theoretical underpinnings of the ecological systems theory, which require participation at all levels of a person‟s environment in achieving positive health outcomes, can be used in this study on social support among pregnant students.

The word „ecology‟ is derived from biological science and it refers to the relationships between an organism and its environment (Sallis, 2008). The term „systems‟ in this case refers to the constant interaction between an individual and their environment and the effect that they have on each other, which may be positive or negative (Wilder, 2009). The environment has physical and social aspects that influence a person‟s health while the person also modifies the environment, as a result of their presence in it. The relationship between an active, growing human being and their ever changing surroundings and how they mutually accommodate each other over a life course is the basis of studies on the ecology of human development (Johnson, 2008). Therefore, social ecological relationships refer to the interrelationships that people have with their physical and socio-cultural environments (Stokols, 1992).

Bronfenbrenner posits that the environment is made up of complex „layers", each having an influence on individuals. These layers are made up of multiple physical, social and cultural dimensions that influence a person"s wellbeing which includes physical health, development, emotional status and social cohesion. Therefore, in health promotion, the social ecological perspective is based on broad overarching paradigms that bridge different fields of research (Stokols, 1996).

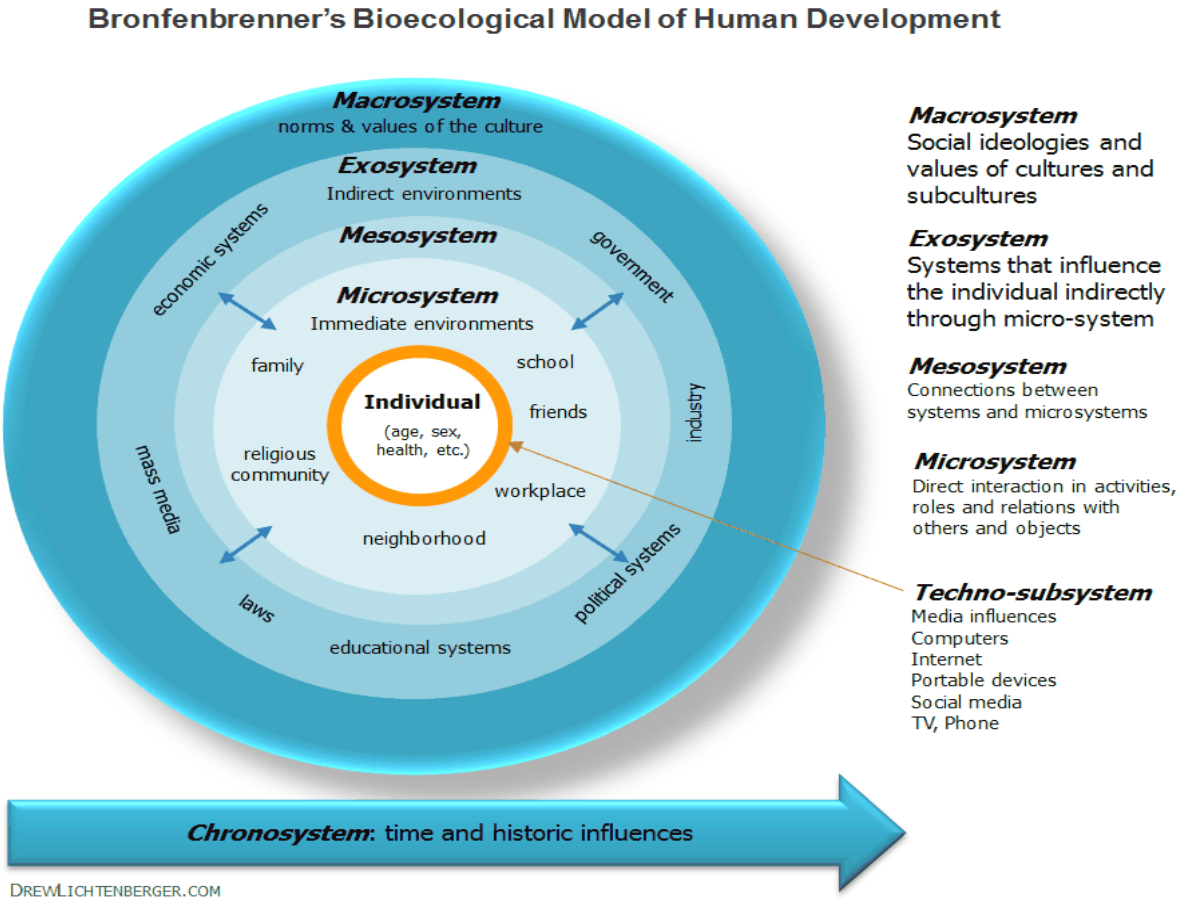

Fig 3.1: Bronfenbrenners ecological systems theory of human development. Retrieved from https://geopolicraticus.wordpress.com/tag/urie-bronfenbrenner/

For this study, the social ecological systems theory is defined at the different levels as developed by Bronfenbrenner. The ecological systems theory is an appropriate framework for this study because the wellbeing of women during pregnancy and the birth outcomes are either positively or negatively influenced by the environment in which they exist and they in turn modify the conditions of their environment. Taking into consideration the principles of the ecological systems theory that state that the environment has an influence on a person, supportive environments have a positive impact on people and their health behaviours (Cohen

& Wills, 1985). Therefore, having supportive relationships during pregnancy determines the physical and emotional wellbeing of a woman and consequently, their prenatal behaviours that affect her health and that of her unborn baby.

3.2 The levels of the ecological systems theory as applied to this study

The micro-system

The microsystem is the system that is closest to an individual and is made up of people that they have direct contact with. This layer includes family, peers, neighbourhood, religious groups and caregivers. Relationships at this level are bi-directional, meaning that the influence that an individual exerts on the people in their microsystem is also the same type and amount of influence that they receive from their environment. Therefore, a person contributes to the construction of their environment as opposed to being a mere recipient of the experiences that they have as they interact with people in the environment. Pregnant women are active participants in their support networks by acting as both providers and recipients of social support and bidirectional exchange of support is linked to increased wellbeing (Stevenson *et al*, 1999).

The people that form the microsystem are also known as social agents. The families and male partners of pregnant students form part of the microsystem as they are in direct contact with them. The attitude that they have towards the pregnancy influences the way that the pregnant student will feel about their pregnancy and hence their behavior (Kroelinger & Oths, 2000). The stability of the relationship that a woman has with her partner also affects her feelings towards her pregnancy. For example, having an unstable relationship with the partner increases the risk of depression in pregnancy (Lancaster *et al*, 2010). In this study, religious groups could also be of influence in the micro-system.

The meso-system

The meso-system refers to a system of the different social agents that are in the micro-system and how they interact with each other. Therefore, in the mesosystem, the different parts of the microsystem do not function independently but are interconnected and exert influence on each other thereby having an indirect influence on the individual. The relationships in the meso-system are also bi-directional between the various structures (Johnson, 2008).

In the context of social support during pregnancy among unmarried women, the families of pregnant students can exert influence on their behavior and relationship with their male partner if they have certain expectations of the partner or the relationship and vice versa. Depending on the type of influence, either positive or negative, this impacts a woman"s behavior or feelings during pregnancy. For instance, in the South African culture, a man is expected to pay „damages" as a traditional fine for impregnating a woman before marriage (Kaufman *et al*, 2000). If the payment of damages or the expectations for a marriage to take place causes conflict between a woman"s family and her partner, this could cause negative behavior between the two social agents which impacts a woman either directly or indirectly. Such experiences could lead to anxiety and depression, social isolation, cigarette smoking and alcohol use during pregnancy. However, when the various structures of the mesosystem interact in positive ways, they exert a positive influence on a person.

The exo-system

In the exo-system, the individual does not play an active role but is still affected by its events either positively or negatively. It is a higher, organizational level that involves decision making, policies and events that a person has no influence over (Jonnson, 2008). In the context of this study, this can be the university environment and clinics and hospitals where a pregnant student accesses antenatal services. For instance, the policies in some clinics for pregnant women to attend antenatal clinic (ANC) with their partner could have a positive influence on the feelings that a woman has about her support structure and consequently result in less anxiety and better uptake of antenatal interventions. Men, being the ones who possess the power in most relationships, particularly in Africa, are seen as the key decision makers in relationships on matters on sexual and reproductive health, hence interventions that involve them have been successful (Semrau, 2005; Varga, 2003).

Partner antenatal attendance has been associated with positive maternal and child health outcomes, particularly in the context of HIV/AIDS in sub-Saharan Africa (Farquhar et al, 2009; Peltzer, 2010). Consequently, male partner involvement in ANC services has in recent years been recognized as a critical strategy to enhance the uptake of PMTCT interventions (Peltzer et al, 2010). Through social support, especially from their partners, women are able to adhere to the course of interventions. Sending invitation letters from the health centre inviting men to attend ANC with their partner has been identified as a health system facilitator to get men involved (Morfaw et al, 2013). Healthcare system policies that

encourage male partner participation not only improve birth outcomes, but also have a positive influence on the relationship that a woman has with her partner and can be regarded both as emotional and instrumental support which improve the mother‟s feelings about her pregnancy.

The university that a woman attends also forms part of the exo-system in this study. The institution‟s regulations on pregnant students could affect a woman either positively or negatively. Given that a student is allowed to withdraw from studies for a period of time after delivery could make one feel less anxious about their maternal adjustment. This means that they can care for their baby after childbirth because they will be less pressured about schoolwork and concentrate on motherhood. Some students might feel the need to withdraw from studies until they deliver for various reasons. Young pregnant women have been shown to seek empathy and safety as they deal with feelings of guilt and shame while pregnant (Atuyambe, 2009). Therefore, the availability of psycho-social counseling for pregnant students in the university environment could also improve the emotional wellbeing of a woman

Another part of the exo-system is the economic situation of the family where a young woman is coming from. This is also an area that one has no control over but would indirectly affect their physical and emotional wellbeing during and after pregnancy as childbearing requires financial resources. In addition, depending on the social economic status of her family, a student could either remain in school after pregnancy or drop out in the event that her family cannot afford to pay for childcare.

The macro-system

This layer consists of cultural values, belief systems, customs and laws that govern the individual and the society in which they live. The macro-system is believed to exert a unidirectional influence not only on the individual but also on the micro-, meso- and exo-systems. Apart from being embodied in the social, cultural, political and economic climate of their community, the macro-system of an individual is also governed by the belief systems of a nation as a whole (Johnson, 2008).

The macro-system in this study is made up of the government departments that are concerned with pregnancy such as the Department of health, Department of education, Department of

social development and the ideologies of the community and cultural values. The ideologies of the society that a woman lives in will determine the type of benefits that they will receive from the environment that makes up her macro-system. African tradition dictates that pregnancy should occur within the confines of marriage. However, premarital pregnancy has become normalized in most African societies as there is now a delay in age when men and women get married and a there has been a decline in formal marriages (Zwang & Garenne, 2009; Wood & Jekes, 2006). For a lot of families, premarital pregnancy is seen as much less of a problem as compared to infertility, which is a perceived risk associated with contraceptive use for girls and women who have not yet experienced childbirth (Wood & Jewkes, 2006). This could be the reason for low contraceptive use among girls and young women. This only leads to unintended pregnancy which nevertheless is accommodated in some families as early fertility is preferred to infertility in the future as a result of early contraceptive use (Jewkes *et al*, 2009). This aspect of the macro-system could have an influence on unmarried pregnant students to view their pregnancies more positively and feel supported.

In South Africa, the department of Social development awards child support grants to the primary caregivers of children below the age of 18 years, particularly in circumstances where the primary caregiver is an unmarried woman, unemployed or people living in poverty and are not able to adequately support the child. In the absence of child maintenance by the baby"s father, unmarried women can access these funds. The availability of such grants, could be a positive factor in the midst of financial worries for unemployed women. UNICEF (2008) found that among the poorest households, child support grants accounted for 40% of the household income. For this reason, eligible caregivers are encouraged to apply for the child support grants through the South African Social Security Agency (SASSA). The child support grants targets the most vulnerable groups with the majority of the recipients being women with lower educational status. Such policies provide support that „cushions" the day to day expenses involved in caring for a child.

In 1996, the department of education came up with a policy that allows pregnant adolescents to continue with their studies as opposed to dropping out of school as was previously the case. As a result of this, pregnant girls and women now have a constitutional right to education. This policy gives pregnant learners an opportunity to complete their studies and increases their chances of being gainfully employed in future. The policy also states that

pregnant girls should be accompanied to school by parents or relatives in the event of an emergency. This is an example of how the macro-system exerts a unidirectional influence on the micro-system. The influence of the macro-system in this case puts pregnant learners in a position where they are able to receive social support from their micro-system.

Given these points, it is clear that the ecological systems model can be used to explain how the different levels of the environment around a pregnant woman can influence her physical and emotional wellbeing either positively or negatively. Opportunities for the improvement of social support networks for pregnant women for better maternal and child health can be identified at the different levels discussed.

CHAPTER FOUR
METHODOLOGY

4.1 Introduction

This chapter describes the methodological procedures applied during this study. It begins with an outline of the research design and a description of the study site and the participants recruited. I then proceed to describe the sampling method applied during the recruitment of participants and methods used in the collection and analysis of the data. This chapter also includes my reflexive role as the researcher in the study and the ethical issues considered while undertaking the study.

4.2 Research design

A qualitative research design is used in this study as it is best suited to answer the research questions. According to Ryan *et al* (2007), qualitative research methods are used when conducting research that involves experiences, attitudes and feelings, as opposed to knowing precise measurements and statistics. Therefore, "qualitative research allows researchers to get at the inner experience of participants, to determine how meanings are formed and to discover rather than to test variables" (Corbin & Strauss, 2008, p. 12). Since qualitative research involves the extraction of meanings from data, the experiences of unmarried pregnant students and the meanings that they attach to their circumstances is the basis of this study (Heise & Leavy, 2006). In order to do this, I had to immerse myself in the lives of my participants and obtain an insider‟s view of the group under study (Ulin *et al*, 2004). The ability to create and understand personal and social meanings of a person‟s lived experiences of a phenomenon in a specific context makes this research method suitable for obtaining the depth of information that is required for this study.

The paradigm driving the choice of methodology for this study is the interpretive paradigm. This paradigm acknowledges that interpretations are dependent on participants‟ abilities to articulate their own experiences and thoughts sufficiently in order for the researcher to reflect and analyse adequately (Baillie et al 2006). In order to answer the research questions of this study, there is need for rich descriptive data that is obtained from participants using questions that allow them to give an account of their experiences in their own words (Guest *et al*, 2012). Thus interviews follow a semi-structured format that allows the participant to be a primary expert. Ultimately, the researcher is able to discern patterns of ideas and experiences

of participants and then weave them together in order to interpret them to others (Ulin *et al*, 2005).

4.3 Study Site

The study was conducted at the University of KwaZulu Natal, Howard college campus in Durban, South Africa. This site was readily accessible due to the fact that I am a student at the institution and it was easy for me to have links with people that introduced me to potential participants. Gatekeeper‟s permission to conduct the study at Howard College was obtained from the registrar at the Westville campus of the University.

4.3.1 Participants

The participants in the study were all female. The criteria for the recruitment of participants was that they should be female students who were studying at the Howard College campus of the University of KwaZulu Natal; that they should identify as being single or unmarried and should be currently pregnant or be in the puerperal period (less than six weeks post childbirth) and willing to participate in the study. Even though all unmarried students who have had a child before qualify to participate in this study, students who are currently pregnant or recently had a baby were chosen because they have very recent memories of their experiences.

4.3.2 Sampling

The sampling technique that was used is snowball sampling. Snowball sampling is a type of purposive sampling which uses participants to recommend others who have information or experience on the phenomenon of interest and also meet the criteria to participate in the study (Ulin *et al*, 2002). Therefore, this allows for the selection of participants based on the purpose of the study and they should be able to offer useful information from their experiences on the phenomenon of interest (Patton, 2002; Terre Blanche & Durrheim, 2006)

I introduced myself to a few students who were visibly pregnant and informed them about the study. I then asked if they met the inclusion criteria and if they were willing to participate in the study. Students who indicated they are married were excluded. On the other hand, contact details were obtained from those who met the inclusion criteria and were interested to participate in the study. Some of them were able to refer me to their friends and colleagues who met the inclusion criteria. However, after recruitment and interactions with potential participants, some of them were excluded based on being seemingly unwilling to divulge

information about their pregnancy. Therefore, selection was based on willingness of the recruited students to participate in the study and to give their perceptions on pregnancy challenges and male partner support. Besides, purposive sampling requires that the researcher chooses certain informants that are going to give rich data as compared to others in order to obtain more insight on the phenomenon under study (Marshall, 1996).

More than 25 participants were recruited but only 17 were selected to participate in the study and among these, 15 were pregnant and two were in the puerperium, a period of up to six weeks post childbirth. The puerperal participants had delivered during the course of the recruitment and familiarization process. All the participants were of African descent and identified as Christians by religion. Three participants were staying in campus residence while the rest (14) were staying outside campus. Their ages ranged from 18 to 25 years with a mean age of 20 years. More detailed information on the participants is provided in the demographics table in the appendices section.

Qualitative research requires interactions between the researcher and the participants, who in this case are people who have personally experienced the phenomenon of interest (Patton, 2002). From the several potential participants that were available, only those who were currently pregnant or recently pregnant were purposively selected in order to get firsthand information of their perceptions on pregnancy and male partner support. A purposive sample of 17 students was selected among the pool of potential participants. This number is sufficient to obtain a rich description of participants‟ experiences because qualitative research is concerned with obtaining a deep understanding of the phenomenon, and small samples are used (Hesse-Biber & Leavy, 2006; Ulin *et al*, 2002). Purposive sampling requires selection of participants based on the purpose of the study and do not necessarily have to be representative of the wider population. In view of this, a small sample is appropriate because the goal, which is to get the meanings that individuals attach to their situation, can be attained (Hesse-Biber & Leavy, 2005).

4.3 Data collection

The method of collecting data used in this study was in-depth interviews. Interviews have the ability to capture data in the exact words that a person uses as they give an account of their personal experiences or their perspective on the phenomenon of interest (Patton, 2002). Individual interviews were conducted in order to get the perceptions of individual participants on the topic of male partner support in pregnancy. This allowed them to talk about their

personal experiences in what they would consider to be a private setting. This environment offered an atmosphere of safety and comfort where they could express themselves without any inhibitions (Kvale, 1996). Most of the participants indicated that their pregnancy was a very personal experience, especially because they were not married and hence they sought confidentiality in the method of data collection. Based on the sensitivity of the information sought, one-on-one interviews were best suited for this study.

4.4.1 In-depth interviews with pregnant and puerperal students

"Interviewing is not merely the neutral exchange of asking questions and getting answers". However it is a process that involves two (or more) people and their "exchanges lead to the creation of a collaborative effort called the interview" (Denzin & Lincoln, 2008, p. 116). In view of this, the researcher has to acquire skills that allow a mutual interaction with the interviewee. Researchers in social sciences have in recent times increasingly called for the interaction as persons with their participants and to acknowledge this action (Denzin & Lincoln, 2008). Long before this, Douglas (1985) recommended that interviewers should be open and be able to share personal situations and feelings to the interviewee in order to earn their trust. Consequently, the interviewee is encouraged to give a more honest and detailed account of their experience, while at the same time giving the interviewer comprehensive responses on the topic of study. Terre Blanche & Kelly (1999) also shared these views stating that a person could feel more comfortable talking about their experience if we share our own experiences with them. This entails the researcher and the interviewee should form a partnership, and together create a narrative that could be beneficial to the group under study (Denzin & Lincoln, 2008). For this reason, I was able to take on an empathetic approach during the interviews and create "a conversational partnership" (Rubin and Rubin 1995, p. 10). Kong and colleagues referred to interviews as a "methodology of friendship" and this has been advocated for particularly in studies involving women (Kong *et al*, 2002, p. 254 as cited in Denzin & Lincoln, 2008, p. 117). Apart from being a methodology of friendship, the empathetic approach is a method that values and upholds human sacredness before any theoretical concerns (Denzin & Lincoln, 2008).

At the beginning of the interview, the interview information sheet was read out to the participants and a consent form was signed. Permission to record the interviews was also obtained and a recording consent form was signed (See Appendix A). Although all the participants were IsiZulu speakers, the interviews were conducted in English as all the

participants were students at the University of KwaZulu Natal where English is the main language of instruction. This was an advantage for me as I am not Zulu speaking. The interviews lasted between 30 and 50 minutes and this gave the participants sufficient time to give in detail, their experiences regarding pregnancy and social support. The participants chose a location of their preference for the interview to be conducted where they felt comfortable to express themselves freely.

An interview guide was developed for the purpose of structuring the interview and giving the facilitator insight into the topics and questions to ask (Kvale, 1996) (See Appendix B). The interviews were semi-structured and this means participants had an opportunity to interact freely and give details of their perspectives on the topic. At the same time, emphasis was made on questions that addressed the topic under study to ensure that they were comprehensively answered (Kvale, 1996). However, participants were made aware of the fact that they were at liberty to avoid responding to questions that made them feel uncomfortable and to withdraw from the interview at any point. This built trust between the researcher and the participants. In total, 17 interviews were conducted between June and August, 2015.

4.5 Data Analysis

Babbie (2010) defines qualitative data analysis as "the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships." (p. 27) In order to do this, the researcher needs to be in constant interaction with the data at an intimate level. Therefore analysing qualitative data is a process that requires one to go back and forth and ultimately produce a detailed account of the phenomenon. This requires interpretative skills (Hesse-Biber & Leavy, 2006; Terre-Blanche& Durrheim, 1999). The interpretative nature of this study entails that a thorough description of the events and contexts of the phenomenon under study be given by the researcher in appropriate language that goes with the phenomenon (Terre-Blanche& Durrheim, 1999).

Following the transcription and familiarization with the data, the identification of themes as described by Braun & Clark (2006) was done. Hence the method of analysis used for this study is thematic analysis. This is a method for identifying, analyzing and reporting patterns (themes) within data (Braun & Clarke, 2006). The first step in thematic analysis is the familiarization of oneself with the data and I did this by reading and re-reading the transcripts and making summaries. During this process, I identified emerging patterns of themes. This

was followed by the generation of initial codes from the data. This involved getting sections of the raw data and identifying their relevance to one or more of the themes under consideration. I then marked the data in different sections and assigned to one of the potential themes. This process involved going back and forth with which codes to place under which theme as some codes can refer to more than one theme (Terre-Blanche & Durrheim, 1999). Relationships between different codes and different themes were noted and the resulting subthemes were identified. It is at this stage that I created the main themes and sub-themes from the initial codes (Braun & Clarke, 2006). Braun & Clarke further add that some initial codes may eventually not fit into any of the themes and are housed as miscellaneous. Finer nuances of meanings were captured after ascertaining the validity of the patterns, also referred to as elaboration by Terre-Blanche & Durrheim (1999). It is at this stage that the "back-and-forth" process of structuring and refining the data was done. Finally, themes were defined and interpretation of the data was done.

4.6 Reflexivity

Mead (1962) described reflexivity as a "turning-back of one"s experience upon oneself" (as cited in Steier, 1992, p. 2). It is important for researchers to be aware of their role and influence in the construction of meanings as they undertake the research process (TerreBlance & Durrheim, 1999). According to Steier (1992), self-reference may have an influence on how methodologies and the research process in general are informed. As the researcher in this study and a student who recently had a baby, I had an important reflexive role to play from the identification of the research problem and throughout the design, recruitment and data collection in this study. The phenomenon of social support in pregnancy and the challenges that come with being a pregnant student are things that I understood deeply having been pregnant recently. Understanding that pregnant women can be sensitive, I had to reflect on my own experience particularly during the recruitment process as well as the interviews. Examples are instances when potential participants were not sure if they wanted to talk about their pregnancy during recruitment and the challenges that most participants said they struggle with during the interviews.

During the analysis of data, it was important for me to construct understandings from a reflexive point. As Steier (1992) put it, "when we make descriptions of social systems, the categories and standards that we apply in order to make sense of our constructed worlds are necessarily immersed in models that we have also participated in constructing" (p. 2). In an

attempt to say something about the participants of their study, researchers may come to the realization that they are in fact saying something about themselves. Reflexivity makes it easy for researchers to understand the actions of their participants through examining how they are a reflexive part of the systems that they study (Steier, 1992).

4.7 Trustworthiness of the study

4.7.1 Credibility

Also referred to as validity, credibility refers to the degree to which the findings of a study are „truthful" (Lacey & Luff, 2001). Terre-Blanche & Durrheim (1999) suggest that the credibility of qualitative research is established during the course of the research process. This is done by constantly looking for discrepancies and employing various research methods to find them (Terre-Blanche & Durrheim, 1999). Increasing the credibility or trustworthiness of a research leads to transferability of the findings which makes a quality research (Golafshani, 2003). In this study, credibility was achieved by constantly comparing the responses from the different participants during the interviewing process as they shared a common status as unmarried pregnant students. Furthermore, the possibility of discrepancies was established through taking note of the perceptions and experiences of the participants with male partner support in relation to the stability or state of their romantic relationship. Credibility was also verified by persistent observations, prolonged engagements, peer debriefing and member checks (Guba & Lincoln, 1985). According to Ulin et al (2002), in order for a research to be credible, its findings should have a relationship with each other that is logical.

4.7.2 Dependability

This refers to the extent to which the researcher can convince the reader that the events and findings occurred in the way that they have been described (Terre-Blanche & Durrheim, 1999). Lacey & Luff (2001) suggest that the results of the research should convince the reader that they are reproducible and consistent hence are reliable. According to Terre-Blanche & Durrheim (1999), "dependability is achieved through rich and detailed descriptions that show how certain actions and opinions are rooted in and develop out of contextual interaction" (p. 63). In this study, dependability and cerdibility was established by providing thick descriptions of the various steps that were taken during the research process

as a result of the interactions between the participants and I and stating why certain actions and opinions arose as a result.

4.7.3 Transferability

This refers to the possibility of extrapolating the results of a research to a different setting or group of people (Polit & Beck, 2012). As a researcher, I gave a detailed description of the findings which could allow readers to deduce the possibility of transferring them to other settings. The participants of this study were specifically selected to answer the research questions in the context of social support among pregnant students. However, the findings could be the similar for other groups because studies have shown that social support is a universal phenomenon as suggested by the social support model which argues that social support leads to increased wellbeing irrespective of the situation that a person is in (Robertson, 2004). However, Polit & Beck (2012) point out that transferability is the work of readers and consumers whose role is to assess the extent to which the findings apply to new situations.

4.8 Ethical considerations

Permission to conduct this study was obtained from the Ethics Committee of University of Kwa-Zulu Natal (see appendix) and gate keepers approval to conduct the study at the University of KwaZulu Natal, Howard college campus was obtained from registrar of the University of KwaZulu Natal (See appendix). All the necessary research protocols were observed during the course of this study.

4.8.1 Participant's autonomy

The principle of autonomy entails that the autonomy of all the participants in the research should be respected and issues concerning the voluntary participation, informed consent and anonymity of the participants should be addressed (Terre-Blanche & Durrheim, 1999). All these issues were addressed and autonomy was the core ethical issue that was considered during this study.

4.8.1.1 Informed consent

Before the interviews were conducted, informed consent was sought from the participants by verbally briefing them about the study and also reading the information sheet that contained a

description of what the study is about, its aims and benefits. Because consent should be voluntary and informed, all questions and concerns that arose during this process were comprehensively answered and clarified (Terre-Blanche & Durrheim, 1999). Participants indicated whether they wanted to take part in the study. They were also given the declaration of consent forms to sign and were informed that participation was voluntary and they could opt out of the interview at any time without any repercussions. The recording of interviews was done with permission from the participants and an informed consent form was signed for this purpose.

4.8.1.2 Confidentiality and anonymity

Some participants were concerned about their anonymity due to the sensitive nature of the topic and were assured of complete confidentiality since their identities would be protected as no other person apart from the researcher and her supervisor was going to have access to the recorded interviews or the transcripts. In addition, no names were mentioned during the interview process and pseudonyms were given to all the participants during the process of data analysis and presentation of results.

4.8.1.3 Beneficence and non-maleficence

This study was designed in such a way that it may be of benefit to the participants, other researchers and the society at large (Terre-Blanche & Durrheim, 1999). Participants were informed to indicate if they experienced distress at any point during the interviews and that counseling would be provided through the University of KwaZulu Natal student counseling centre. However, none of them indicated a need for counseling.

By getting the perceptions of pregnant students on male partner support and social support in general, their challenges through pregnancy and the puerperium and their support needs may be understood. The findings of the study could influence policy both at health and educational levels through interventions that address the support needs of pregnant students.

The principle of non-maleficence is an ethical requirement which states that no harm should be done to the research participants or any other person or group through this research. None of the participants were harmed in any way either physically and emotionally and the potential benefits of this study outweighed any potential risks. (Terre-Blanche & Durrheim, 1999) In fact some participants reported feeling “lighter” or relieved after sharing their experiences of pregnancy with regards to their challenges and male partner support.

4.8.2 Storage of data

The audio recordings and transcripts will be kept at the University of KwaZulu Natal, Department of psychology at a location only accessible to the researcher and her supervisor. These will be kept for a period of five years for the purpose of use for future research, after which they will be destroyed. This was communicated to the participants and consent was obtained.

4.9 Conclusion

This chapter presented the methodology of the study. It described in detail how the study was conducted and this includes the research design, sampling of participants, the collection and analysis of the data, and the ethical considerations of the study.

CHAPTER FIVE
INTERPRETATION OF FINDINGS (PART ONE)

Challenges of pregnant students

5.1 Introduction

In this chapter, I present and discuss the findings of the study because the issues emerging and their interpretation are intertwined. The data was analysed using thematic analysis and a number of themes were identified in relation to the focus of the study. This chapter is the first of two chapters that present and discuss the findings of the study. In this chapter, I will present and discuss the challenges faced by unmarried pregnant students. The results of the current study will be interpreted and linked to previous research. The various levels of the ecological systems theory in this study and their influence on challenges and social support among pregnant women will be discussed.

Demographic characteristics of participants

In total, 17 unmarried students participated in the study. Among these, 15 were pregnant and two were in the puerperal period. For the purpose of confidentiality, all the participants of this study have been given pseudonyms in the presentation of the findings. The demographic characteristics of the participants are shown in Table 5.1.

Table 5.1: Frequency distribution of the demographic variables of the participants

Demographic characteristic	**Number of participants**
Age (years)	
18-19	7
20- 21	8
22- 23	1
24-25	1
Year of study	

1st year	8
2nd year	6
3rd year	1
4th year/ Honours	2
Residence	
On campus- university residence	3
Off campus- university residence	3
Off campus- communal residence	2
Off campus- alone	1
Off campus- at home	8
Gestational stage	
4- 5 months	3
6- 7 months	6
8- 9 months	6
Puerperium (less than 6 weeks)	2
Number of previous pregnancies	
None	15
One	2

Specific Findings

5.2 Challenges faced by pregnant students

Participants were asked about the challenges that they face as pregnant students. Generally, they considered pregnancy to be a potentially good experience, in circumstances where an individual is in a stable relationship, independent and financially stable. However, for most of the participants, it was an experience that came with a lot of challenges. The challenges encountered by each individual were at times unique to their different situations in their relationship, at home, in the community and at school. Nevertheless most of the challenges said to be experienced were common among participants.

Six main themes were identified among the challenges faced by pregnant students. During the data collection process, some of the themes would emerge from other themes during the interviews and some themes would emerge more than once from separate issues. As the participants began to share how they found out they were pregnant, they spoke about the reactions from their partners and their parents. While talking about their parents regarding the pregnancy as shameful, they spoke about their parents‟ social status in their community and the embarrassment the participants would feel as a result. The theme on financial constraints would also emerge while talking about their parents sanctions. This was followed by how they struggled to cope with their academic work during the first few weeks of the pregnancy. As the pregnancy progressed, they began to face financial constraints in preparing for their unborn baby resulting from their lack of income. This theme also emerged as they spoke about their relationship challenges with their partner as a result of the partner‟s refusal to take responsibility for the pregnancy. As the participants shared their challenges at school, they also spoke about the stigma they would sometimes experience from their colleagues.

Table 5.2 Table of themes emerging from the data

Aspect	Theme
Challenges confronted by pregnant students	1. Parents knowledge of pregnancy and reaction 2. Coping with the academic load 3. Financial constraints during pregnancy 4. Relationship problems with male partners 5. Social concerns over pregnant state 6. Unexpected pregnancy experiences and adjustment

5.2.1 Parents knowledge of pregnancy and reactions

One of the more commonly reported challenges among the participants was keeping the news of the pregnancy from their parents in its initial stages. Most of them said they feared facing their parents and the response they would receive after learning about the pregnancy Having to hide the pregnancy as they experienced it‟s early symptoms was said to be a challenge.

Previous South African studies have shown that pregnancy is a major cause of school drop outs among female students (Kaufman *et al,* 2001; Zwang & Garenne, 2008). School drop outs among pregnant students can be due to a variety of factors and one of them is the refusal by parents to continue paying school fees for their pregnant daughter. Mbali, a first year student was worried about the sanctions she thought her father was going to put in place once he became aware of her pregnancy. This included no longer paying for her school fees. She feared that her only option would be to drop out of school and move in with her partner because her father would chase her away from home.

> It‟s been very difficult because as am talking to you, my parents don‟t know about it [the pregnancy]. They are so strict, especially my father. He is so strict. He‟s staying at Joburg [city of Johannesburg], [he‟s] working there. I am pretty sure that he is going to cut me off [paying for her studies] because of the pregnancy. [?] I know because this has happened to my sisters. That‟s what he does. Am stressed, but am trying to control it because it‟s not healthy for the baby. [Mbali, seven months pregnant, October 12th, 2015].

Some students who lived in campus residences opted to stay away from home and avoid meeting their parents because they were afraid of how they would respond if they knew about the pregnancy.

> I told her [her mother] am not coming home this vac [school holiday] because I will be working. I won‟t be working, it was just a way of not going home. Whenever my sisters get pregnant, my mother would not talk to them and would not take care of the baby [Zinhle, six months pregnant, August 17th, 2015].

Hiding their pregnancies from their parents was a major source of stress for participants. In addition to this, awaiting their reaction was said to be even more stressful. Lindiwe who is

about to complete her honors degree speaks about how difficult it was for her to tell her parents.

> The whole stressful part was telling my parents and the family that, you know, am pregnant. That was like, for me, the most stressful part. It took me like, probably like three months.… I was here on campus which was even better because if I was at home, it was going to be even more stressful [Lindiwe, 22 years old, October 12th, 2015].

These excerpts show that pregnant students have a difficult time telling their parents about their pregnancy due to fear of sanctions from their parents. Due to this, participants described themselves as being in a vulnerable situation where they were struggling with pregnancy symptoms and at the same time were unable to share what they were going through. Consequently, they did not receive the support they needed at the beginning of their pregnancy.

Barbara, a second year student narrated her experience before her parents found out about her pregnancy.

> I was lucky that when I fell pregnant it was during the December holidays so with all the morning sickness and just feeling dizzy I was at home but it was terrible because no one at home knew so I couldn‟t have any support. [Barbara, 20 years old, August 24th, 2015].

Most participants who had fathers reported previously having very close relationships with them before they got pregnant. However, they said this completely changed after they learned of their pregnancy. A number of the participants said their parents‟ reaction to the news of their pregnancy caused them a lot of stress. Some participants reported strained relationships with their parents, particularly their fathers, throughout their entire pregnancy. The tension at home was thus reported to be a source of stress in their pregnancy.

> He [her father] couldn‟t speak to me, he speaks to me when he talks about how much I need, those things, he is just concerned with my education only but there is nothing more.…Things that have happened at home -the relationship [with her parents] is no longer the same. It affects me a lot. I feel neglected by my own

family, I feel like they have abandoned me. They have the right to be like this, they have… but on the other side, I just feel like they are not fair. I know I made a mistake okay, fine. But the way they are doing it, it‟s like, I don‟t know how to describe this. It‟s been difficult [Busi, 19 years old, August, 24th, 2015].

The effect that it had on my parents, cause when my father found out that I was pregnant which was recently, he cried like a baby. My mom couldn‟t talk like for a week or something. It was tough, I could not even study. I had examinations coming up in the next four days and I could not study. I would take my book, it was politics [the examination]. I would take my book and just start crying. They still can‟t look at me in the eye especially my father [Samantha, 19 years old, August, 10th 2015].

Most of the participants expressed guilt over their pregnancy because of the turn of events in their homes. They felt that they had lost their parents trust and the relationships they had with them had been ruined as a result of the pregnancy. Generally pregnancy was considered to be a disappointment to their parents and guardians.

This thing [the pregnancy] is really disturbing. I see that I must not disappoint her [her mother] in future because I have disappointed her so many times. This is really disappointing. [Thuli, 19 years old, September 30th, 2015].

The pregnancy thing made me frustrated cause it‟s gonna break our relationship [with her father] now (with her father), yeah. It makes him sad, I even see in his eyes cause sometimes I think it comes back to his mind like „no, this child just ruined her life‟ you know [Nomthandazo, 19 years old, August 25th, 2015].

Because of the way they were treated by their fathers, some of the young women expressed regret over the pregnancy. Some of the participants said they had disappointed their parents, who in most cases, were considered to be respected members of their community.

He [her father] kept saying to me “I trusted you so much and I still can‟t believe it”. I started regretting and everything, as much as I had bonded with the baby,

> My father is a priest so he is a well-respected man and people fear him [Samantha].

Other participants expressed concern about how they perceived their fathers image to have changed to a bad one in the eyes of the community as a result of their pregnancy. For this reason, people in their community would gossip about them and were likely to lose the respect that they had for them.

> I cried at night and then during the day I was a normal person and then at night it strikes me [the reality of the pregnancy] like they [neighbours] are going to gossip about my dad now [that] am pregnant. My dad is such a person that he knows people and he`s the guy that can be a role model to somebody. He doesn`t have much he`s is just an average guy but people in our community do come to him for advice because he is a respectable man. [Nomthandazo, 19 years old, first year student].

> My dad built this image that he‟s got good girls you know all that so it was like a disappointment and you know the neighbours are forever talking [Amahle, 18 years old, October, 23rd, 2015].

The desire by young women to keep their pregnancy a secret from their families also resulted in late initiation of prenatal care. The young women expressed initial uncertainty about the fate of their pregnancy. The desire to hide the pregnancy from their families and the shame of being seen by others while seeking antenatal care (ANC) also contributed to late initiation of ANC. Samantha talks about starting ANC late because of this.

> Having to hide the pregnancy from my father whenever he was around was an issue. I had to suck in my stomach and I started going to the clinic very late, I was going at five months and the nurses were very angry [Samantha]

Young women struggle to inform their parents about their pregnancy and when they do, they usually experience some form of punishment and experience stress and guilt.

5.2.2 Coping with the academic load

Whereas other researchers have shown that pregnancy is the major cause of school drop outs among female students, the participants in this study have had go through pregnancy while attending to their academic demands (Willan, 2013; Kaufman *et al,* 2001). All the participants in this study were attending to school work for the most part of their pregnancies. This entailed attendance of lectures, writing and submission of assignments, tests and exams. Because of their pregnancy, participants reported experiencing a lot of stress with respect to fulfilling their academic obligations. Participants who got pregnant during the course of the semester reported struggling with physical exhaustion, fatigue, nausea and morning sickness in the first trimester of their pregnancy as previously indicated by Behrenz & Monga (1999). Therefore, it was difficult to study or keep up with their academic load. Most participants also spent their last trimester of pregnancy whilst in school and reported experiencing the same difficulties and sometimes, a greater degree of exhaustion as suggested by Elek *et al* (1997). Participants indicated that coping with the academic workload was difficult because they were constantly feeling tired and sleepy as indicated by an honours student called Lindiwe in the following excerpt:

> Walking around has been such a hassle, even going for that one seminar is so hard- sore feet, my sore back but then that only happens now in my third trimester. But during my first trimester, my first trimester was bad cause I was so sick but then I had to force myself to go to class [Lindiwe, eight months pregnant].

Lindiwe‟s experience is not uncommon. In fact, fatigue and exhaustion are major causes of maternal morbidity (Luke *et al*, 1999). The current study found that severe fatigue and nausea are usually accompanied by drowsiness. It is therefore not surprising these two first year students, Rachael and Nomthandazo, lost concentration in their academic work which resulted in poor grades:

> I dropped so hard in first semester cause it was when I found out I was pregnant and everything was so messed up. I couldn‟t concentrate, I couldn‟t pay my full focus on my studies, I dropped. Then second; when am trying to study, I would be sleepy, I would get a book then feel drowsy and find myself sleeping so that affected me [Rachael, five months pregnant, September 22nd, 2015].

> Time management, I won`t even lie... time management for school, it‟s been difficult. School wise I think my brain is functioning too slowly I won`t even lie even if am reading maybe, I will read this like maybe a paragraph this size [gestures], I wouldn`t recall the importance of the paragraph easily [Nomthandazo, first year student, nine months pregnant].

Pregnancy symptoms experienced in the first trimester affected students academic performance negatively. The findings by Chou *et al* (2003) also showed that there is a correlation between pregnancy symptoms such as fatigue and morning sickness and maternal depressive symptoms. That being the case, these phenomena have significant physical and psychological implications in an academic setting and can cause students to lose their zeal to study.

> You don‟t do things as usually. You don‟t study as you are supposed to, you don‟t feel like it. You always feel sleepy. And you don‟t feel like going to lectures [Slindile, 2 weeks puerperal, August 3rd, 2015].

> At school I would say the only thing (challenge) was sleeping. I never wanted to study. I was sleeping whenever I was in class, I was tired [Xoli, five weeks puerperal, September 29th, 2015]

The change in sleeping patterns coupled with severe fatigue caused students to spend less time studying and in some cases, they had to take energy supplements to help them cope with schoolwork.

> Ah sometimes I have to sleep early and not study. [ ] I don`t know this baby (is) always tiring me hey, it‟s too heavy. My mother always say that I sleep too much now I have to take some treatment (for energy) every day. [Thuli, second year student, eight months pregnant]

Most of the young women in this study reported late initiation of prenatal care and thus experienced low haemoglobin levels during pregnancy. The World Health Organization (WHO) estimates that on average, 57 percent of women in Africa develop anaemia during pregnancy and anaemia is a major cause of maternal morbidity and mortality (WHO, 2007).

Adolescence and unintended pregnancy are both risk factors for anaemia in pregnancy. In its severe form, anaemia is characterized by fatigue, weakness and dizziness. WHO also states that lifestyle, nutrition and health seeking behavior during pregnancy determine the risk of anaemia. Unfortunately, women with unintended pregnancy have been shown to exhibit poor health seeking behaviour (Aviram *et al*, 2013). In the current study, participants experienced dizziness and weakness and this was attributed to the late initiation of prenatal care and poor nutrition. Ultimately, their academic performance was affected.

> When I got pregnant, I had weak blood (low haemoglobin) so it meant, it affected me in school. I was always tired so I always wanted to sleep. So I did not find much time to study cause if I walked in the house I had to find the bed like now and I slept long hours [Samantha, first year student, seven months pregnant].

Other participants reported experiencing dizzy spells and weakness which made them feel unwell.

> When we were in the queue [at the mall], I don‟t know what happened but I couldn‟t see. I couldn‟t see, my eyes were black. I felt like falling. Luckily I was with someone and they gave me water. I didn‟t like that feeling. [Thobile, eight months pregnant, August 4th, 2015].

Participants mentioned that sometimes they had to make hard decisions between seeking healthcare and attending to academic work. This sometimes resulted in not attending classes or missing examinations. This was common in the last trimester of pregnancy.

> [Previous pregnancy]-I came here maybe I was about 6 months (pregnant). When I came on campus I usually did not attend all my lectures, (I) had to miss some of my lectures because I had to visit at the clinic to check if my baby is okay. She was born on the 3rd but she was supposed to be born on the 10th so I had to make it faster (opted for a caesarian section)…. [Current pregnancy]- Sometimes I have to leave early if I feel that I have a problem with the baby inside I have to leave and go to the hospital and my appointments are usually on the day that am attending (lectures). I have to go see the doctor sometimes. [Thuli, eight months pregnant, second pregnancy]

Being unable to attend classes and write examinations resulted in some participants to lag behind in their academic work. Thuli continues to talk about how she had missed an exam because she had just delivered her baby.

> Last year I had one sup (supplementary examination) and I did not write it in the first semester when I was pregnant. I didn`t know that I had to come back because my baby was too small. I didn`t come back to write the sup so I have to do it this year. I have to do five modules and the sup that I missed last year. Am really studying hard this year. I don`t sleep, I don`t sleep [Thuli, eight months pregnant].

Participants also spoke about being constantly sleepy and hungry in the third trimester and the need to always carry extra meals or money to buy food whilst on campus as they would become very hungry in between lectures.

> When I was at school, I would get hungry and I was like oh my God am so hungry. I had that thing. I always had to carry extra cash, extra money and all [Xoli, five weeks puerperal]

> Eating I eat a lot, I get hungry. Sometimes I bring lunch on campus. Have to bring more money to buy food, yah. [Thuli, eight months pregnant]

The struggle to balance studies and pregnancy was a challenge among most participants and it included all factors related to their pregnancy that changed their academic lifestyle.

5.2.3 Financial constraints during and after pregnancy

It was important among most of the participants to have enough financial resources during pregnancy. Being full time students, most of the participants did not have an income of their own and were dependent on their parents and guardians for financial support. Parents normally paid for their school fees and provided pocket money. However, pregnancy came with its own financial demands which sometimes could not be met by the financial resources provided by parents. Because they were unemployed, participants expressed how they had experienced financial difficulties either as a result of their pregnancy needs or the reduced financial support from their parents. Lack of financial resources also affected health seeking

because in certain cases, some participants did not have money for transportation to ANC services as two students point out.

> When you‟re pregnant you have to go to the clinic (antenatal clinic) each and every month and they are going give you a date to come. And then when you have to go to the clinic, it happens that you don‟t have money because you have to travel - get a taxi, then you don‟t have money. Then I have to go around at res [student‟s residence] up and down, borrowing money to go to the clinic then people will be like “I don‟t have money, I don‟t have money”. It‟s so painful [Rachael, six months pregnant].

> Sometimes I don‟t have money for travelling to the clinic so support is much needed [Thobile, seven months pregnant].

The issue of unavailable financial resources seemed to result from the low financial support from parents because of their dissapointment and the unmet expectations of financial support from male partners. One participant spoke about receiving less money from her parents which she also had to use for her baby‟s nęeds .

> Now I have financial constraints because what [money] I get the baby gets half and I get the other half [Xoli, 21 years old, five weeks puerperal].

The unavailability or reduced financial support from their parents resulted in participants not being able to buy maternity clothes during pregnancy.

> She`s only paying school fees and buying me clothes but not a lot of clothes. I have to wear small clothes. [Thuli, 19 years old, eight months pregnant].

Some parents made it clear that they were not going to provide money for clothes as one participant points out.

> For the clothes, they [her parents] are no longer buying for me. They told me that they will no longer buy me clothes [Busi, 19 years old, five months pregnant].

When it came to hospital bills and preparations for childbirth, participants expected their partners to provide financial support. Some of the participants mentioned lack of financial support from the father of their baby during and after pregnancy which caused a lot of stress for them. One participant expresses her disappointment as she talks about the challenges she has experienced in trying to obtain financial support from the father of her child.

> It‟s a challenge, it‟s a big challenge with finances he [father of her child] will make an issue and an issue and an issue and am like I told you I don`t work, I don`t have nothing yet [money]. So for me that just hurts cause I have realised that he just doesn`t wanna be ready and he just doesn‟t care at all [Xoli, third year student, new mother].

There was a concern from some of the participants when it came to choosing the hospital that they wanted to deliver their baby from. They said they did not have a choice because of their financial dependence on their partners and thus were unable to access the kind of medical facilities that they would have preferred.

> If your partner decides that you have to go to a government hospital cause he doesn‟t have money to pay, there is nothing you can do so I think it‟s a very devastating position to be in [Barbara, seven months pregnant].

Sometimes, partners were reluctant to spend a lot of money on hospital bills in spite of their ability to afford private health care as Nomthandazo, whose partner worked in another town put it.

> I have been telling him that Hillcrest hospital is a beautiful private hospital. It should cost R8000 or something and I cannot afford but he [her partner] can afford that, he can. If he does pay, since am 9 months pregnant, I can go and pay for all the facilities and book for my bed then anytime the baby wants to come I can go easily. But since he hasn`t done that, most probably am going to go to a public hospital which I don`t like [Nomthandazo, 19 years old]

Unintended pregnancy can be a financial burden for students, who on their own are not able to provide for their child. Parents of pregnant adolescents are also in most cases not ready and sometimes unable to support the child (Zwang and Grenne, 2008). In this study, financial

challenges resulted in some of the participants being unprepared for delivery in terms of the material needs of the mother and her baby. This was in the final days of pregnancy when they were almost due for delivery. The inadequate financial support from their partners was said to be the reason for this. In some cases, male partners were financially overwhelmed and did not have enough resources. One participant in her final week of pregnancy said:

> The circumstances surrounding the pregnancy [unintended] made it hard for us to be prepared-financially he wasn‟t ready and I wasn‟t ready. Then he had to start making preparations for him to go and pay at home [damages to her parents] and he pays for all the medical bills and things financially really aren‟t flowing too smooth for him. [Khanyisile, nine months pregnant, August 6th, 2015].

5.2.4 Relationship problems with male partners

Unintended pregnancy, a common problem among young people in tertiary institutions, can have a negative impact on their romantic relationships. Young women in this study had expectations of support from their partners and unmet expectations from partners support resulted in conflict. It has been shown that relationship stability prior to pregnancy determines the amount of support that will be given by male partners (Guzzo & Furstenberg, 2007). Some participants reported that they had initially been told by their partners to have an abortion because they did not want to have a child, consistent with previous literature (Santelli *et al*, 2003). In the end, the relationship did not survive and it ended within the first few months of pregnancy.

> When I was telling my boyfriend am pregnant, he asked me to do an abortion and I was like what the hell? I told him no, I wasn‟t gonna do it so we argued. We continued dating but at the end of the day he still dumped me [Thandeka, four months pregnant, August 4th, 2015].

Researchers have previously shown that relationships among young unmarried partners are usually unstable and an unintended pregnancy can disrupt a young woman‟s relationship with the baby‟s father (Guzzo & Furstenberg, 2007; East *et al*, 2012; Unger and Wandersman, 1988). For some participants, constant arguments in the relationship resulted in a communication breakdown and eventually, the relationship came to an end.

> There was a time where we just used to fight and fight there was a point he started disrespecting me and am like I can`t take this any more so I decided to just cut off all communication and that‟s what I did and stopped talking to him, cause even like now we don‟t talk at all the only time I spoke to him is if I want something from him, if he doesn‟t have it, okay [Xoli, new mother].

The participants said that they experienced stress as a result of conflicts with their partners. Young women expected support from their partners and the unavailability of this support from their partners was a source of frustration. Receiving support from their partner was the biggest expectation and the perceived lack of support caused some participants to feel neglected and hence regretful over their pregnancy

> I felt like he neglected me. I was so irritated and I was crying like a baby. I felt so sad and I felt like you know, I wish I was not pregnant, like at the same time am like I love you baby [her unborn baby], but at this point in time, I wish I wasn‟t [Zinhle, 25 years old, seven months pregnant].

The unmet expectations with regards to support from male partners was said to be the reason behind most of the arguments with their partners, as shown in previous studies (Gee & Rhodes, 1999). Sometimes, young women would „provoke‟ their partners so that they could vent and express their frustration and an argument would ensue

> His support is weak. It makes me angry, It makes me angry not to anybody but to him and when I want to voice out, I just send sms [text] to provoke him if he talks then am just gonna blow [Nomthandazo, 19 years old, nine months pregnant].

> When my boyfriend left me (left her due to conflicts), I hated him! I would curse and send him sms [text] and threaten him telling him if you don‟t come back you‟ll never see your child and such and such [Khanyisile, nine months pregnant].

Some participants attributed the arguments they had with their partners to the hormonal changes they were going through during pregnancy.

> Mood swings, hormones- they are causing a lot of stress and fights between me and my baby daddy in such a way that sometimes I think of giving up on him. We fight over just small things, small things [Mbali, five months pregnant].

> You tend to fight a lot and sometimes you might break up over that but you have to understand because with me I don‟t know what‟s happening but I think it‟s the hormones. Sometimes I would be shouting at him, the next minute am like no it‟s the hormones, it‟s not me, you just have to understand, it‟s the baby [Zinhle].

Some of the participants who were no longer in relationships with their baby‟s father said the amount of support they received from them was very minimal and in some cases no support was given at all. It appeared that due to the absence of intention for the pregnancy, male partners were not emotionally and financially ready for the new responsibility. This was a challenge particularly for those whose families were unable to provide everything for the baby. Some of the participants who had already had a baby reported that the baby‟s father had not been to see the baby or sent any form of material or financial support for the baby.

> He has not seen the baby from day one. I would say in a way, it‟s like am just a single parent and decide for him (decisions) and the only time I get to tell him is I have decided on so and so and so. At times I don`t even consider his opinion. It‟s just an opinion he won`t do anything about it [Xoli, five weeks puerperal].

Unintended pregnancy has serious implications on both the mother and the infant such as negative psychosocial effects, heavy smoking during pregnancy, delayed prenatal care, increased risk of anaemia, preterm birth, low birth weight and lack of breastfeeding (Korenman *et al,* 2002; de Vienne *et al*, 2009; Aviram *et al*, 2013). However, unintended pregnancy in unstable relationships does not only have serious implications on maternal and child health but also on a child‟s social identity when paternity is denied. It is common for young men to deny paternity of the child because they do not want to assume the financial obligations of parenthood (Kaufman *et al*, 2000). One participant shares her experience.

> I got pregnant in February then towards the end of the month we broke up. So I didn‟t know like how am I going to tell the father of the baby cause we already broke up. So when I told him he refused, he just denied my pregnancy, started calling me names, insulting saying that I‟ve been sleeping around. It was so painful I was crying each and every day (Rachael, 20 years old).

5.2.5 Experiences of social stigma

This study found that a lot of young unmarried women feel a sense of shame because of their pregnancy. A number of participants mentioned experiencing feelings of shame and embarrassment at school and in their communities as a result of their pregnancy. This was worsened when people would stare at them and that was considered to be a negative attitude.

> Facing people, it‟s been hard like you know some people stare at you like they‟ve never seen a pregnant person before. There‟s so many girls that get pregnant on campus [Lindiwe, honours student]

> When I came here on campus last year, I was pregnant and this year also, am pregnant [second pregnancy]. So a lot of people that know me stare at me and get surprised [Thuli, second year student].

Society was also said to have double standards when it came to how they judged pregnant young women. People were said to show a different, more positive attitude when they noticed the presence of a male partner as compared to when a pregnant young woman was alone.

> Walking around school is a problem now with all the stares. It angers me and I think it‟s so hypocritical in a way cause their stare types change when am alone it‟s like “you fell pregnant and you‟re still studying” and then when my boyfriend is with me, the stare type changes all the way to “oh they love each other, how sweet”. [Samantha, first year student]

> If my boyfriend was not there for me it was not going to be easy because sometimes you are walking in town people are like “where‟s the father of the baby? So why are you walking alone?”

Social stigma has been associated with negative outcomes such as social isolation and low self-esteem (Wieman *et al*, 2005; Zwang & Garenne, 2008). Because of the negative attitudes from people around them and the fear of stigma, some participants said they experienced isolation and they had lost some friends in the process.

> I pushed a lot of people away because of my pregnancy, I lost some friends. I just wanted to be left alone to deal with this [Samantha]

The negative attitude from certain friends was said to be a reminder that because of their pregnant state, they were now different from their peers hence they felt the need to stay away from them. Other studies have reported similar findings where girls that have recently become mothers feel that they have experienced a change in social status due to motherhood (Varga, 2002). Due to this, there is a perception that they cannot relate with others who have not been pregnant before. One participant talks about how certain friends distanced themselves from her and she also felt she was different from her peers hence isolated herself. This was initially accompanied by feelings of neglect but she later came to accept it because she realized she was different from them.

> Some of my friends ignore me due to the pregnancy cause they don‟t wanna walk with me to school and I also see myself as totally different from them. At first I felt so neglected now I have accepted that am pregnant and things won‟t be the same. I usually walk alone. Some friends will support me, some will not.

This participant attributed the neglect to her choice to keep her pregnancy, which most of her friends had not done as they chose to terminate their own pregnancies. Therefore, she felt she was seen as a bad reminder of their past actions.

> Some see me as a reminder since they aborted their babies, am a reminder of the bad things they have done before so the easiest way to forget the bad things they have done is to neglect me. At first I was hateful but now am okay, I‟ve accepted. Real friends will stick with me, the fake ones will just go [Thobile, second year student].

Researchers have shown that social stigma is usually an outcome of pregnancy among unmarried young women, particularly adolescents and it has potential psychosocial effects on young women. In extreme cases, it can result in social isolation in an attempt to avoid negative comments (Atuyambe *et al*, 2009; Zwang & Garenne, 2008). The fear of social stigma caused some young women to delay ANC because they did not want to be seen by members of the community at antenatal clinics.

> I was afraid that my neighbours will see me going to the clinic especially to the maternity department and they will start gossiping about me. At first I was like eish they gonna say bad comments, you know how people especially townships [Nomthandazo, 19 years old].

> I think they judge [people] cause they think no…you are still at school, why should you fall pregnant [Naledi, second pregnancy].

These findings show that the socio-cultural context of pregnancy among unmarried young women still plays a role in the discourses that society creates about early motherhood. It can be agreed therefore that the acceptance of the pregnancy in the family as well as the community determines its psychological and social consequences (Atuyambe, *et al*, 2009).

5.2.6 Unexpected pregnancy experiences and adjustment

Some participants said they had a negative experience of pregnancy, which was different from what they had perceived. They said they had had a completely different view of pregnancy before and found it was difficult to adjust to their pregnancy status. Before pregnancy, they had expectations of getting special treatment, relaxation and being excused from certain things but found out that it was not always the case. They still had to meet their obligations at home and at school.

> I thought it was lovely [pregnancy], I thought oh you get to be treated like a queen as compared to soldiers, this and that, this and that. I never really thought that unfortunately you need to toughen up, you need to pass your exams, you need to go to work, come home, you need to cook, you need to clean, you need to wash, you need to be on the board all the time [Khanyisile, Honours student, 9 months pregnant].

Most participants admitted that with pregnancy, „what you see is not exactly what you get" and you only know what is involved after you experience it.

> It"s not what you expect [pregnancy]. You see pregnancy is something else, I don"t know how to put it, like, when you are not in the situation, the way you

> look at that situation is different from the way you see it when you are in that situation [Slindile, third year student, two weeks puerperal].

One participant said she only realized after getting pregnant that pregnancy was not just a period that came and went away. She realized that it was actually the process that preceded motherhood, a lifelong role and responsibility that she found was not easy to accept.

> I thought it was not something big, just the thought of having a baby, nothing much, that you have to stop certain things for that particular period of time when you‟re pregnant. But when I became pregnant, it was different, like it changes the rest of your life. It‟s not like that period only. It changes the rest of your life now you‟ll have someone in your life, not just someone, but someone in a different way- someone who belongs to you, your responsibility, so that is a lifelong process and it‟s not easy to accept [Thobile, seven months pregnant]

Unintended pregnancy can cause high levels of stress among young people due to lack of readiness for pregnancy and parenthood (East *et al,* 2012). The case might be worse for students who also have academic goals. The pregnancy is therefore seen to be a disruption to the plans that the young person had made for herself. The realization that a child is going to be a lifetime responsibility and a financial burden for parents on whom they are dependent can result in regret,

> At first it was quite stressful cause it was unplanned. I feel like I had other plans for the future and this year and it [pregnancy] happened. So at first it was kind of stressful [Lindiwe, 22 years old, honours student].

> Basically last year I had so many goals and I used to talk I want this, I want that, I wanna be like my sister cause my sister basically she doesn‟t have a kid only her husband came with a child [Nomthandazo, first year student].

Some participants reported that pregnancy had caused a lot of changes in their lifestyle which they had to adjust to and this proved to be difficult given their age and social context because they had to adapt to a new lifestyle.

> So far being pregnant at a young age is not an easy thing cause we as youngsters we like partying, drinking, wearing short things so when you are pregnant when you are young, life tends to be not like it was before. Right now I have to wear something long, comfortable for the baby and also for me, the things I eat, I don‟t have to go to parties anymore [Thobile, 19 years old].

Khanyisile goes on to add how she felt about her pregnancy experience, not having enjoyed it and how she had come to learn some valuable lessons:

> I feel a little bit sad that I didn‟t really get to enjoy this as much as I thought I would because I have had so many…, it‟s been a real rough rollercoaster ride for me, it hasn‟t.., am not gonna lie and say oh it‟s been very nice, it hasn‟t been very nice. It‟s been really rough and it‟s been a very eye opening experience you know.

Some participants mentioned that they had experienced health problems during pregnancy and had to seek healthcare. Sometimes the health problems were stress related.

> For me it wasn‟t all glorious [pregnancy]. Stressful, stressful to the point that last Monday a campus doctor was set to meet me and I had a very high blood pressure. He wanted to admit me in hospital but I just went through a checkup now and it‟s gone down a bit [Khanyisile, nine months pregnant].

One participant narrates her experience with a health problem and she did not have money to seek private health care and had to wait long hours at a public hospital to get medical attention.

> On Tuesday I went to the hospital and had a bad experience and for like the following three days, I had abdominal pains I didn‟t know what was happening, I was so scared. I went to the hospital cause I didn‟t have money for the doctor, mainly I go to see a doctor, yeah I didn‟t have money and then I got there. I had to wait for like from 8:00 to 12:00 hrs for the doctor to come, I had pains, like I

> couldn‟t feel the baby in my womb and thought maybe my baby had died and what not, I was crying all day [Zinhle, six months pregnant].

These findings extend prior research showing that unintended pregnancy among young people is a risk factor for maternal morbidity and mortality (Orr et al, 2008). Other negative maternal and child health outcomes of unintended pregnancy have been well documented (Cheng *et al,* 2008, Kost *et al,* 1999; Paul, 2005; Arslan, 2005).

5.3 Conclusion

Pregnant students in universities are at age and social context that makes them vulnerable to several challenges. Due to academic demands, lack of income, dependence on parents, unstable relationships and social stigma, pregnant students experience more challenges during pregnancy as compared to other women. These challenges result in emotional distress, anxiety and depressive symptoms which can affect the psychological wellbeing of pregnant women and elicit negative behaviours like smoking and alcohol use. Due to lack of pregnancy intention, pregnant students are more likely to delay initiation of prenatal care and risk developing anaemia and having low birth weight babies, some of the major causes of maternal and neonatal mortality.

CHAPTER SIX
INTERPRETATION OF FINDINGS (PART TWO)

Support needs of pregnant students and male partner support received

6.1 Introduction

In this chapter, I continue the interpretation of the findings. I focus on the experiences of support during pregnancy and puerperium among unmarried students with emphasis on their support needs and support received from male partners. Emerging themes on support needs of pregnant students and male partner support received were interpreted and discussed. The role of health systems in the promotion of better maternal and child health through male partner support will also be discussed

Table 6.1: Table of themes emerging from the data

Aspect	Theme	Subtheme
Support needs of pregnant students	1. Emotional support 2. Instrumental support 3. Help with information on pregnancy and childbirth 4. Male partner support	**Period when the most support is needed** (a) Throughout pregnancy (b) At the beginning of pregnancy (c) At the end of pregnancy **Male partner support required** (a)Emotional support (b)Instrumental support (c) Financial support
The level of support received from male	1. Emotional support	

partners	2. Spending time with their partners 3. Accompanying their partners to doctor‟s appointments 4. Financial support	

6.2 Support needs of pregnant students

Support during pregnancy was perceived to be very important among all the participants. Social support is a part of pregnancy that all the participants said they could not do without. The support needs of the participants were similar in many ways but sometimes unique to their situation. The following were the themes emerging from the interviews.

6.2.1 Emotional support

Emotional support was considered to be the most important type of support among participants. A number of participants expressed their need for a „listening ear‟ and the desire to be understood and not be judged for getting pregnant. Their accounts showed that they experienced feelings of sadness and loneliness and considered themselves vulnerable because they got pregnant whilst pursuing their studies. Weiss (1973) suggested that personal vulnerabilities and situational constraints can have an effect on relationships resulting in the phenomenon known as loneliness. Perlman & Peplau (1981) defined loneliness as „the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively‟ (p. 31). Due to this loneliness, the young women in this study expressed a need for social relationships that would offer constant assurance that someone was there for them. Studies have associated loneliness with depression, a serious condition which during pregnancy can result in adverse maternal and birth outcomes and is a risk factor for postpartum depression (Robertson *et al*, 2004; Stewart *et al*, 2006). Therefore, to minimize these feelings, emotional support was considered to be the most important type of support that they needed to receive among all others.

> It feels good to have people around and knowing that you are loved. Although you made mistakes - not that a baby is a mistake – but being pregnant while you are studying, being something that you have not planned obviously, so knowing that although you have made that mistake, but people haven‟t abandoned you. People around you like your loved ones and your family- that they still love you [Slindile, 20 years old, 2 weeks pueperal].

In comparison to financial support, receiving emotional support and having people who were going to be there for them in times of sadness was said to be important and it made their pregnancy easier to handle.

> I think if you have that emotional support, everything just falls into place, the finances and everything don‟t really matter [Khanyisile, nine months pregnant].

> I just don‟t need money in that kind of way. The kind of support that I would really like, that I would really expect is for people to be there for me, to give me that much attention, to be there when I feel sad [Rachael, six months pregnant]

For some participants, having someone available to offer this support was important regardless of who was offering it. They reported that the availability of emotional support made a huge difference in their lives regardless of its source because their greatest need was to feel loved and cared for. Western studies have shown that larger support networks have a positive influence on young mother‟s pregnancy and parenting experiences (Voight *et al*, 1996; Glazier *et al*, 2004). Receiving support from different sources was associated with lower emotional distress and a better outlook on pregnancy. This was seen as a distraction from the challenges they were experiencing as a result of their pregnancy, consistent with Cohen & Will‟s (1985) stress buffering model of social support. Having people to talk to and understand them, without judging them was important for participants.

> A person who is pregnant just needs support, love - no matter how bad the situation is or how it‟s happened. But when I look at this pregnancy of mine, I just feel like it‟s a mess up. Support from all perspective; family or boyfriend or husband or whoever, friends, so that she can feel happy -it is important [Busi, 19 years old, five months pregnant].

> Having people to talk to and that understand, that don‟t judge you for what happened, are really there for you, lending their ear more than their mouth, people to talk to [Samantha, seven months pregnant].

A plethora of studies has linked social support in pregnancy to maternal wellbeing and lack of social support has been associated with adverse maternal and child health behaviours and outcomes such as smoking and alcohol use, maternal anxiety, depressive symptoms, preterm births, low infant birth weight and postpartum depression (Feldman *et al*, 2000; Turner *et a*l, 1990; Collins *et al*, 1993; Dunkell-Schetter *et al*, 1996;; Dudas *et al*, 2012; Shah *et al*, 2010).

While emotional support from different sources was appreciated, male partner support was said to be very important. Receiving emotional support from their partners was considered to be the ultimate pregnancy experience and was associated with feeling positive about the pregnancy and childbirth. They also indicated that emotional support from partners was required because it was easier to share their feelings about pregnancy and childbirth with their partners as compared to other people.

> I do get it [emotional support] from mom sometimes...I don`t know, am not able to talk everything (with mom), but with my boyfriend I do you know, everything. I just summarise with her [mom] but with my boyfriend I do [talk about everything] [Nomthandazo, 19 years old, first year student]

Participants said they needed to receive support from their partners as partners were expected to „take responsibility for their actions" and offer support in difficult times.

> It has to be my partner [greatest source of emotional source] cause I feel like we both did this so he needs, whenever am down, he needs to be there for me [Barbara, 20 years old, second year student]

Rachael and Thandeka who were no longer in romantic relationships with the father of their unborn baby revealed how important it was for them to receive emotional support from their former partners. They reported the fear, loneliness and frustration that they experience as a result of lacking partner support.

> I understand that my family is there for me and if they weren"t there, it was going to be more painful. But him, I also need him you know. He"s the father of my baby. I have never been pregnant before. Like I wouldn"t know how am going to experience... how am going to handle the pregnancy when he"s not there for me [Rachael, first year student].

> I think it"s important to receive support from your partner; it kind of gets lonely sometimes. It"s a sad feeling actually, sometimes you get mad and stuff and you really can"t talk to your mom so you just hold it inside [Thandeka, 19 years old].

6.2.2 Instrumental support

Receiving help with tasks and help to manage their time was an important support need of most participants. This was seen to have a buffering effect on task overload (Cohen & Wills,

1985). Their narratives revealed that instrumental support was most needed at the end of the pregnancy because as the pregnancy progressed, it became more difficult to be mobile. Therefore, they needed people to be around and help them with chores, school tasks, accompanying them to certain places especially hospitals or going to buy them food and groceries. One participant noted that she needed company every time she was going to the health facilities unlike before she got pregnant.

> If I was sick and I wasn‟t pregnant I‟d be like, "no please, don‟t come, I‟ll go by myself". Now! [whilst pregnant], Now I can‟t go to the clinic by myself, I‟ll just call anyone, call my sister or my aunt, she‟s always there she‟s like no I‟ll take you. If it [support] had to stop now, I don‟t know what I would do [Amahle, 18 years old, seven months pregnant].

Another participant revealed how overwhelming the tasks had become in her last trimester of pregnancy and the importance of receiving instrumental support during this period.

> When you are nearing your end [approaching delivery], you have so much to do. You have got school things to do, you have got doctors‟ appointments consistently one after the other, you have to buy this, get this, get that, that‟s when you need a more rigid support system [Khanyisile, honours student, nine months pregnant]

These excerpts show that apart from the need to feel better about their situation, pregnant students need help with tasks to relieve them of physical stress. In addition, receiving help with tasks also had an effect on emotional wellbeing. Previous research has shown that instrumental support from family and community plays a major role in helping young women cope with stress during pregnancy and early postpartum period (Unger & Wandersman, 1988).

6.2.3 Receiving information on pregnancy and childbirth

The narratives of the participants in this study revealed that young women, particularly first time mothers are usually inexperienced with pregnancy and childbirth and are in need of advice and information. Participants reported that they needed people around them that could help them with information about pregnancy, childbirth and how to care for their baby.

> I do not have experience on how to bath the baby, feed the baby well when it‟s crying, what‟s wrong. They [people] should tell me what to expect if am not figuring out, they must assist me [Nomthandazo, nine months pregnant].

In their accounts, they also revealed that their experiences of pregnancy were usually characterized by ignorance and they sought information from people around them. This was apparent even during the interview process when some participants would ask me to pause the recorder as they wanted to ask me some personal questions on pregnancy and childbirth. One participant narrates how she relied on her mother to explain things that she did not understand from her ANC card.

> when she comes back [her mother] I give her my card (antenatal clinic card) to read it and ask what is this basically about cause sometimes they don`t explain it fully. They just summarise the whole thing [Nomthandazo, 19 years old, nine months pregnant].

Information seeking was common among participants and some of them would use the internet to get information on issues that they did not understand.

> I used to google things from the internet and obviously find…things that didn‟t make sense, I was just alone cause no one at home knew [Barbara, 20 years old, seven months pregnant].

Young women also need information on what to expect during the differnet stages of pregnancy and childbirth

> At the beginning of pregnancy, maybe you are not sure what is happening to you, may be for some people it‟s the first time you don‟t know what is happening all the sickness. At the end...that‟s exactly what‟s happening to you, breaking water and all that. Some of the things you wouldn‟t know so someone should tell you [Naledi, nine months pregnant, second pregnancy].

Young women require guidance on pregnancy with respect to proper nutritional practices, adequate prenatal care and preparation for labour and delivery. This is because inadequate nutrition in pregnancy is a risk factor for low infant birth weight, a major cause of neonatal mortality (Collins *et al*, 1996; Paul, 2006). Young mothers usually have to spend more time in hospital due to neonatal complications such as low birth weight as compared to older

mothers (Aviram *et al*, 2013). Due to lack of information on proper nutrition practices, some young women risk having low birth weight infants as illustrated below:

> After I fell pregnant I did not eat. I don‟t usually eat. I didn‟t know that when you fall pregnant you have to change your lifestyle and do things in a certain way. It was a shock when I went for a scan when I was five months pregnant and they said my baby looks like he‟s two or three months, he was underdeveloped. So the doctor said "it‟s either your child is gonna be disabled or when you give birth you‟re gonna have to stay in hospital for a long time cause he‟s really small" [Samantha, 19 years old, six months pregnant].

This excerpt is an example of the risks associated with inadequate nutrition and late initiation of prenatal care, which is common among women with unintended pregnancy. Therefore, as previous studies have shown, unintended pregnancy is a risk factor for low birth weight (Arslan *et al*, 2005; Orr *et al*, 2008).

Period when the most support is required

When asked about the specific period during pregnancy when they feel the most support is required, participants had different views and three main subthemes arose in the following descending order.

Throughout pregnancy

Most of the participants said they required support throughout their pregnancy and into the puerperium because they felt their support needs were not going to change over the course of the pregnancy. Therefore, they said that they needed to receive support through every period of the pregnancy.

> Throughout the pregnancy you need support because there are times where you feel like I wish I could just give up everything like you know, school cause sometimes you find it frustrating and you don‟t wanna deal with it. I think you need that pillar of strength every day; someone that will be calling you and asking you „How are you doing? How‟s everything? How‟s the baby?‟ Like I think every day during pregnancy even after pregnancy [Zinhle, 25 years old, six months pregnant].

> Throughout the whole pregnancy even if the baby is here I need support why should they stop at some stage I think I do need the support (all the time) [Nomthandazo, 19 years old, nine months pregnant].

Towards the end of pregnancy

Some participants felt they needed more support as they approached their delivery date. The support required at this stage was mostly instrumental support. Previous studies have shown that receiving instrumental support late in pregnancy can help young women cope with physically taxing demands some of which may be harmful at advanced stages of pregnancy (Collins *et al*, 1993). Similar to these findings, participants in this study indicated that it was difficult to balance ANC schedules and academic obligations in the final trimester. This suggests that in the last trimester of pregnancy, students experience a task overload. For this reason they are in need of instrumental support in the final trimester of pregnancy.

> It was at the end (when she needed more support). When you feel like the baby is about to come, you have to prepare for everything. With school work it‟s very hard. Because at the end, I had to attend clinics more than before, like almost every week. So the time you are attending clinics and everything, you are using up the time for studying [Slindile, 20 years old, two weeks puerperal].

One adolescent expressed her need to always have someone with her so that she would be well prepared in the event of labour.

> Mostly it‟s at the end when you‟ll be delivering (when she needs the most support) because at that time you have a lot of complications, you need someone to look after you because you can deliver anytime. You need to have transport that will take you to the hospital immediately and always bring your card so that you are well prepared [Thuli, 19 years old, eight months pregnant,].

At the beginning of pregnancy

A few of the participants said they needed the most support, particularly emotional support at the beginning of the pregnancy. This was a period when they had just found out about their pregnancy which was something new to them. At the same time, they were still dealing with its acceptance whether personally or in their relationship. Therefore, they indicated that at

this initial stage of pregnancy, they required some form of assurance from someone that they were going to be supported.

> I think I needed more support at the beginning. It was something new to me. I kind of needed someone to hold my hand and say „it‟s gonna be fine, am gonna be there for you, don‟t worry, we‟ll get through this together‟ [Thandeka, 19 years old, four months pregnant].

In addition, this was the period when they were likely to be hiding the pregnancy from their family when in actual fact, they needed their support. Therefore, they found it difficult to share their stressors with others.

> It was difficult before I told my parents „cause you know when nobody knows at home and you start experiencing these things with your boyfriend and you get pissed, like you wanna tell someone but you can‟t. [Amahle, 18 years old, seven months pregnant].

Support at the beginning of pregnancy, particularly the recognition and acceptance of the pregnancy by the male partner has been associated with better emotional wellbeing and early initiation of prenatal care (Korenman *et al*, 2002). Therefore, it is important to receive support at the beginning of pregnancy for better maternal and newborn health outcomes.

The different experiences that the participants had in their pregnancies determined what they perceived their support needs are and the period that they were required.

6.2.4 Support in the puerperium

Research has recently focused on support in the postpartum period, particularly among adolescent mothers (Mbenkenga *et al*, 2011; Gee & Rhodes, 2003; Raman *et al*, 2013). Young women usually require support and guidance after childbirth and in the case of students; they need support with childcare as they continue with their studies. Due to academic demands, limited financial resources and family and relationship instability, young mothers are prone to high levels of stress and require social support. Social support in the early postpartum period can promote better adjustment and maternal satisfaction for young mothers (Unger & Wandersman).

Except for two who were not sure, most participants expressed their intention to continue with their studies after their child is born. This means that they would require people to help

them look after their baby as they returned to school upon delivery. Therefore, financial support and help with childcare were important support needs among the students because they did not have an income of their own, as also shown by Sriprasert *et al* (2014). When participants were asked about financial support, their accounts revealed that providing for the child was the father‟s responsibility.

> The baby needs so many things so as to grow in a good state; nappies, warm clothes, milk, formula since am not going to breastfeed so financially it will be much required from him. [She gives an example]-cause my cousin gave birth in April and the father of the baby hasn‟t given her a single cent since she gave birth, since she fell pregnant she hasn‟t received any money from the baby daddy and telling me things are difficult so financially it is so important [Thobile].

When asked about childcare, most participants‟ responses were that their mothers or female guardians were going to look after the baby upon delivery. In cases where mothers were unavailable due to distance or employment, they were still going to offer support by paying a helper to look after the child. Therefore, parents were also going to provide financial support to a large extent. In the South African context, it is common for the mothers of unmarried young women to take up the role of caring for their grandchild as the young mother returns to school (Kaufman et al, 2001). According to Preston-Whyte (1993), black South African women have the highest rate of non-marriage. Therefore premarital fertility is common and although young unmarried mothers may be reprimanded for getting pregnant, their child is usually welcomed into the family (Kaufman *et al*, 2001). Consistent with the findings by Raman *et al* (2014), this study found that mothers are usually the biggest contributors of different types of support when adolescents and young women have a child and their support is considered to be very important. Young women in this study placed a lot of reliance on their own mothers and depended on them for childcare.

> My mother is going to take care of the baby. She‟s a stay at home mom and like I said, she is very supportive. She even said that “no it‟s my first grandchild so it‟s okay, I will take care of the baby” [Samantha, first year student]

> I‟ll still be in Durban when I give birth cause am giving birth in September. So my mom will travel to here. My mom said “give me the child then you go back to school” and she‟s gonna take care of the baby...In terms of finances my mom will

> support me. I don‟t know about my child‟s father whether he‟ll be there or not [Thandeka, second year student].

Those who didn‟t have mothers (due to death) or those whose mothers worked faraway would receive help from other older female members of the family such as aunties and sisters.

> My mother`s sister, she lives in Maritzburg, she did say she can take care of baby once the baby is born so that I can go back to school and study cause that is what I want to do. She was the one who volunteered to do that [Nomthandazo, first year student]

> You know children are very expensive and am like two years from getting a job now so I will need financial support and emotional support. Next year I feel like there will be complications since am not gonna understand how to be a parent at such a young age so they (aunt and sisters) have to help me [Amahle, 18 years old, first year student]

6.2.5 Male partner support

One universal theme that emerged in all the interviews with respect to support needs was receiving support from the male partner. Male partner support was considered to be the most important source of support that pregnant students required. Most participants mentioned that lack of support from their partners could result in them experiencing a lot of stress which could affect their wellbeing and that of their unborn baby.

6.2.5.1 Partner's emotional support

Receiving emotional support from partners was the biggest support need among young women. Male partners are seen to help in psychological adjustment of young mothers and provide support and comfort (Gee & Rhodes, 2003). When compared to other support needs, most participants reported that they would rather have their partner to be there for them emotionally, offering support and encouragement to them throughout their pregnancy. The emotional support required by some of the participants ranged from the simplest acts of care like being there to talk to them or calling them every day. Once again, emotional support was said to be more important in comparison with other types of support.

> I would like to be supported emotionally because money doesn‟t buy love. It is the tender loving care that is most important. I appreciate that cause that is what is important, that is what I prefer, It‟s what I need [Naledi, nine months pregnant]

> If you throw money at me and not ask me how my appointment was, wanting feedback, to look at the scan, I would be a bit worried [Barbara, second year student]

Participants said that their partners needed to be their greatest source of support because they were the reason why they got pregnant. Therefore, they needed to take responsibility for „what they did‟ and „compensate for their mistake‟. This means that male partners were expected to play a major role in providing support and relieving emotional distress.

> You know when you are pregnant, I think you expect alot from people and when you know that this person is the baby‟s father, it‟s like you want them to do more. You want them to try anyway and compensate for doing what they did to you [Zinhle, second year student, six months pregnant]

> I think it is important cause sometimes you feel like this person (partner), it‟s his mistake-you know, cause if it wasn‟t for him I actually wouldn‟t be pregnant so he has to be there for me [Busi, five months pregnant].

One participant who was no longer in a relationship with her baby‟s father emphasized the importance of the involvement of both partners during the processes of pregnancy, birth and parenting.

> Just like it takes both male and female to do the whole process, it takes both to see the process through until the end and until after the birth and everything, there has to be both (partners) [Xoli, five weeks puerperal].

Partners support and better relationship quality was considered to be a greater need among participants. It was important for the participants to keep their romantic relationship with their partner throughout the pregnancy and after childbirth. Partner support has been associated with general life satisfaction and greater wellbeing (Unger & Wandersman, 1988). There was a general view among participants that the relationship with their partner should remain as it was before pregnancy or improve with the prospect of a child. However, it was found that in a lot of cases, relationships became weak as the pregnancy progressed. In some cases, the pregnancy led to the end of the relationship. Consistent with previous studies

(Unger & Wandersman, 1988; Gee & Rhodes, 1999), this study found that relationships that young mothers have with their partners are likely to be disrupted when they become pregnant or weaken over time. Participants revealed that relationships become more about the wellbeing of the unborn baby and less about the romantic relationship between the partners. Participants reported feeling neglected and expressed longing for a romantic relationship as they did before the pregnancy

> I feel like by falling pregnant, I lost the boyfriend and gained the baby daddy cause now our relationship is based on "Is the child fine?" There is literally no time for me and him. We go to the same school, but we would go like two weeks without seeing each other and for me it‟s like not normal, that‟s not like us. It‟s horrible cause I feel neglected in a way I, not the child but me [Samantha, first year student].

> I don`t want him to treat me as the mother of his babies, I want him to treat me also as his girlfriend. Now we usually talk about the baby a lot. We don‟t talk about us. I want us to date like we used to before, go out with him, watch some movies and get a lot of support from him [Thuli, second pregnancy].

6.2.5.2 Partner's instrumental support

Having a partner who is available to provide material goods and help with tasks was important among the participants. Instrumental support such as having the partner‟s company when they go places and buying them foods that they crave for was considered to be an important support need. The smallest acts of help with tasks were considered to be of great importance even in cases where partners could not offer financial support.

> Sometimes people ask questions about him [her partner] when you are walking alone. I need the support. If he was not there for me, it would have hurt me you know, to know that people are laughing at me [Thobile, eight months pregnant].

One participant complained about her partner who is not usually willing to help her with tasks.

> Sometimes he‟ll be sleeping [when he visits her in her campus room] and I have to do my school work then when I ask him to do something like can you please get me some water, sometimes he‟s gonna be like he‟s tired or when I want him to do something for me he‟s gonna complain [Zinhle, six months pregnant].

Instrumental support was considered to be crucial particularly in matters involving Doctors‟ appointments and preparations for the arrival of the baby. Most young women would like their partners to accompany them when they have appointments with their gynaecologist or obstetrician. In cases of medical emergencies, partners were required to be present, consistent with the findings by Raman *et al*, (2014). Going to the hospital together was considered to be an important aspect of instrumental support as it assured them that they were not going through their pregnancy alone.

> Before I fell pregnant, I really didn‟t notice anything and it didn‟t matter. Now it‟s more like I want more, more time with him. Sometimes when you go to the clinic and you see people with their boyfriends and then I‟ll be thinking like, where‟s mine? Even though I know where he is but I„ll be like I also want that, you know [Amahle, seven months pregnant].

> You know when am going for antenatal, I wanted that my man should be next to me, we should be in this together like he said but when I have to go to the clinic, he‟s not there. [Zinhle]

However in cases where partners lived far away or were busy with work during hospital visits, this type of support was not expected.

> He can‟t come because he stays far in north coast so he doesn‟t come. I don‟t think he‟s unsupportive because I understand the situation. [Naledi, 21 years old, nine months pregnant].

> I live far, my boyfriend lives in pinetown so he is too far most of the time. I only go to the clinic on Tuesdays and he goes for work. [Nombuso, eight months pregnant].

6.2.5.3 Partner's financial support

All the participants said their school fees are paid by their parents. Therefore, the financial resources expected from male partners were for issues concerning the pregnancy. Financial needs from partners included money to buy foods that they crave, maternity clothes‟, hospital bills and requirements for the baby. However, more financial support was expected after delivery as compared to during pregnancy.

> I need him not to like run away from his responsibilities when the baby is here, thats all am just hoping for, that he‟ll be a father and support his child [Lindiwe, 22 years old, eight months pregnant].
>
> When the baby comes, I wanna make him to have that thing in mind that no I have responsibilities and I must act accordingly, that‟s all I want [Nomthandazo, first year student].

Financial support did not always mean physically receiving money from their partners. Having their partners buy or pay for their needs was also regarded as financial support.

> Well my partner is not good at giving money and all that but he can do everything and anything to support but like I said, he put me on his medical aid, he can buy me anything that I crave for, but giving money no. So he supports me, yes [Naledi, second year student].

Partners were expected to be the primary providers for all things concerning the pregnancy and the baby. However some partners lacked adequate financial resources to provide the level of financial support expected. This was in cases of unemployed partners (students included). Nevertheless, it was still seen as a man‟s responsibility to provide financial resources for his partner and their baby and the absence of financial support was associated with being irresponsible.

> He hasn‟t seen the baby from day one. He‟s just a guy who drinks whose living his life who only cares about finances when I tell him the baby needs this then he will say, I will tell you when I have it even if he has it he tells me he doesn‟t have it again. He is irresponsible! I just can`t trust him at all. [Xoli, five weeks puerperal].

In most cases, parents provided more financial support during pregnancy. While a low level of partner financial support during pregnancy was well tolerated as a result of this, its importance after childbirth was emphasized. This was because of the numerous needs the child was going to have.

> My needs are going to change, I want him to support my babies more than me cause they are my first priority now [Thuli, 19 years old, second pregnancy]

> When the baby comes I will also need someone to help me with the baby like a nanny. Of course that will need someone who is gonna pay for that, obviously it‟s gonna be my partner. So after the baby comes there should be financial support. [Barbara, second year student, seven months pregnant].

The payment of damages (*Inhlawulo*) was considered to be a form of financial support *Inhlawulo* is a traditionally sanctioned fine that young men have to pay to the girl‟s family as compensation for taking away her virginity without her parent‟s consent (Kaufman *et al*, 2001). This study found that most of the participant‟s partners had not paid this fine to the young woman‟s family. This was said to result in stress and anxiety because it was seen to have an effect on their parents‟ acceptance of the pregnancy into the family (Zwang & Garenne, 2008). In various South African cultures, the establishment of the paternity of a child and its acceptance through payment of damages are viewed as events that give the child a social identity that is acknowledged by the community (Kaufman *et al*, 2001; Zwang & Garenne, 2008). In the current study, men who paid damages to their partner‟s family were perceived to be more responsible and could be entrusted with caring for them. The payment of damages was observed to have a calming effect on angry parents and associated with a more positive attitude towards the pregnancy. Therefore it was considered as a type of support that was required of partners to assure the family of his responsibility.

> After my partner‟s family came and she (mother) saw that they were reasonable people and they paid everything, she calmed down [Barbara, 20 years old].

> My sister is the one who advised me about (partner) paying the damage in December because that is when my dad is coming from Joburg. I want him (father) to know that even if he chase me, he will know that everything was done perfect and am not staying with, what can I say, a thug or anything. I want him to know that am staying with the real man [Mbali, 20 years old].

On the other hand, men who did not pay damages were seen as untrustworthy.

> To be honest sometimes I think he is going to run away since he hasn`t paid damages and he can see the other girls and forget about me you know, you know how boys are [Nomthandazo, nine months pregnant].

> My mom just said (when she knew about the pregnancy) all you had to do was mention it (the pregnancy) a lot sooner so that I know the father of the baby cause you know they run away [Thandeka, four months pregnant].

6.3 Perceptions on lack of male partner support

Overall, it was agreed among all the participants that male partner support is important in pregnancy. The lack of support from partners was associated with stress, loneliness, anxiety, depression and complications in pregnancy, congruent with the findings of previous studies (Unger & Wandersman, 1988; Turner, 1990, Hildingson *et al*, 2008). When asked about the relationship between male partner support and maternal and child health, all the participants said that poor or lack of support could have negative effects on their unborn child. The lack of emotional support from male partners during pregnancy was seen to have grave consequences for both the mother and her unborn baby such as depression, resentment and abortion.

> As much as you are the one carrying the child, you can‟t go through everything by yourself. I think if you don‟t have your partners support, you can end up having resentment towards that person, even to the extent of the child as well - somebody who has no doing or contribution towards the circumstances or events leading to you not having that support [Khanyisile, honours student].

Studies have shown that the decision to have an abortion is usually influenced by the lack of partner support, particularly in cases of unintended pregnancy (Santelli *et al*, 2003). Study results from other African countries like Uganda and Zambia have shown that young women usually opt to have an abortion when their partner is unwilling to accept paternity (Atuyambe *et al*, 2005; Webb, 2000). Research in reproductive health has shown that half of the abortions carried out globally are unsafe (Kost *et al*, 1998). Therefore lack of partner support could result in young women conducting potentially risky abortions, thereby contributing to maternal morbidity and mortality. The absence of partner support is likely to render the pregnancy unwanted (Schroelinger & Oths, 2000). As a result, pregnant young women consider male partner support to be crucial for the wellbeing of both the mother and her child. Having support from their partners in the initial stages of pregnancy was reported to be a factor that discouraged some young women from having an abortion, regardless of the other challenges that they experienced. One participant revealed that she thought about abortion in

the early stages of her pregnancy because she was afraid of her father‟s reaction but went ahead with the pregnancy because of the support she received from her partner.

> I think support is very important when you first find out that you are pregnant cause when you are not supported or lonely, you find out that pregnancy is life changing and a lot of things are going through your mind, like abortion. You are so confused. I could NEVER abort but I can‟t lie to you and say I didn‟t think about it. I thought of things like abortion, suicide, a lot of things for a really long time [Samantha, seven months pregnant].

Lack of partner support was considered to have an indirect effect on the wellbeing of the unborn baby. One participant complained about feeling alone and emphasized the importance of being happy for the sake of the baby.

> When you don‟t have your partner‟s support you tend to complain a lot and tend to feel alone and that I think has an impact on the baby in an indirect way because when you‟re pregnant, you have to be happy all the time. You‟re not doing it for yourself but for your baby [Zinhle, six months pregnant].

Some participants had concerns over the risk of contracting sexually transmitted diseases in case their partner was unfaithful.

> If he decides to go and sleep around that‟s gonna affect me and my baby and because there are so many diseases you can catch, he‟ll just be putting both our lives at stake [Barbara, seven months pregnant].

Participants who were no longer in romantic relationships with their partners reported feeling stressed, sad and lonely as a result of the lack of it. To relieve the stress, they were tempted to engage in harmful behaviours like smoking and alcohol use. It was clear in these cases that these young women did not receive any support from their partners and they expressed their desire for male partner support.

> It was quite an emotional breakdown when we broke up so at some point I felt like I could do anything, anything to get rid of the stress, drink alcohol, smoke-anything. That too could harm my baby [Thandeka, first year student].

> It helps the woman not to stress a lot to know that there is somebody, she has a wall to lean on...cause some times your family won`t support you but you know I

have a partner my partner is there like something happens my partner is there 100% cause in a way I just feel like he didn‟t play a role [Xoli, new mother].

6.4 Health systems role on social support and influence on male partner support

Studies have shown that health professionals are able to contribute to the psychological wellbeing of women during pregnancy and postpartum by offering support that mediates stress and anxiety (Sarason & Sarason, 1990). However in most cases, the only types of support they offer are informational and educational support and rarely emotional support, which pregnant students could be in need of (Razurel *et al*, 2003). Atuyambe and colleagues (2009) found that health workers in public health facilities exhibit negative attitudes towards young pregnant women, particularly, adolescents. Furthermore, lack of confidentiality causes young women to shun antenatal clinics. African studies in the area of PMTCT have also shown that this is a barrier to partner involvement at clinics (Morfaw *et al*, 2013).

When asked about their experiences at antenatal clinics, participants reported that the health staff at the clinics had a negative attitude towards them. They felt stigmatized because of their age and status as students and this was because of what the nurses would say about them.

> "Ooh at first I had hell, like the nurses ask you basic questions: "how old are you?" Then when you say 18 then everybody is like "*hau*?" then instantly when you say you go to Howard College everybody assumes like "no wonder, it‟s expected". [continues to mimic] "Where‟s the baby daddy?" Am like "he‟s working". They‟re like "yeah, you have a working baby daddy cause that‟s what you do". They weren‟t really saying it to my face but you can hear them gossiping [Amahle, 18 years old]

When asked about how the health systems influence male partner support among pregnant women, particularly partner ANC attendance, almost all the participants said they had never attended antenatal clinic with their partner. Some participants said they did not want their partners to go to the clinics with them because of the female dominated environment at the clinic and the amount of time spent at the clinic. In addition, nurses did not seem to be concerned about the absence of partners.

> I was suggesting (to her partner) that no, you remain…I would tell him you can come but leave me there. You don‟t have to stay with me. Clinics are just

> something else. The nurses don‟t even ask about my partner. [Thobile, 19 years old]
>
> Antenatal, no am not attending those. It‟s just hectic, the crowds. I prefer to go to the doctor [Khanyisile, 21 years old]

Some participants said they were not attending antenatal clinics but instead were consulting specialists like gynaecologists and obstetricians to monitor their pregnancy. This was mostly because they felt they needed to be checked by gynaecologists as clinics do not provide this service.

> With my partner first of all he said he doesn‟t want me to go to clinics and all that so he put me on his medical aid. He didn‟t want me to be going to the clinics. There‟s nothing wrong with the clinic but for me he preferred the gynaecologist who is gonna do everything [Naledi, second pregnancy]

A few of the participants mentioned that their partner did accompany them to the clinic on one occasion but did not do so on subsequent visits. While they had the desire to have their partners come to the clinics with them, they mentioned that they did not see the purpose because nurses at the clinic did not involve men in any of the activities.

> He came with me to the clinic on my second appointment, when I was about four months. It means a lot to have someone with you. But they didn‟t ask him to do any tests [Slindile, new mother].
>
> The nurses would just ask randomly that where is he? Not really formally like he has to be there. [Nomthandazo, nine months pregnant]

Overall, it was established that most young women attend ANC only because it is a requirement for accessing delivery services at public hospitals. Women who do not attend ANC can only deliver from a private hospital, which none of the participants could afford except for those whose partners or parents were paying for the service. Therefore, young women whose parents or partners had taken responsibility to pay for private healthcare did not attend ANC at public facilities The ANC services were generally considered to be unfriendly for young unmarried women, especially students. In addition, partner attendance was not specifically encouraged or recommended by health workers. Almost all the participants visited private practitioners for services that they could not easily access at public facilities such as scans, mostly with their partners. Therefore, young women had the desire to

attend health services with their partners but this did not happen in public facilities because of the time spent at ANC, female-dominated environment, overcrowding and negative attitudes of health workers to young women.

6.5 Types of support received from male partners

Male partner support was given to the participants in different forms and on different levels. The level of male partners support was mostly determined by the type of relationship that existed between the two. Participants who experienced a lot of problems in their relationships reported low male partner support as compare to those that had a few problems. The nature of the support given was also determined by partner‟s social economic status. Partners who were in employment offered more financial support as compared to those that were unemployed. The following themes arose from the type of support that pregnant students received from their partners.

6.5.1 Emotional support

Emotional support was reported to have been received by some of the participants, especially those who were still in a relationship with their partner. Their narratives revealed that receiving emotional support from their partners made them feel appreciated. Receiving support from a male partner has been associated with overall life & maternal satisfaction (Unger & Wandersman, 1988). Participants who were no longer in a relationship with the father of their baby were less likely to receive emotional support from them. These findings are consistent with the conclusion that relationship quality is a contributor of the level of support that a male partner gives (Stevenson *et al*, 1999). In this study, partners gave emotional support which ranged from verbal assurances of support or encouragement to consistent communication. Male partners were said to offer encouragement and assurance that everything would be alright especially when the participants were feeling down.

> When I was down he was able to like support me and tell me everything is going to be fine, try to make me watch funny videos, like download cute pictures of mummies and babies so he was very supportive [Barbara, employed partner]

> He gives me emotional support like when I just feel completely down and I need to be uplifted, you know, he does give me the support that I need [Lindiwe, honours student, dating fellow student]

Young women who reported a high level of emotional support from their partners had lower emotional distress and reported better psychological wellbeing as compared to those that did not, as also shown by Tanner-Stapleton *et al* (2012). Generally for participants, receiving emotional support meant being cared for and was associated with being fortunate, in comparison with the experiences of other young women who have had unsupportive partners.

> I highly appreciate it (partner support), it means a lot you know. The support from him is incredible. I feel as if am lucky cause others don‟t get this support am having [Thobile, employed partner]

Receiving assurance that they were not alone in their experience gave the young women courage to be positive about their pregnancy. It was also reported to be a buffer against negative feelings.

> It means everything [to receive partner support], it means am not alone in this. It shows that this is our child, it takes away a lot of negativity that I would feel and I think in a way am lucky [Samantha, dating fellow student]

> "We are in this together"- thats what he used to tell me. "We are pregnant together". So this gives me courage. What would I have done if I was alone? [Thobile].

6.5.2 Instrumental support

Some participants said their partners had played a positive role in catering to their needs during pregnancy. This involved buying food, gifts and spending time with their partners.

> He used to come here on campus and bring me food when he‟s free, when he doesn`t have lectures. When am at home...he`ll bring me some food, the things that I was craving for [Thuli, dating fellow student, different campus].

> Most of the time, he likes taking me out, when he takes me out he has to buy me something. I don‟t know he has this perception that pregnant women should always be smiling. On the regular we book in hotels, like recently he brought me products, like these massage products for stretch marks and whatever it‟s just the small things that matter actually [Amahle, working partner, different city].

Participants expressed their gratitude for having their partners support because some participants had earlier assumed that they were going to be abandoned by their partners.

> I thought when I got pregnant he‟ll be leaving me at home, no walks together, we won‟t go to the mall or the restaurant together but things are still the same, he still wants everybody to see me with him [Thobile].

Some of the participants mentioned being accompanied by their partners to gynaecological checkups and pregnancy scans. This was done by most of the male partners except for those who were working or lived far away.

> When I go to the doctor, he‟s always there, if he can‟t make it he arranges for someone to pick me up [Amahle].

> When am sick, he‟s always there to help me with money to go to the doctor, he goes with me, yeah and just, just being there. It‟s not like he‟s running away from his responsibility or me, he‟s always there, we‟re always spending time together [Lindiwe].

6.5.3 Financial support

Participants reported that they received financial support, most of which was used to cover hospital expenses. This study found that most young women are not satisfied with the financial support given by male partners. Among the reasons for low financial support were unemployed male partners and relationship problems.

> He‟s been contributing what he can, though it‟s not what I expect but he‟s been paying for those doctor expenses [Khanyisile]

Generally, most of the participants reported receiving money for hospital bills above anything else.

> When I need to go to the doctor he gives me money [Mbali]

> I‟ll be going for a scan this month so he‟s given me the money [Thobile]

6.6 Conclusion

The challenges faced by pregnant students entail that they require a good support network for better pregnancy experiences and ultimately better maternal and newborn health outcomes. The findings of this study were that pregnant students need emotional support, instrumental support, financial support and support in the puerperium with respect to childcare and everything else that their child requires. Although support from different sources was

required and appreciated, male partners support is the most important support that pregnant students require, with emotional support being considered to be the most important. Like previous studies have shown, receiving emotional support from partners is associated with greater maternal wellbeing and lower emotional distress. The absence of male partner support on the other hand is associated with negative feelings such as loneliness anxiety, depression, resentment and sometimes termination of pregnancy. This also has adverse effects on the unborn child. Young women received different types of support from their partners. However, the level of support received was largely determined by the quality of the relationship. It was also found that relationships among young people are usually unstable and are likely to be disrupted by a pregnancy as some of the relationships had come to an end.

CHAPTER SEVEN
CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The purpose of this study was to explore the support needs of young women during pregnancy and the puerperium; to explore the kind of support pregnant students perceive as most important and to explore the type of support that is given to pregnant students by their male partners and its implications on maternal and child health.

7.2 Findings and implications for maternal and child health

In this study, I found that pregnant students experience several stressors relating to their age, social context, the nature of their relationships, demands of their academic environment, lack of income and dependence on parents. Previous studies have shown that early pregnancy makes young women vulnerable to physical and psychosocial stress factors (Jewkes *et al*, 2009; Pettifor, 2004; Sriprasert *et al*, 2014). As I demonstrate in this study, students in tertiary institutions experience pregnancy as a stressful period. Because social support has been shown to be a buffer against stressful life events, it is imperative for these young women to receive support from their environments to help them cope with the stressors experienced in pregnancy (Voight *et al*, 1996). The ecological systems theory helps illuminate the stressors experienced by pregnant students and at the same time identify their support needs and the challenges associated with receiving support.

7.2.1 Challenges faced by pregnant students

At the micro level, parents play a major role as sources of stress as well as support. Young women are usually dependent on their parents for their material and financial needs. Parents pay for students‟ tuition fees, books and living expenses and have expectations from them regarding their achievement of goals. They therefore see pregnancy as a threat to the achievement of the dreams that their parents have for them. The findings show that parents usually express anger and disappointment when their children get pregnant. Participants reported strained relationships with their parents, particularly their fathers. It has been shown elsewhere that parents of young mothers usually express disappointment with their daughters when they get pregnant whilst still pursuing their studies and this is usually accompanied by sanctions (Zwang & Garenne, 2009; Kaufman *et al*, 2001).

Because of the fear of how their parents will respond to their pregnancy, most young women keep their pregnancy a secret from their parents for extended periods of time. This is a challenge because as this study has shown, young women hide their pregnancy from their parents and other people around them and therefore delay initiation of prenatal care.

At the community level, the fear of stigma from the community was also a factor that contributed to the delay in initiation of prenatal care as young women did not want to be seen at the ANC clinic. This is because according to the cultural values and belief systems in their society, students are expected to complete their studies before they fall pregnant Therefore, social stigma plays a role in delaying prenatal care. These challenges at both the micro- and macro- levels have consequences for maternal and newborn health. This is because late initiation of prenatal care has been linked to adverse birth outcomes such as low infant birth weight (Kost, 1998; Cheng *et al*, 2008). Early management of prenatal conditions such as hypertension, diabetes, anaemia and the implementation PMTCT interventions are also dependent on early initiation of prenatal care in order for them to be successful. Therefore, it is imperative for the health system to encourage early initiation of prenatal care among pregnant students through supportive environments order to mitigate maternal adjustment.

At the micro-level, I found that the strain between young women and their parents results in severe psychological stress during pregnancy. This study also found that parents of pregnant students usually apply sanctions which include withdrawal of financial and material support. This is consistent with the findings by Zwang & Garenne (2008) who found that this is done to deprive them of financial resources to visit friends or buy new chlothes. According to Atuyambe and colleagues (2005), the deprivation of financial resources by their parents could be a form of punishment for „wasting school fees" and the embarrassment to the family. The current study found that this results in stress because they have no income and are dependent on their parents for financial support. Psychosocial stress in pregnancy has a negative impact on pregnancy outcomes (Woods *et al*, 2010). Previous studies have shown that the perceived lack of social support from family is a risk factor for depressive symptoms in pregnancy which have been associated with poor postpartum maternal attachment (Perry *et al*, 2011; Dudas *et al*, 2012). Therefore anxiety and depression during pregnancy does not only have the potential to affect maternal health but could have a negative effect on infant health as well.

The lack of financial resources also affects health seeking among pregnant students because they cannot afford to travel to antenatal clinics. This also has implications for policy because health facilities at universities do not provide ANC services. Therefore, students have to travel, usually by public transport to antenatal clinics which are outside the university. Considering their financial challenges, the health policy-makers need to consider introducing ANC services at clinics in universities so that they may be closer and easily accessible to students.

At the macro-level, it might appear that early childbearing is normalized in modern South African culture (Wood & Jewkes, 2006). However, the socio-cultural context of pregnancy among young women results in social stigma. Pregnant students are stigmatized in the academic environment as well as in the community. This study found that pregnant students are sometimes abandoned by their peers because of the pregnancy. This leads to social isolation, a common effect of pregnancy among young people (Speraw *et al*, 1987; Zwang & Garenne, 2008). Social isolation has been associated with loneliness, emotional distress and depressive symptoms. Experiencing depressive symptoms in pregnancy has consequences for maternal and child health outcomes because it is associated with low birth weight (Wiemann et al, 2005; Evans *et al*, 2007).

The current study found that at the exo-level, social stigma is also experienced by pregnant students at health facilities. This finding is consistent with the results from a previous study by Atuyambe *et al* (2009) which showed that health personnel exhibit a negative attitude towards pregnant adolescents. Attendance of ANC is mandatory in order to access delivery services in South African state health facilities. However, experiencing social stigma at state health facilities is likely to result in young women shunning ANC services. Yet most of them cannot afford to use private healthcare services. Therefore, the attitude of health workers hinders health seeking among young pregnant women.

This has implications for policy because adolescents contribute almost a third of births in South Africa (Pettifor *et al*, 2004). It is imperative for health policy-makers to treat young mothers as important recipients of MCH services because they are susceptible to various obstetric risks (de Vienne *et al*, 2009, Aviram *et al*, 2013). Therefore, the need for pregnant students to access MCH services cannot be overemphasized. Studies on reproductive health among South African youth have also shown that social stigma from health professionals prevents young people from seeking contraceptives at health facilities (Wood & Jewkes,

2006). The department of health needs to intervene by engaging their health promoters to design interventions that train health professionals in MCH services to be more accommodating of young women. This intervention should help change the attitudes of health professionals and reduce the stigma experienced by pregnant students and young women in general.

The study found that pregnant students experience stress when it comes to coping with fatigue, exhaustion, task overload and meeting their academic demands. Young women reported experiencing the most fatigue in the first trimester of pregnancy. However the period of pregnancy that is characterized by the most fatigue has always been a topic of debate among researchers (Behrenz & Monga, 1999; Affonso *et al*, 1990; Elek *et al* 1997). Chou et al (2003) found pregnancy symptoms such as fatigue, nausea and vomiting in the first trimester are associated with maternal depressive symptoms. This results in a negative attitude towards school work due to the lack of zeal for academic work. In this study, I found that experiencing these stressors had negative ramifications on academic performance as they hinder concentration on academic work.

The university environment forms part of the exo-system of pregnant students and excelling in their academic work is crucial for the completion of their studies. At the same time, attendance of ANC services is mandatory and is perceived to be important. The interaction of these two parts of the exo-system poses a challenge for pregnant students. This is because they have to make tough decisions when it comes to choosing between attending classes and seeking healthcare, particularly in the third trimester of pregnancy. This has implications for health policies at the exo-level considering that the campus clinic does not offer ANC services. This means that students have to travel to other clinics to seek ANC and this takes time, during which the students are supposed to attend classes. Therefore the health system- need to consider introducing ANC services at campus clinics to bring the services closer to students and encourage attendance of ANC. Further, this is important because a substantially large number of students get pregnant every year and are in need of these services in tertiary institutions (El- Adas, 2007).

Another challenge that was experienced at the interpersonal level was relationship problems between pregnant students and their partners which were found to be common in the current study. Pregnant students expect to receive support from their partners. However, as shown in previous studies, their expectations of partner support are not usually met. Therefore, this

results in disappointment, conflicts with their partners and sometimes difficult break ups as shown in previous studies (Belle, 1981; Leadbeater *et al*, 1996). Low partner support can be a result of unintended pregnancy (Orr & Miller; kroelinger & Oths, 2000). The current study found that experiencing an unintended pregnancy can lead to the disruption of a relationship. This results in emotional distress for pregnant students who may have to experience pregnancy without the support of their partner.

Pregnant students experience stress due to the instability of their romantic relationships and the conflicts that result from unmet expectations from their partners. This is supported by studies which have shown that the level of perceived partner support is directly related to maternal distress (Dudas *et al*, 2012; Tanner-Stapleton *et al*, 2012). In addition, studies have also associated perceived lack of partner support with infant distress and low infant birth weight (Tanner-Stapleton *et al*, 2012; Shah *et al*, 2014). Therefore, male partner support during pregnancy is important because it has a positive effect on maternal mental health. At policy level, the inclusion of partners has potential to play an important role in maternal mental health interventions.

All these stressors that pregnant students face have repercussions for maternal and newborn health. This study shows that unmarried young women are exposed to a lot stressors because of their age and social status.. Furthermore, being a student contributes to the level of stress because of the academic obligations that they have to fulfill. Stress in pregnancy has been linked to adverse maternal and child health outcomes (Woods *et al*, 2010; Dudas *et al*, 2012). Therefore, in line with Cohen and Will‟s (1985) stress buffering hypothesis of social support, pregnant students perceive social support to be important during pregnancy. I found that pregnant students perceive their pregnancy experience to be better and less stressful when they have a good support network. Previous studies have also shown that perceived social support may have a positive effect on pregnant women causing them to perceive their pregnancy as less stressful (Norbeck & Anderson, 1989; Collins *et al,* 1993; Feldman *et al,* 2000). In the current study, it was also found that perceived lack of social support on the other hand is associated with worry, loneliness, social isolation and emotional distress as shown in other studies (Wiemann *et al*, 2005; Zwang & Garenne, 2008; Dudas *et al*, 2012).

7.2.2 Support needs of pregnant students

The current study explored the support needs of pregnant students and it was found that pregnant students need emotional support, instrumental support, informational support and

financial support. Emotional support was described as having people who are available to share their feelings with, encourage them and show acts of caring towards them. Instrumental support includes receiving help with tasks such as shopping or going for medical check-ups. Pregnant students also indicated that they require informational support which is receiving information on pregnancy, childbirth and how to take care of a newborn baby. Lastly, financial support is needed to buy food, maternity clothes, to cover transport costs and medical expenses and to prepare for the arrival of their unborn baby. All these types of support play a role in fostering positive maternal and child health outcomes. The findings by Feldman and colleagues (2000) indicated that women who receive different types of support from multiple sources in pregnancy have infants with higher birth weights. In addition, Feldman and colleagues (2000) found that women who receive different types of support from several sources are more likely to report a more positive pregnancy experience as compared to women with low support. In this current study, I found that large support networks in pregnancy have a positive influence on maternal and psychological wellbeing.

Among the support needs of pregnant students, emotional support is perceived to be the most important type of support among pregnant students. Acts of caring from people give pregnant students a positive outlook on pregnancy and their impending motherhood and a sense of control of their situation. Given the several challenges that they are faced with, pregnant students need emotional support to enhance wellbeing as they try to cope with these stressful events. Researchers have studied the stress buffering effects of social support and found that supportive environments during pregnancy are likely to result in increased maternal wellbeing and less emotional distress (Cohen & Wills, 1985; Norbeck & Anderson, 1989; Gee & Rhodes, 1999). In the current study, perceived emotional support was also associated with enhanced foetal wellbeing. Pregnant students indicated that receiving emotional support improves their psychological wellbeing which they perceive to have a direct effect on the health of their unborn baby.

There is need to encourage supportive networks among pregnant students to mitigate pregnancy adjustment and foster increased maternal psychological wellbeing. At the exo-level, creating support groups in the academic environment for pregnant students could be a start to linking them with others in their situation and to foster exchange of emotional support. Studies have shown that the reciprocal exchange of support results in greater wellbeing in comparison with being a mere recipient of social support (Maton, 1987; Stevenson *et al*, 1999). Because pregnant students desire to be understood, exchanging

support with people in a situation similar to theirs would be more effective in facilitating greater emotional wellbeing. This is because from my observation during recruitment of participants and data collection, pregnant students were more willing to open up to someone who is or has been in their situation. Therefore, support groups for pregnant students could complement the university counselling facilities which for some students might appear to have a top-down approach. Incorporating these into psychological health services would result in some form of psychological empowerment that would give them a sense of control over their situation (Laverack, 2004).

7.2.3 The support perceived to be the most important among pregnant students

While support from different sources is important for pregnant students, they identified male partner support as their most important source of support. Male partners are expected to take responsibility and be available to offer support to young women throughout pregnancy and after childbirth. I found that the type of support mostly needed from partners is emotional support which includes verbal assurances of support and encouragement. The availability of support from male partners gives young women a more positive attitude towards their pregnancy and assures them that they are not alone thereby reducing emotional distress. Other studies have shown that perceived male partner support is associated with lower maternal and infant distress (Tanner-Stapleton *et al*, 2012). On the other hand, young women indicated that the lack of male partner support results in anxiety, stress, feelings of abandonment, depressive symptoms and pereceived poor foetal wellbeing. Previous studies have associated perceived lack of social support from partners with maternal depressive symptoms and a higher risk of low birth weight infants among adolescents (Dudas *et al*, 2012; Shah *et al*, 2014). Therefore, male partner support plays an important role in increasing the psychological wellbeing of pregnant young women.

7.2.4 Types of support received from male partners of pregnant students

Pregnant students receive different types of support from their partners. However, the level of support that young women received from their partners was dependent on the state of their relationship. Students who reported being in a relationship with the father of their baby received more emotional support as compared to those whose romantic relationships had ended. Relationship quality has an effect on the level of support that a pregnant woman receives from her partner (Stevenson *et al*, 1999; Rini *et al*, 2006). This study found that romantic relationships between pregnant students and their partners sometimes do not survive

until the end of the pregnancy. In fact, most of these relationships become weaker over time (Unger & Wandersman, 1988; Gee & Rhodes, 1999). Therefore, low levels of partner support are common among young women.

The current study found that pregnant students receive financial support from their partners which is usually used to cover medical expenses. However, some young women reported low financial support from partners. This could be because some of the partners were unemployed and did not have abundant financial resources to cater for other needs. However, even some employed partners did not offer much financial support. These findings indicate that relationship quality plays a major role in the benefits that a young woman receives from her partner. Previous studies have shown that unmarried women are less likely to receive financial support from their partners as compared to their married counterparts (Feldman *et al*, 2000). This means that marital status also determines the level of financial support that a woman will receive from her partner. Because of the low financial support from their partners, pregnant students usually depend on their families, especially their mothers for financial support.

Another finding of this study is that male partners usually accompany young women for medical check-ups and scans at private hospitals. However, young women also expressed the desire to have male partners attend ANC with them. This does not usually happen due to the amount of time spent at ANC clinics, the female dominated environment and the negative attitudes from the nurses. Other studies have had similar findings on barriers to partner attendance of ANC (Byamugisha *et al*, 2010; Morfaw *et al*, 2013). Further, during antenatal visits, nurses only ask about male partners but do not necessarily encourage partner attendance of ANC. Therefore, there is minimal influence from the health systems on partner attendance of ANC. Health systems have a role to play in fostering supportive relationships between pregnant women and their partners. Partner support has been shown to positively influence the emotional and physical health of pregnant women (Tanner Stapleton et al, 2012; Ney, 2013). Therefore, encouraging partner attendance of ANC through invitations from the clinics would allow men to accompany their women to the clinics. This could give women the perception that they have a supportive partner and result in increased wellbeing.

Research on HIV/AIDS prevention has shown that male partner involvement at antenatal clinics contributes to the success of PMTCT programmes (Farquhar et al, 2004; Aluisio et al,

2011; Peltzer et al, 2011). Therefore, male partner involvement at clinics not only improves maternal psychological wellbeing but it also influences newborn health in the context of HIV/AIDS. Male partner support can also be used to encourage early initiation of prenatal care and adequate nutrition as well as to discourage negative maternal behaviours such as smoking and alcohol use. Further research needs to be done on the role of the health systems in encouraging male partner support in pregnancy especially among young people who have been shown to be a vulnerable group. There is also a need to explore the perceptions of men on the support that they give to unmarried pregnant partners (students) and how effective they perceive it to be.

7.3 Limitations of the study

This study explored the challenges, support needs and level of male partner support among unmarried pregnant students at the University of KwaZulu Natal, Howard college campus. While any unmarried, pregnant student qualified to participate in this study, only African students participated in this study. The snowball method of sampling that was used meant that the initial participants, who were African students, recommended other pregnant students in their social network, who were also of African descent. As a result, potential participants from other races i.e white, Indian, coloured, e.t.c did not participate in this study. Therefore, the findings could be biased and be a representation of experiences and perceptions of African, pregnant students.

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APPENDICES

APPENDIX A

PROJECT TITLE: Male partner support during pregnancy among young single women in Durban

RESEARCHER

Full Name: Thandiwe Phiri

School: Applied Human Sciences

College: Humanities

Campus: Howard College

Proposed Qualification: Master of social science

Contact: 071 756 3152

Email: thandiwemsipu@gmail.com

SUPERVISOR

Full Name of Supervisor: Dr. Olagoke Akintola

School: Applied Human Sciences

College: Humanities

Campus: Howard college

Email: akintolao@ukzn.ac.za

HSSREC RESEARCH OFFICE

Full Name: Prem Mohun
HSS Research Office
Govan Bheki Building
Westville Campus
Contact: 0312604557
Email: mohunp@ukzn.ac.za

I, Thandiwe Phiri, Student no 214582135, am a Masters student in the School of Applied Human Sciences, at the University of Kwazulu Natal. You are invited to participate in a research project entitled: Male Partner support during pregnancy among young single women in Durban. The aim of the study is to explore the types and level of support that students at the University of KwaZulu Natal receive from their male partners during pregnancy.

Through your participation, I hope to understand your perceptions, challenges as well as support received from your partner during your pregnancy. I guarantee that your responses will not be identified with you personally. Your participation is voluntary and there is no penalty if you do not participate in the study. Please sign on the dotted line to show that you have read and understood the contents of this letter. The interview will take approximately 45 minutes.

APPENDIX B

DECLARARTION OF CONSENT

I……(Full Name) hereby confirm that I have read and understand the contents of this letter and the nature of the research project has been clearly defined priorto participating in this research project.I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Participants signature…….

Date……

APPENDIX C

Interview guide

1. Can you talk about your pregnancy experience.
2. Is this your first pregnancy? If not how is it different from the previous one(s)
3. Aside from your own experience , what do you think pregnancy should be like?
4. Describe some of the challenges you face in your pregnancy ? As a student?
5. What do you think the people around you can do to help you cope with pregnancy? Why?
6. What is the age of your pregnancy? At what stage of pregnancy do you feel you need the most support from family or friends? Why?
7. How/ where are you going to have your baby from? Why?
8. What kind of support do you feel you will need the most after you have the baby?
9. Who is going to help you during that period?
10. What do you think about male partner support during pregnancy? Clinics?
11. To what extent is your partner involved in your pregnancy?
12. From the support needs you have already mentioned, which ones do you feel are the most important to you? Why?
13. Which ones has your partner taken up or has been doing the most?
14. Which ones would you like your partner to give you?
15. What does it mean to you to have your partner support you in those ways/ how do you feel if they don‟t show that support?
16. How does/did the involvement of your partner influence the decisions you make concerning your pregnancy.
17. Do you think there is a positive relationship between partner support and mother and child health?

Appendix D

Socio demographics table of participants and their partners

P	Age	Year of study	Stage of pregnancy	Month of delivery	Residence during semester	Mode of transport to school	Participant's Home outside campus	Partner's Residence and social status
1	20	2nd	2 weeks puerperal	May	Campus residence (on campus)	Walks	Umlazi	Umlazi (Student)
2	19	1st	4 months 3 weeks	October	University residence (off campus	Student"s shuttle	Harding	Harding (Unemployed)
3	19	2nd	7 months 3 weeks	July	Chesterville	Public transport	Richards bay	Chesterville (Employed)
4	21	4th	9 months	June	Springfield	Private transport	Richards bay	Springfield (Self employed)
5	20	1st	6 months	September	Phoenix	Public transport	Phoenix	Campus (Student)
6	25	2nd	6 months	September	Campus residence (on campus)	walks	Newcastle	Pietermaritzburg (Employed)
7	20	2nd	7 months 2 wks	July	Pinetown	Self-driven	Morningside	Morningside (Employed)
8	19	1st	5 months	October	University residence (off campus)	Students shuttle	Hammarsdale	Hammarsdale (Unemployed)

9	19	1st	9 months	June	Hammersdale	Public transport	Hillcrest	Pinetown (Self employed)
10	21	2nd	9 months	July	Montclair	Self-driven	Montclair	Northcoast (Employed)
11	19	2nd	8 months	September	Pinetown	Self-driven	Pinetown	Umlazi (Student)
12	21	3rd	5 weeks puerperal	July	Communal residence near campus	walks	Escombe	Escombe (Employed)
13	20	1st	8 months	September	Savannah park	Public transport	Jozini	Pinetown (Unemployed)
14	19		6 months	October	University residence (off campus)	Students shuttle	Eastern cape	Town (Unemployed)
15	22	4th	8 months	November	Campus residence (within campus)	Walks	Pietermaritzburg	On campus (Student)
16	20	1st	5 months	January	KwaMashu	Public transport	Maphumulo	KwaMashu (Employed)
17	18	1st	7 months	December	Umbilo	Private transport	Umlazi	Umlazi (Employed)

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

17 June 2015

Ms Thandiwe Msipu Phiri 214582135
School of Applied Human Sciences
Howard College Campus

Dear Ms Phiri

Protocol reference number: HSS/0584/015M
Project title: Male partner support among young unmarried pregnant women in Durban

Full Approval – Expedited Application

In response to your application received on 28 May 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: *Research data* **should be securely stored in the discipline/department for a period of 5 years.**

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr **Shamila Naidoo**
On behalf of Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Dr O Akintola
Cc Academic Leader Research: Prof D McCracken
Cc School Administrator: Ms A Ntuli

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: [illegible] / [illegible] / [illegible]
Website: www.ukzn.ac.za

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UNIVERSITY OF KWAZULU-NATAL
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6 May 2015

Ms Thandiwe Msipu Phiri
School of Applied Human Sciences
College of Humanities
Howard College Campus
UKZN
Email: 214582135@stu.ukzn.ac.za

Dear Ms Phiri

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN) towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"Male partner support among young unmarried pregnant women in Durban".

It is noted that you will be constituting your sample by approaching and performing interviews with students who are pregnant and are willing to participate in the interview on the Howard College Campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MR B POO
REGISTRAR (ACTING)