# "I hustle to put food on the table for my children": A Longitudinal Qualitative Analysis Of Financial (In)Security Among Pregnant And Postpartum Women Living With HIV In Cape Town, South Africa

**By**

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"I hustle to put food on the table for my children […] I learnt a lot from my mother […] My mother was not […] dependent on my father, but she was also an independent woman and we never went to bed hungry. I learnt to raise my children the way my mother did." ~P111

## Introduction

### *HIV care (dis)engagement : A Literature review*

The world has seen significant health advocacy efforts following the start of the HIV/AIDS epidemic, which boosted prevention strategies and access to treatment to an unanticipated degree (Brandt, 2013). Despite the significant success in widespread prevention, however, HIV remains prevalent among marginalized communities and populations globally (Crockett et al., 2019; Goldenberg et al., 2017; Kwena et al., 2019). Sub-Saharan Africa, in particular, has the highest HIV prevalence rate – an estimated 25.6 million people in the region lived with HIV in 2021 (WHO, 2022). The World Health Organization identified communities that are at most risk of HIV acquisition (MARPs) globally as follows: men who have sex with men (MSM hereafter), people who inject drugs (PWID hereafter) and commercial sex workers (CSW hereafter); however, in South Africa, young women aged to 15 to 24 are among the most vulnerable populations to HIV acquisition, and they accounted for 88 000 new HIV infections in 2018 (Bisnauth et al., 2020; Marinda et al., 2020).

High HIV prevalence rates among young women are due to both biological reasons (for example, increased biological susceptibility to HIV infection due to co-occurring genital tract infections) and biosocial contexts within which they live – for example, age-disparate transactional sex in low-income young women place them at higher risk of HIV infection (Mojola, 2014; Royce et al., 1997; Shisana et al., 2010). In addition to the biological and

biosocial factors, structural factors place young women in Southern Africa at disproportionately high risk of HIV infection (Harrison et al., 2015). Existing literature has shown a link between gender and HIV acquisition in this context, such as increased risk from gender-based violence against young women (Harrison et al., 2015; Shannon et al., 2012).

Among treatment advocacy efforts on behalf of young women, HIV management for pregnant and postpartum individuals is under-researched. This paper will refer to this sub-population as women living with HIV (WLHIV) in accordance with WHO literature (WHO, 2015). However, the authors recognize that individuals may not necessarily identify with the term "woman" due to differences in gender identity and/or the cultural understanding of the word. Moreover, we recognize that not all the study participants equate an HIV diagnosis with "living" with HIV. For the results and discussion, the word 'mother' is often used to mirror participants' and interviewers' language, as seen in transcripts primarily translated from isiXhosa to English.

In South Africa, all pregnant women who visit a healthcare setting during pregnancy are tested for HIV, and if positive, are started on lifelong antiretroviral therapy (ART) immediately (WHO, 2015). This strategy of starting pregnant women on ART regardless of the severity of their HIV is referred to as Option B+, and has been adopted in multiple (over 90% of) African countries (Maingi et al., 2022). Option B+ has been pivotal to countries' efforts at improving patients' linkage to care after diagnosis (Matthews et al., 2020) as well as Prevention of Mother-To-Child Transmission (Maingi et al., 2022).

Unfortunately, though, the rates of disengagement from HIV care after giving birth in South Africa are alarming (Clouse et al., 2018; Phillips et al., 2014; Psaros et al., 2015). A cohort

study in South Africa found that 49% of pregnant individuals diagnosed with HIV during pregnancy had disengaged from care (missed at least one healthcare appointment or completely failed to show up to healthcare consultations) by six months postpartum (Phillips et al., 2014). The same study also noted that disengagement from HIV care was more than twice higher in the postpartum period compared to the antenatal period, which marks postpartum as a crucial time to understand mothers' needs and ways to support them in their healthcare engagement (Phillips et al., 2014).

In thinking about mothers' ability to remain engaged in healthcare, and their overall wellbeing, it is of paramount importance that literature discusses other aspects of their lives which are intricately linked to their identity, lived experiences, and self-efficacy. For many low-income women in South Africa, postpartum is not only about baby care, but about transitioning back into the workforce or addressing the challenges and transitions that mothers may experience (Luthuli et al., 2020). As Cohen and colleagues argue, "drugs alone will not get us to 90-90-90" (Cohen et al., 2020); it is important that in addition to biomedical interventions, we understand and address the socioeconomic conditions in which individuals live and work.

*Black women's labor participation in South Africa: An overview*

For this paper, we aimed to understand individuals' socioeconomic status through the work they engage in and other external financial support systems they have access to. We define work as any socially organized activity that individuals are involved in, which contributes to their financial income, and does not include uncompensated labor (Glucksmann, 1995). We

use the term "**formal work**" to loosely refer to work that is regularly and consistently compensated by a different entity, and offers stability to the worker; whereas "**informal work**" refers to self-employment and other types of compensated labor within which individuals rely on flexible, inconsistent payment, with little or no job security –such as domestic work and/or seasonal part-time employment.

To understand the current state of employment and labor participation among South African women, we looked at a review by Casale and colleagues that analyzed the changes in employment/labor patterns for South African women between 1994 and 2019 (Casale et al., 2020). In essence, the book chapter uses population data to demonstrate that despite the increased participation of women in the labor market since the end of apartheid, 1. Black women in South Africa face higher unemployment rates than their white female or Black male counterparts; 2. women are compensated at a much lower rate than men; and that 3. mothers in particular are paid much less than other women in South Africa – a socioeconomic concept referred to as the motherhood penalty (Casale et al., 2020; Magadla et al., 2019).

During apartheid, discriminatory policies such as pass laws, which required that all Black individuals carry a passbook if they travelled within the country, limited the geographic and social mobility for many Black South Africans (Cowell & Times, 1985). In comparison, since the end of apartheid in 1994, some progress has been made to encourage more Black women to participate in the economy, such as the Employment Equity Act of 1998 which advocated for equitable representation of women in the workforce (Employment Equity Act, 1998). As such, removing restrictions on the movement of Black South Africans (as well as the areas in which

they could work) after apartheid increased many Black women's job prospects and mobility (Casale et al., 2020).

Regardless of these policy-level strides, in 2019, the unemployment rate among Black South African women was 45%, compared to 11% among their white female counterparts (Casale et al., 2020). Close to half of all working-age Black South African women, therefore, are either in informal employment, or have no means for self-generated income.

That is to say, despite the policy-level efforts toward equitable economic participation and financial security for South African women, there remains a stark disparity in the number of Black South African women that are actually employed. One would assume that, given the alarmingly high rates of unemployment among Black South African women, they are less educated than their male counterparts. However, research shows that South African women tend to be equally as (and sometimes more) educated as their male counterparts (Spaull & Makaluza, 2019) –but the fields which they tend to work, such as healthcare and education, are compensated much less and not nearly as valued (Spaull & Makaluza, 2019).

As a result, Black women in South Africa are not only at an increased disadvantage for employment compared to their white counterparts, but when employed they are compensated at much lower rates than their male counterparts. Moreover, due to other conflicting responsibilities, women are less likely to enroll in postgraduate studies (Spaull & Makaluza, 2019) and are more likely to engage in other uncompensated labor activities such as caring for a family member, child caretaking, and other similar activities. (Magadla et al., 2019).

Relevant to our research population, Posel and colleagues argue that women who are raising children are further burdened by this economic disparity because they are less likely to be living with their intimate partner –and as such– do not have a second income on which to depend (Posel et al., 2016). Given this complex context and the illustrated disparities that affect Black South African women, we expect that an analysis of the financial security of our participants will include not only their employment status, but the structural support mechanisms available (such as the child support grant, the disability grant, or a family member's pension fund); and the presence/absence of financial assistance from their family and/or intimate partners.

*Theoretical Framework: Black Feminist Theory*

It is important to preface this work by acknowledging that Black feminist thought was formed by groups, communities, and societies outside of academia –and continues to be bolstered outside of the academic realm. This paper is "both individual and collective, personal and political, one reflecting the intersection of [communities'] unique biography with the larger meaning of [our] historical times" (Hill Collins, 2000, p. vi).

Patricia Hill Collins indicates that Black feminist thought "explicitly [grounds its] analysis in multiple voices, [highlighting] the diversity, richness, and power of Black women's ideas as part of a long-standing African-American women's intellectual community" (Hill Collins, 2000, p. vii). In a nutshell, Black feminist theory aims to: 1. Expand on traditional feminism by focusing on the lived experiences shaped by the identities that individuals hold (including race,

socioeconomic status, ability, gender, sexual orientation), and how these are shaped by systems of power; 2. Intentionally disrupt traditional power structures by recognizing knowledge creation as a collaborative and communal enterprise (Few et al., 2003; Hill Collins, 2000, p. viii); and 3. Prioritize equity and justice, by identifying the different ways in which systems of oppression operate, and advocate for marginalized and oppressed groups (Hill Collins, 2000, p. 9).

To operationalize Black feminist thought in this paper, our interpretation of the results and discussion uses an **intersectionality** framework. An intersectionality framework helps to understand what factors influence participants' access to financial resources –such as education level, disparities in compensation, and structural violence (Crenshaw, 2019).

Our main research question for this paper aims to explore how WLHIV in South Africa perceive financial security and navigate engaging in care during the pregnancy to postpartum transition using the lens of Black feminist thought. This paper aims to explore financial independence, which is defined as one's ability to cover their financial expenses without relying on others, as well as financial security, defined as one's access to adequate financial resources such that their needs are regularly met.

## Methods

*PAM study recruitment*

This paper is based on secondary analysis of data from a larger study (Pregnancy, Adherence, and Motherhood, or PAM study) which was conducted in Cape Town, South-Africa between March 2018 and May 2019 (DiClemente-Bosco et al., 2022). Recruitment was done at Gugulethu Midwife Obstetrics Unit (GMOU) –a healthcare facility in Gugulethu, following these criteria: a) individuals 18 years or older, b) at 32-35 weeks of pregnancy, c) diagnosed with HIV (information for which was obtained from clinic records), d) prescribed antiretroviral therapy, and e) fluent in isiXhosa or English. The exclusion criteria included a) participation in another HIV treatment-related study, b) being classified as high risk for factors other than HIV, and c) inability to fully comprehend the consent process.

Participants were recruited from amongst pregnant mothers in the waiting room awaiting their antenatal consultation. A trained study recruiter on-site identified participants who were diagnosed with HIV –from clinic records– and spoke with each potential participant privately to explain the study. Following informed consent, 30 pregnant individuals were enrolled in the study. The PAM study aimed to identify social, cultural, and structural factors that influence women's treatment adherence during pregnancy and postpartum. This paper, in particular, uses data collected from the PAM study with an aim of exploring participants' perception of financial security during pregnancy and postpartum, and understanding how their illness may (or may not) influence this experience.

*Study design and data collection*

The qualitative study utilized semi-structured in-depth interviews which were conducted with thirty individuals during late pregnancy, and followed up 3 more times until 1 year postpartum. These timepoints were selected by the study team to reflect transitions in mothers' experiences: timepoint 1 was during **late pregnancy** (n = 30); timepoint 2 at **6 to 8 weeks postpartum** (n = 26, attrition n=4); timepoint 3 at **4 to 6 months postpartum** (n=23, attrition n = 7); and timepoint 4 at **1 year postpartum** (n = 25, attrition n=5).

More details about the development of the interview guide and the research team can be found in one of the primary publications from the PAM study (DiClemente-Bosco et al., 2022). Interviews were conducted in isiXhosa or English (as per the participant's preference) by a trained member of the research team in Gugulethu –who identifies as Xhosa[1], then translated and transcribed in English. After each completed interview, participants received a ZAR100 (equivalent to $10 at the time) food voucher as reimbursement for their participation.

*Data analysis*

This paper uses an analysis of interviews from **pregnancy** (n=30) and **4 - 6 months postpartum** (n=23) to offer a longitudinal perspective and reflect changes in mothers' expectations with returning to work, partner/family financial support, and what financial stability looked like. The interview guide[2] for pregnancy specifically asked about the participants' employment and socioeconomic status, whereas the interview guide for 4 – 6

[1] COREQ attached
[2] Socioeconomic status sections of interview guides 1 and 3 in Appendix d

months postpartum asked generally about available resources and the support that participants receive/need. This paper analyzes responses from these sections, but also incorporates related responses throughout the interview, such as participants' mention of their families' and/or partners' financial support.

Data from 1 year postpartum (timepoint 4) were excluded from this analysis because the interviews were relatively short and lacked the richness that would generate an insightful analysis. In addition, a precursor to this paper, which was submitted for an undergraduate thesis by M.K., focused solely on 6 – 8 weeks postpartum (timepoint 2), which captured the transition from childbirth, and mothers' experiences of returning to work, or looking for jobs in this respect. The authors, with guidance from colleagues and mentors, decided to conduct analysis for the current paper by comparing timepoints 1 and 3, which would offer a rich discussion through the longitudinal lens; without distilling the potential depth that can be understood from each individual timepoint.

The longitudinal qualitative analysis is modeled after a description of longitudinal analysis by Tuthill and colleagues (Tuthill et al., 2020). The data analysis was primarily done by M.K, with feedback from J.P., A.D.H., as well as members of the Women's Health Interventions and Transitions research group –information about whom is provided in the COREQ attached to this submission. J.P. was the Primary Investigator on the parent study, and A.H. was her research mentor in this study, thus both are thoroughly familiar with the data and the study setting.

Firstly, M.K. familiarized herself with the data by reading through the 53 transcripts and writing notes as part of the audit trail[3]. Black feminist thought was chosen as the primary theoretical basis of analysis after this familiarization step, due to participants' responses about empowerment, agency, and financial support. Secondly, M.K. read through the transcripts again, and used thematic content analysis for the two cross-sections (timepoints 1 and 3) separately to generate themes. For this step, she drew from Green and Thorogood's explanation of thematic content analysis (Green & Thorogood, 2018), and used NVivo software for data management (released in March 2022). M.K. imported an a priori codebook which had been developed for timepoint 2 analysis[4] into NVivo for this analysis, and included additional inductive codes that were specific to the new timepoints[5].

She then used open coding, followed by reiterative coding to revise the coding structure and draw major themes from the two separate timepoints. For rigor, M.K. then discussed the major themes from each cross-section with J.P. and the WHIT research team, and built on feedback to draw a comparison between the two timepoints. Comparison was done between the two timepoints using a matrix (attached as part of the supplemental data) with each of the main themes. The main themes were discussed with both J.P and A.D.H. and further refined. Finally, M.K. cross-referenced the comparison matrix with the team's research coordinator in Cape Town –N.T., to ensure that the findings were appropriately translated.

[3] Audit trail will be attached to supplemental data in future iterations
[4] Initial codebook available in Appendix b
[5] Final codebook available in Appendix a

## Results

This analysis is based on a total 53 interviews: 30 at enrollment (late pregnancy) and an additional 23 interviews at the follow-up point of 4 – 6 months postpartum. At enrollment, exactly one-third of the participants were first-time mothers. Moreover, 30% of the participants had at least completed high school (Table 1). A substantial proportion of participants reported not being involved in formal employment at the time of data collection –83 % at enrollment and 87% at 4-6 months postpartum (Table 1).

A significant proportion of the participants were eligible for, and received the national child support grant. The child support grant is a social assistance grant disbursed through the South African Social Security Agency (SASSA) to eligible low-income women with children. This grant is available to South African citizens who earn less than R52 800 a year (R4 400 a month) if single, or less than R105 600 a year (R8 800 a month) total if married (Department of Social Development (National), n.d.). In our study, almost half (43%) of mothers at enrollment, and over two-thirds (70% of the remaining participants) at 4-6 months postpartum received the child support grant funds.

Table 1. Sociodemographic characteristics of study participants

| **Demographic characteristics at enrollment** | | | |
|---|---|---|---|
| **Age (N = 28)** | | **Highest education level attained (N=30)** | |
| **Younger than 20** | 1 (3%) | No formal education | 0 (0%) |
| **20 - 29** | 15 (54%) | Some high school | 21 (70%) |

| | | | |
|---|---|---|---|
| **30 - 39** | 10 (36%) | High school - completed | 8 (27%) |
| **40 to 49** | 2 (7%) | Some college/University | 1 (3%) |
| **First-time mother? (N=30)** | | **Married?** | |
| **Yes** | 10 (33%) | **Yes** | 1 (+3 living together) |
| **No** | 20 (67%) | **No** | 26 (12 single, 14 divorced) |

| **Socioeconomic status** | | | |
|---|---|---|---|
| | **At enrollment (pregnancy) N = 30** | **At 6 to 8 weeks postpartum (not included in this analysis) N = 26** | **At 4 to 6 months post-partum N = 23** |
| | | | |
| **Social grants** | | | |
| **Child grant** | 13 (43%) | 12 (46%) | 16 (70%) |
| **Disability grant** | 0 (0%) | 0 (0%) | 0 (0%) |
| **Care dependency grant** | 0 (0%) | 0 (%) | 0 (0%) |
| | | | |
| **Employment type** | | | |
| **Informal work** | 4 (13%) | 0 (0%) | 0 (0%) |
| **Formal employment** | 5 (17%) | 0 (0%) | 3 (13%) |
| **Homemaker** | 14 (47%) | 21 (81%) | 19 (83%) |
| **In school** | 2 (6%) | 1 (4%) | 0 (0%) |
| **No employment, or actively looking for a job** | 5 (17%) | 4 (15%) | 1 (4%) |
| **Total** | 30 (100%) | 26 (100%) | 23 (100%) |

Note: Values included in table 1 are calculated as percentages of the remaining participants at the respective timepoint. Our analysis offers a comparison of the themes at each timepoint, not

of each unique participant across timepoints. Values for the descriptive characteristics at 6 - 8 weeks postpartum have been included in the table, to provide context, but this timepoint is thoroughly analyzed in a separate paper that is yet to be published (Kopeka et al., 2022).

It is important to reiterate that financial stability for a lot of the participants is not merely about being formally employed; but spans a variety of factors (individual, communal, and structural) which many of the mothers have to negotiate on a daily basis for their livelihood. The major themes derived from the longitudinal analysis illustrated that between late pregnancy and 6 months postpartum; participants were often unable to continue working (at least in the same capacity), which led to a strain on their available financial resources. This strain was further exacerbated by, and directly affected, the increasing costs related to the healthcare needs of the mother and newborn. As a result of the financial strain, many participants had to depend on financial assistance from their partners and from their families. However, this support was often unreliable and/or disempowering for the participants, and infringed on their sense of agency.

**Theme 1: There was an increased financial strain on participants between pregnancy and 6-months postpartum, due to a limited ability to (return to) work and the unique health needs of the mother and newborn.**

During late pregnancy, many of the participants reported that they were not working at the time. A small proportion of the participants (5 out of 30 at enrollment) were in formal employment. For individuals in formal employment in South Africa, they may receive benefits during the maternity leave from the Unemployment Insurance Fund (Unemployment Insurance

Contributions Act, 2002), though this is not mandatory. However, for the majority of the participants engaged in informal work, the transition period was an uncompensated hiatus – which created a gap in their income. For some participants, this gap acted as a barrier to accessing healthcare services – e.g., for transportation to the hospital when needed. When asked, "have you experienced not going to a clinic or work because you do not have money?", P116 responded, "Yes, there are those times, but it doesn't happen often, its rare because I know my dates so I save money". Participants who were self-employed were particularly vulnerable to pronounced financial precarity, either because they were unable to work as usual during this period, or due to the unreliable nature of running a business. For example, P112, who rented out a room at the back of her house, faced food insecurity when her tenants did not pay rent on time. She said, "for instance, when I do not have food, my sister helps me a lot because sometimes my tenants do not pay rent and I rely on that rental income".

In comparison, at postpartum, participants noted an increased strain on their already limited financial means, resulting from their healthcare needs, and the new baby's basic needs. To illustrate, P108, who was looking for jobs at 6 months postpartum, could not afford to take her sick baby to the doctor. "It has been raining and we are staying far away to walk to [named] clinic and we didn't have money to take a taxi which is costing R8.00". In this instance, the parental work hiatus exacerbated the participant's financial insecurity; and affected not only her own ability seek necessary healthcare, but that of the newborn as well.

Amidst the financial strain during postpartum, many low-income participants in informal work were unable to return to work earlier to make up the income gap, often because they could not afford childcare. The inability to return to work earlier created a cycle of financial

precarity that further strained the participants' financial ability. P111, who ran a business selling baked goods, explained her limited ability to work as thus, "I find it difficult sometimes to do other things since I have a baby to take care of. For example: I cannot go out to sell when it is cold […] I put my baby on my back when I am going out to sell my stuff and I have to stop before time when she is tired on my back". As illustrated, the transition to postpartum saw an increased financial need for healthcare costs and baby's care –which was unfortunately juxtaposed with a restricted ability to generate the necessary income.

Although the child support grant could be used to alleviate this financial strain, participants found the application process burdensome and inaccessible. To apply for the grant, a child's parent or caretaker has to provide the child's birth certificate, the caretaker's national identification document, the caretaker's proof of income, and proof that the applicant is the primary caretaker. Once the application is processed and approved, the caretaker receives a monthly stipend (currently valued as ZAR480 or USD28) per month for each child. Due to the process outlined above, caretakers can only apply for the grant and receive the grant after a child is born.

P112, for example, when asked what she was looking forward to the most, said "I am glad that we will receive the child support grant. […] at least I won't suffer too much […] It will help me I'll be able to buy nappies and milk for the baby." Unfortunately, however, many participants found the application process difficult to navigate. For example, P112 was not fully aware of the necessary steps to apply for a grant but was eligible to receive the funds for her older child. When asked about the grant, she expressed her confusion "I thought I can only make a birth certificate after giving birth", to which the interviewer explained "for [the current

pregnancy] you can only do it after giving birth. Remember you have got a child that doesn't have a birth certificate and who needs it".

At postpartum, participants similarly expressed that the grant application process was complex, time-consuming, and decentralized, which acted as a barrier to accessing the funds soon after the new baby's birth. P101 in particular struggled to apply for the child support grant after giving birth: "when I visited [the social security agency] I was told that some of the machines were not working. About two weeks ago when I was there the fingerprint machines was not working, the following week I was lazy to go then last week I was there, but they returned me because I did not have an affidavit. They didn't even explain to me or tell me whether I should come back, but tomorrow I am going there again. By five o'clock I should be there, five o'clock or half past four in the morning". P101 compared the application process to a "death sentence".

Amidst inaccessible social assistance programs, a majority of our participants (who are in informal work) faced considerable financial precarity during late pregnancy and postpartum, which was an additional barrier to accessing healthcare.

**Theme 2: To navigate the limited financial resources, participants often depended on financial assistance from their partner (and/or their partner's family) and their own family.**

Given the financial precarity that participants anticipated and faced during this transition, many had to depend on their interpersonal networks for financial assistance. Our participants often relied on the financial support of their partner (or their partners' family) and their own family. However, participants expressly stated that they wished to "make [their] own money" (P105) and to have the ability and agency to "do things on [their] own" (P109).

### a. Uncertainty of the partner's financial support

Many participants mentioned that they received some financial support from their partners. However, many of the mothers expressed dissatisfaction with relying on their partner for financial assistance, or having to ask for money. When asked, "does your partner support you [financially]?" by the interviewer, P105 replied, "yes, but you will never be satisfied as a woman. A woman always wishes to have her own money." Some participants made a clear distinction between receiving financial assistance from their partners, and requiring this assistance. The latter is void of choice, and was justifiably less preferred. P115 phrased it as thus "I am independent […] When my child was sick I never asked anything from [my partner] and I never forced him to support me with anything, so I never required any assistance from him". In this instance, the participant was proud of her independence in that she had the ability to take of her older child without the need for her former intimate partner's involvement.

Along a similar vein, during postpartum, participants felt that needing a partner's financial support deprived them of their self-esteem as a good mother to their child. To illustrate, P107's

thoughts about needing her partner's financial support were: "it makes me feel small, my sister, because I do not have any confidence because I do not provide for my kids. I feel that I live to make responsibilities for other people, so it makes me feel very small".

In addition, participants often expressed that they were anxious about the uncertainty associated with their partner's financial support. For some mothers, this uncertainty was due to the fear that their partners would leave them after childbirth, and it affirmed the need to find other avenues for income, independent of their partner. P115 feared that "the father of the child [would] cheat or leave [her and the baby], so [she] shouldn't be depending on him". P107 echoed this fear by saying, "fathers to our babies happen to change in a long run. […] I don't want to be his burden […] I want to learn to be independent".

Given the lived experiences (as shared by the participants) and the transitions faced by some of the participants by 6 months postpartum, this was undeniably a justified worry for the expecting mothers. Although for some mothers, they were no longer in a romantic relationship with the newborn's father by 6-months postpartum, a prevalent occurrence among participants was that some of their partners lost their jobs or sent money less reliably, and thus –with the new baby – they faced an increased pressure on the already-scarce financial resources available.

This sub-theme introduces a nuance between participants' need for independence and agency, contrasted with the need for mutual support during this transition period. Participants stated that they wished to have their own money –which is an avenue for independence – but also equally expressed the need for reliable support when available. As such, having one's own

money would mean that a participant has greater agency over her own decisions, but having a supportive partner who offers reliable support (inclusive of financial) was also appreciated.

### b. Partner's and Participant's family contributing to childcare

Given the uncertainty in employment that some participants' partners faced, their families tended to support the newborn and the mother by either buying food or taking on the responsibility of childcare. This was done both within and outside the context of marriage. For context, only one of the participants reported being married, with an additional three participants who actively lived with their partners.

During pregnancy, this support usually occurred as a discussion around future plans for "raising the child". In this context, raising the newborn meant that the newborn's paternal/maternal family offered to take on the daily responsibilities of living with the newborn, often in the Eastern Cape, while the mother looked for a job or found a way to sustain the child financially in the city of Cape Town. P114, who planned on going back to school postpartum, said that she would leave her baby with her partner's sister, "we both agreed [to the baby staying with the father's sister …] and also I want to go back to school", she said.

Similar to P114, participants who planned on returning to work earlier than anticipated counted on their family and their partners of their family to provide childcare. When asked by the interviewer, "if perhaps you would get a job before the baby is six months old, where would

you have the baby kept during the time you were at work?", P125 (the one married participant) answered "I can leave it with my mother-in-law" –who also lived in/around Cape Town.

When the child was 4 to 6 months old, a lot more mothers were faced with the reality of navigating the process of job applications, re-entering school, or thinking of ways to become financially independent. When asked by the interviewer, "when are you planning to go back to work?", P112 replied, "I am planning to look for jobs in December and I have asked my partner to travel with my baby to Eastern Cape …As long as I will have a chance to look for jobs in December. […] I don't have a nanny to take care of my baby because […] I don't have money to pay for a nanny since I am not working". In this case, her partner's family is not directly offering money for the baby's needs, but rather, they are offering an equally valuable service of taking care of the baby (and its needs) while the mother navigates the job re-entry process.

In this theme, participants tapped into their interpersonal networks to offer support during the pregnancy to postpartum transition. Although some forms of support were seen as disempowering, such as requiring partners' financial support when the participant had no income at all; childcare support from the newborn's paternal and maternal families eased the job seeking process and enabled earlier work return.

**Theme 3: Participants equated being a "strong, independent woman" with financial security, and often navigated ways to become financially independent.**

During pregnancy, mothers were often hesitant to reach out to their family for financial support, because they perceived this as burdening them. When asked about her financial support structures, P106 said, "My sister doesn't demand her money back but I feel guilty [depending on her] because she is unemployed". Similarly, when asked about her future motivations for returning to work, P108 said "I don't want to be a burden to my mother […] I don't want to depend on her financially; I want to buy nappies and clothes for my baby out of my pocket without asking money from my mother". While P106 emphasizes that her family, in addition to their financial support, is already under a lot of financial strain; P108 reiterates an aforementioned motif: wanting to take care of her child herself, and have her own income.

Although participants were not always able to help their family members financially, they mutually offered help with chores or caretaking tasks for the family's other children. P107 felt that she contributed to her family in both ways: "[My sister] is older than me. She spends most of her time at work, when she is at work, I am responsible to take kids to preschool […] When they come back, they [sit] and play with the baby and I would look after them. My sister is the one who buys almost everything we need at home, but at times when she is stranded, I also borrow transport money for her from my partner to buy bus tickets". In this dynamic, the participant not only takes care of her sister's children, but the participant and her partner sometimes offer financial support to her sister. This reciprocity of assistance (financial or otherwise) seems to be more empowering to the participant.

Participants' understanding of financial ability was deeply intertwined with their self-perception as "strong, independent women[6]", who could take care of their children. This wording was used in the interview guide based off of previous research on women's empowerment in sexual health decision-making in Cape Town (LoVette et al., 2022; Sullivan et al., 2018). In this respect, mothers not only wanted to reduce their reliance on family members for financial support, but they wanted to be able to sustain their own children. P103 said: "I wanted to go back to school but I had to think about who is going to put food on the table for my baby?[…] I had to drop out from school and work for my baby". This perception of what a strong, independent woman ought to look like seemed to be both an individually and a communally formed identity.

In a similar manner, P111 shared a comparable definition of independence, which was largely influenced by her admiration of her own mother**, "I hustle to put food on the table for my children when my husband is unable do it […] I learnt a lot from my mother […] My mother was not […] dependent on my father, she was an independent woman and we never went to bed hungry. I learnt to raise my children the way my mother did to us**". For cultural context, "hustling" could look like taking short-term jobs or day shifts, doing manual labor, etc. to generate an income. Like P103, P111 linked strength to being able to afford her child's needs. Both women's definitions were deeply inscribed in their positionality as women who had to navigate motherhood and find their own strength within extremely disenfranchising contexts.

[6] Wording used directly in interview guides

## Discussion

Our results indicate that WLHIV in Cape Town, South Africa face financial precarity during the transition from late pregnancy to at least 6 months postpartum. In our study sample, participants' inability to continue working during late pregnancy or to return to work in early postpartum, created a gap in their regular sources of income. This transitional period is also associated with rising health-related costs (such as transportation to a clinic) for both the mother and the newborn, further exacerbating the financial strain.

Although many of our participants were low-income and would be eligible for the national child support grant, some participants found the application process challenging to navigate, time-consuming, and that services were decentralized. By 6 - 8 weeks postpartum (refer to table 1), the proportion of participants who received the child support grant (46% ) was fairly similar to during late pregnancy (43%). Granted that this proportion increased to 70% by 4 to 6 months postpartum, the rate at which the application was approved is concerning – especially for time-sensitive needs such as food and transportation to the clinic.

As a result of the financial precarity, many participants had to rely on their intimate partners and/or family for financial assistance or financial assistance during late pregnancy and early postpartum, which participants often reported as disempowering. Many participants perceived gaining financial stability – whether through returning to work or eventually getting the child grant support funds – as tantamount to being a "strong independent woman".

The limited literature about women in informal work in South Africa has also highlighted financial precarity during pregnancy and postpartum (Luthuli et al., 2020), as indicated by our findings. Recent research in South Africa has shown that women who are not formally

employed tend to have a disproportionately unreliable sources of income during pregnancy and postpartum compared to their counterparts in formal employment (Horwood, Hinton, et al., 2021; Luthuli et al., 2020). Consistent with this literature, our main findings show that during pregnancy, mothers' ability to work was limited, and they anticipated getting support from institutional structures such as the child support grant. However, our participants mentioned that the application process was difficult to navigate, a challenge which was discussed in more detail in the literature (Luthuli et al., 2022).

Although Luthuli and colleagues have contributed commendably to the informal work literature in recent years — by doing research with young, low-income South-African women (Horwood, Haskins, et al., 2021; Horwood, Hinton, et al., 2021; Luthuli et al., 2020, 2022)—their study population is not specific to WLHIV; and does not address the unique needs faced by WLHIV; such as a need for more rigorous engagement in care. In our study, we found that the financial precarity women face may act as a barrier to continuing to access healthcare—which would be detrimental to the dyad. Our research goes a step further, by understanding the financial needs of these young, Black South African women from pregnancy to postpartum and factoring mothers' HIV status into our analysis.

Prior research in South Africa has also echoed our findings about the importance of interpersonal networks in providing financial assistance during the pregnancy to postpartum transition, which led to lower rates of food insecurity among women who received this additional support (Horwood, Haskins, et al., 2021). Our qualitative analysis complicates the apparent financial support by integrating participants' perception of agency and independence – which were not explored in the referenced cross-sectional survey.

Even though during pregnancy, our participants mentioned that they either expected to or received financial support from their male partners, existing data in South Africa indicates that male partners tend to disengage from this financial support postpartum (Carnelley, 2012). Even in the instance that a male partner is mandated by the court to provide monthly child maintenance payments, these responsibilities are rarely complied with (Carnelley, 2012). It is therefore unsurprising that participants in our study viewed a partner's financial support as an unreliable source of income, and that a longitudinal analysis of our data showed a noticeable change in male partners' involvement in the participant's and newborn's economic support.

*Contextual analysis*

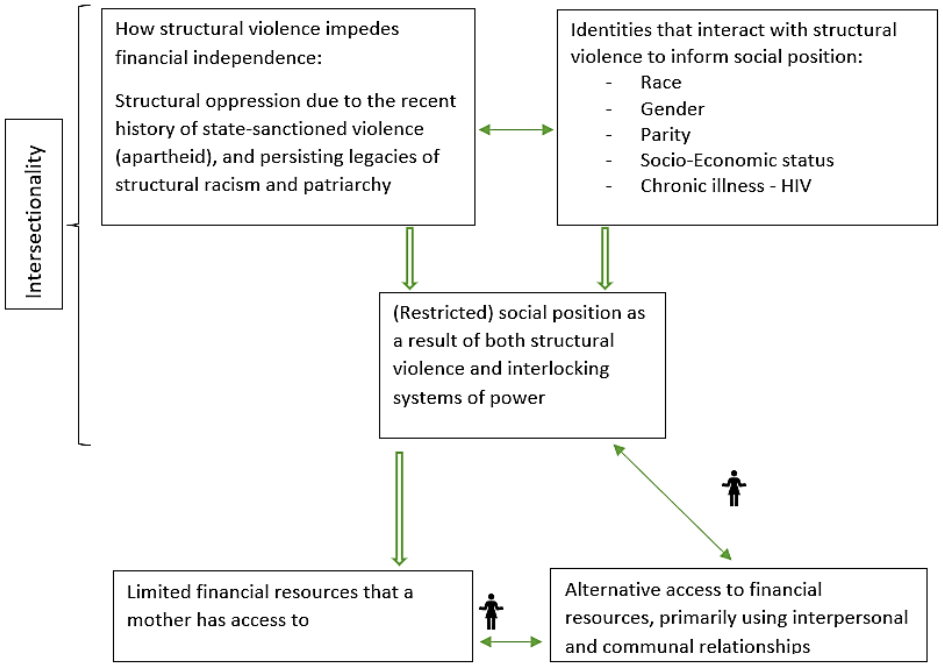
The heightened economic (in)security for the participants in this study as well as black South Africans more broadly, must be understood within the historical and social context within which they live. Following South Africa's transition to a democratic nation in 1994, following 48 years of the apartheid regime, legislation and other efforts to address societal inequalities have been put in place. Due to the unequal distribution of assets and wealth which resulted from the confluence of these racially-based systems, and continue to persist, Black South Africans are the poorest subpopulation in South Africa, and at an increased disadvantage from gaining economic mobility ("Unpicking Inequality in South Africa," 2021). In addition to the persisting economic injustice that Black South Africans face, Black South African women continue to be sidelined from the labor economy, or compensated at significantly lower rates when they do find employment (Posel et al., 2016).

Our participants are at a unique social position of being Black, female, low-income individuals living with HIV, all of which interact with structural violence at both a macro and micro scale. Structural violence can be broadly understood as social structures that systemically and adversely impact individuals or groups of people (Farmer et al., 2006). Due to interacting systems of racial and gender oppression, our participants, and the average Black woman in South Africa, are at a significantly higher disadvantage from obtaining adequate employment, which also impacts their ability access healthcare.

The unavailability of equitable labor laws to protect low-income women in the informal sector (which is another form of structural violence) meant that individuals who are pregnant or have children are at a disproportionate risk of financial precarity because, given their low education attainments, could not access jobs that provide maternity benefits. Moreover, in contrast to their HIV-negative counterparts, our participants were expected to attend healthcare appointments more frequently postpartum, to access both their individual HIV care and their baby's care. In their instance, baby healthcare consisted of not only routine immunization appointments, but prophylaxis care to prevent vertical HIV transmission. The need to access healthcare more frequently further limited their ability to work and/or exacerbated their financial strain.

Figure 1 below illustrates our analysis and interpretation of participants' experience using an intersectionality framework. Our analysis explains the interaction between participants' social positions regarding their race, gender, parity, socio-economic status, and HIV status [top right box in figure 1]; and the additional interaction between this social position and systems of power [top left box in figure 1] including systemic racism and misogyny.

*Figure 1 Conceptual framework*




Key:

Interacting factors

Factor contributing to an outcome

Participants as agents in affecting change

Although intersectionality helps to understand the unique and shared challenges Black South African women living with HIV experienced, our research suggests the need to explore individual and communal resilience when confronted with financial precarity. This is introduced in the bottom half of figure 1 . In our study, participants often depended on community and interpersonal support during the pregnancy to postpartum transition, to lessen the financial gap and dearth of structural support mechanisms. Therefore, these findings suggest the need to focus, going forward, on women's resilience and how frameworks of resilience contribute to women's coping in the face of precarity.

*Strengths and Limitations*

Recruitment for this study was conducted out of a healthcare facility; and thus, excluded individuals that have no access to healthcare services. However, South Africa has Universal Primary Healthcare, which explicitly includes free access to antenatal care –and is available to refugees and asylees as well (Refugees Act, 1998). Additionally, data collection for this study was done between March 2018 and May 2019, and has thus not been able to capture any impacts due to the COVID-19 pandemic and associated public health measures. From our review of recent literature, research has shown that women in South Africa were among the most affected sub-populations by the COVID-19 pandemic, due to their overrepresentation in the people-facing service industry, and the implications of South Africa's strict lockdown on their ability to work were dire (Casale et al., 2020).

A notable strength of this research is that it centers the voices of WLHIV in this context, and asks specifically what their experience has been, which is characteristic of Black feminist work. The longitudinal nature of analysis further allows for a nuanced scrutiny of the (un)available financial support structures for low-income families postpartum. Although the parent study was not tailored for Black feminist thought in particular, the interview guide asked specifically about participants' independence, perceived strength, and their identity as (primarily) Xhosa women in South Africa –which allowed for a rich analysis of identity, social position, and systems of power.

*Implications and recommendations*

Although some challenges faced by our participants are unique to being pregnant and having an HIV diagnosis, the results may be transferable to other contexts in which individuals living with chronic illness do not receive adequate support postpartum. We recommend earlier disbursement of child support grant funds by SASSA, which would give mothers adequate time to get the required documents for their application –such as proof of income. Perhaps caregivers could apply for the SASSA grant during late pregnancy –when they would typically stop working – and the first funds would be dispersed well ahead of childbirth to cushion the transitional financial strain.

However, a long-term, critical recommendation is that employment fields that are typically female-dominated be compensated just as much as traditionally male-dominated fields. Similarly, we recommend that Black South African women be intentionally recruited for educational and career opportunities, not merely to fill a quota, but that they are adequately supported within the educational system and in their professional development.

In addition, we recommend that individuals living with chronic illness, inclusive of HIV, receive transportation assistance to healthcare facilities particularly during late pregnancy and postpartum when this might be most needed. To operationalize this recommendation, local healthcare facilities could utilize mobile clinics, which are already in use for COVID-19 testing services (Ridgard & Dalal, 2022) to reach participants who live in townships that are further from healthcare facilities.

Finally, we recommend additional childcare support for low-income mothers such as a subsidy for nursery/creche fees; such that mothers can return to work earlier if they wish. This

support could also be in the form of a grant specifically for an informal caregiver, separate of the child support grant. Caregiving is an invaluable form of labor that demands time, effort, and incredible emotional support. It is only right that those who provide childcare are as cared for, not only by their families/partners/communities, but on a structural level equally.

## Conclusion

This paper has touched on a number of structural, communal, and interpersonal level factors that influence individuals' ability to remain in care postpartum. Among other factors, financial security was a prominent factor for our study participants. To build on the robust foundation laid by HIV activists for subsidized ART; it is important that we provide sufficient and context-informed support for individuals diagnosed with HIV –especially among communities that are historically and/or systemically disadvantaged.

For our participants, and perhaps other low-income Black WLHIV in South Africa, implementing Option B+ was an important first step to starting individuals on necessary HIV treatment. Next, it is imperative that financial barriers to accessing care (such as transportation costs, expensive childcare, or the unavailability of paid maternity benefits for informal workers) be addressed appropriately. As seen in our research; parents living with HIV do their absolute best to seek healthcare for themselves and their newborns, but this is significantly limited by interlocking systems of power and oppression within which they live.

## Reflexivity statement

My professional background is in Public Health; I am currently a student completing my Master of Public Health program at Brown University. Although I identify as Southern-African, and have spent the formative years of my life (the first 18 years) in Lesotho, my tertiary education training has been in the United States –and thus my academic work is heavily influenced by North American pedagogy. I am cognizant of the different communities, cultures, and backgrounds that have influenced how I perceive the world. My identities as a Black, low-income, and African woman are inextricably linked to my general interest in women's health; from my decision to look into financial independence among WLHIV, to my analysis and interpretation of the findings. As a young Mosotho woman, my experience with the HIV pandemic in my community introduced me to public health –and continues to influence my interest in advocacy and social justice within health.

For these reasons, my undergraduate honors thesis used an intersectionality praxis. I wanted to learn about the illness experience of individuals at a higher risk for HIV acquisition, and how they navigate the systems of power within which they live. Although my thesis project felt necessary to my intellectual growth, I felt that it was not nearly enough. My wish was to use a framework that not only acknowledged the disparities, but went a step further in exploring ways in which communities have navigated their circumstances, and negotiated for improved resources for themselves. This is why I chose Black feminist thought for this paper.

My aim is for this research to primarily benefit the communities of people with whom it was conducted. In the longer term, my goal is for this paper to form a part of advocacy efforts for more equitable support for WLHIV and low-income mothers in South Africa.

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Appendices

A. Codebook

| Name | Description | Files | References |
|---|---|---|---|
| 1. Breastfeeding | This includes the decision whether or not to, as well as the timing of breastfeeding, and how this impacts the decision to (or experience to) re-enter the workforce | 36 | 61 |
| 1.1. Decision on feeding method | Initially one code of breastfeeding, which was later broken down to timing and decision. Decision on feeding method will indicate a mother's active choice to either breastfeed, formula feed, or mix feed, and the reasons (only related to work re-entry) that impacted this decision. | 25 | 36 |
| 1.2. Initial concerns about breastfeeding | Specific to timepoint 1; this code will be for specific concerns that pregnant moms may have about breastfeeding. | 1 | 1 |
| 1.3. Timing of breastfeeding | Initially one code of breastfeeding, which was later broken down to timing and decision for feeding method. Timing of breastfeeding will indicate a mother's planned breastfeeding timeline, and any justification behind this decision. | 21 | 24 |
| 2. Childcare and work | Emerging code frm timepoint 2. This code includes a mother's decision for childcare, the barriers and facilitators to childcare, as well as feelings regarding childcare, in the context of returning to work or looking for a job. | 45 | 104 |
| 2.1. Baby staying with family members | Within childcare, this code is used to indicate a mother's consideration of or feelings about leaving the newborn with a family member, or taking the newborn to live with family elsewhere, in deciding on work (re-)entry. | 25 | 38 |
| 2.2. Friend or community member taking care of child | | 2 | 2 |
| 2.3. Kindergarten or Creche | Within childcare, this code is used to indicate a mother's consideration of or feelings about taking the newborn to a creche or kindergarten. | 9 | 11 |
| 2.4. Nanny or paid professional | Within childcare, this code is used to indicate a mother's consideration of or feelings about leaving the newborn with a nanny or similar paid caretaker, in deciding on work (re-)entry. | 16 | 19 |

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|---|---|---|---|
| 2.5. Plan to take care of current baby | | 23 | 33 |
| 3. Communicating birthplan with employers | | 3 | 4 |
| 4. Competing interests between work and postpartum | This includes a participant's direct mention of competing interests that may act as barriers to work (re-)entry | 20 | 40 |
| 4.1. Baby's healthcare needs | This indicates a baby's unique needs that may act as barriers to a mother's work return, such as baby getting sick often, thus making job seeking a challenge. | 3 | 4 |
| 4.2. HIV and return to work | This will include the mother's considerations of her HIV treatment and care, and how this plays a role in her work (re)entry experience or considerations. | 19 | 34 |
| 5. Employment type | Timepoint 1, this code will be used to discern whether moms are 1. completely unemployed, 2. part-time employed, 3. full-time employed, or 4. self-employed | 50 | 118 |
| 5.1. full time regular employment | this code will be used for individuals with full-time employment, which isnt self-employment | 7 | 15 |
| 5.2. no income or employment at all | Some people may say they are unemployed, but then go on to say they sell a few things here and there. This code is only for individuals who have no means of generating their own income at all | 38 | 83 |
| 5.3. Still in school | This code is for participants who are still in school | 9 | 21 |
| 5.4. part-time employed | This code will be used for individuals who work less than 5 days a week | 8 | 10 |
| 5.5. self-employed | | 6 | 10 |
| 6. Fertility decisions related to work and income | Emerged from timepoint 1, at P118. This code indicates amother's feeling about her current birth, or future ones, based off her income or financial situation | 8 | 9 |
| 6.1. Family influence on fertility decisions | This code is used for scenarios where a family's financial support (or lack thereof) influences a mother's decisions or feelinsg about fertility | 0 | 0 |
| 6.2. Partner influence on fertility decisions | This code is used for scenarios where a partner's financial support (or lack thereof) influences a mother's decisions or feelinsg about fertility | 3 | 4 |
| 7. Financial motivations for going to work | This will include the mother's financial reasons behind her decision to return to, delay or not return to work. It will be in terms the mother's | 33 | 87 |

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| | financial status, and not include the partner's financial (in)ability –which will be coded in the partner's indirect role in the mother's decision. | | |
| 7.1. Financial freedom or independence | Emerging code from timepoint 2. This includes a mother's perceived financial independence as motivation for returning to work or looking for a job. e.g. Participant 105 Interviewer: What motivates you to return to work? Participant: I would like to play a role of meeting my husband halfway but that doesn't mean he is unable to do everything on his own. I don't want to depend on him all the way. | 26 | 55 |
| 7.2. Need for baby support financially | Emerging code from timepoint 2. Includes a mother's perceived need for the financial ability to take care her baby, and the perception of this need as a motivation for returning to work. | 21 | 27 |
| 7.3. Unexpected arising financial needs | Specific to timepoint 2 and 3, this code will be used for expenses that arose unexpectedly for the mom, such as unforeseen baby expenses for childcare | 1 | 1 |
| 7.4. Unexpectedly lost their previous financial support | Emerging code from timepoint 3. Specific to timepoint 2 and 3, this code will be used for an unexpected situation which 'forced'/accelerated mom's need to go back to work. For example, separation from a partner who provided financial support | 3 | 4 |
| 8. Following policy recommendations | This code indicates a participant's mention of following clinic recommendations in the context of deciding on her work (return), whether these acted as barriers or facilitators to work return. | 27 | 58 |
| 8.1. Clinic recommendations about feeding | Within policy recommendations, this code indicates participants' mention of, or discussion about clinic recommendations regarding their feeding method. | 10 | 13 |
| 8.2. Seeking baby healthcare | Within policy recommendations, this code indicates participants' mention of, or discussion about clinic recommendations regarding seeking healthcare for the baby. | 19 | 30 |
| 8.3. Seeking healthcare for self | Within policy recommendations, this code indicates participants' mention of, or discussion about clinic recommendations regarding seeking healthcare, such as referral to different clinics, decision on follow-up dates, etc. | 13 | 15 |

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| 9. Future plans for financial need | | 6 | 13 |
| 9.1. Plan to continue her studies | | 4 | 7 |
| 9.2. Plan to find formal employment | | 3 | 5 |
| 10. Interpersonal relationships that affect decision to work | The people involved in the mother's work (re-)entry experience. It will involve three subthemes: Partner relationship, Family, and Friends | 35 | 82 |
| 10.1. Community and friends and return to work | Community and Friends: Includes the participant's other immediate support structures such as neighbors, close community members. e.t.c e.g. P126 My plan was my mother to look after her, but she has got a job now. My baby's aunt is also available but she lives in (location name removed) but I wouldn't like to take her to the aunt because I will also have to go stay there with them which I am not preparing to do. | 2 | 2 |
| 10.2. Family and return to work | Includes the participant's immediate family, as well as the partner's family, who are involved directly or indirectly in the mother's work (re-)entry experience e.g. of active involvement: P126 Participant: There is another lady who stays in (location name removed) she said she is available to look after my baby, but we haven't finalized this offer because she spoke with my mother. e.g. of passive involvement: P108 Interviewer: You have mentioned that you would like to go back to work? | 19 | 30 |
| 10.3. Partner relationship and return to work | Partner relationship: Includes both the active and passive involvement of the mother's intimate partner in her decision to go to work. e.g of active involvement: P110 Interviewer: When would you like to go back to work? Participant: I had a conversation with my partner yesterday confessing how much I love my baby and I can't leave him (my baby) at all. I said I prefer to go back to work when he is one year old. | 33 | 50 |
| 11. Mother's feelings about returning to work | this broad code will explore the mother's feelings in relation to going (back) to work, how these influence her decisions, and how these play into her overall work (re-)entry experience | 15 | 26 |

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| 11.1 Anticipation | Includes general feeling of worry, anxiety, stress, fear or panic. This may be related to the mother's HIV status, or just general worries about the baby | 1 | 1 |
| 11.2. Duty | Includes the mother's feeling of responsibility towards the baby, or to herself e.g. P104: Interviewer: What motivates you to return to work? Participant: I don't want to depend on others. | 3 | 7 |
| 11.3. Empowered | Emerging code from tmepoint 2. Includes a mother's feeling of empowerment (anticipated, experienced, or perceived) in regard to returning to work. | 10 | 16 |
| 11.4. Hesitation | Includes a mother's hesitation or apprehension when asked about their plan to return to work or look for a job | 0 | 0 |
| 11.5. Worry | Initially coded as trust. Includes feelings of worry about security when making a decision about the baby's care, and how it factors into the mother's work (re-)entry experience e.g. deciding on a creche vs getting a nanny vs a trusted family member | 2 | 2 |
| 12. Other sources of financial support | This code will be used for sources of financial support that are nto from the mother herself. It will include finacial support from the partner, from her family, from social support grants | 48 | 192 |
| 12.1. Anticipated child grant for current baby | In timepoint 1, this code will be used for a mother's plan to apply for a child grant on behalf of the new baby. However, in timepoint 3, it will include a mother's plan to apply for the grant, a grant that is being received, AND current ongoing grant applications –all on behalf of the newborn. | 9 | 18 |
| 12.2. Barriers to getting baby's grant | Will include a mother's stated challenges to getting the grant for the newborn | 3 | 7 |
| 12.3. Facilitators for applying to current child grant | Will include factors that help the grant application or receipt process | 2 | 2 |
| 12.4. Family financial support | This code will be used for mentions of the mom getting financial assistance from her family. This includes her partner's family support, but excludes her partner's direct support | 30 | 57 |
| 12.5. Friend or community financial support | | 3 | 4 |

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| 12.6. Partner financial support | This code will be used for mentions of the partner providing financial support | 43 | 99 |
| 12.7. Previous birth child grant | This code will include financial support that mom gets from the child grant of other children she is raising | 10 | 14 |
| 13. Structural support for work (re-)entry | This code indicates structural support that influences work return, but is primarily concerned with HIV treatment adherence, such as adherence clubs, counselling, etc. | 12 | 23 |
| 13.1. Adherence club | This indicates a participant's mention of their previous or current involvement with an adherence club. From the interviews, adherence clubs are a form of HIV retention intervention that enrols participants with a low viral load, and entice their continued adherence by providing quicker service, pre-packaged medication, and fewer follow-up demands. | 10 | 20 |
| 13.2. Social support groups and social workers | This includes any organized social support such as counselling and meeting with social workers. | 2 | 3 |

B. Initial codebook developed from previous paper

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| 1. Breastfeeding and its impact | Breastfeeding : This includes the decision whether or not to, as well as the timing of breastfeeding, and how this impacts the decision to (or experience to) re-enter the workforce |
| 1.1. Decision on feeding method | Initially one code of breastfeeding, which was later broken down to timing and decision. Decision on feeding method will indicate a mother's active choice to either breastfeed, formula feed, or mix feed, and the reasons (only related to work re-entry) that impacted this decision. |
| 1.2. Timing of breastfeeding | Initially one code of breastfeeding, which was later broken down to timing and decision for feeding method. Timing of breastfeeding will indicate a mother's planned breastfeeding timeline, and any justification behind this decision. |
| 2. Childcare and work | Emerging code. This code includes a mother's decision for childcare, the barriers and facilitators to childcare, as well as feelings regarding childcare, in the context of returning to work or looking for a job. |
| 2.1. Baby staying with family members | Within childcare, this code is used to indicate a mother's consideration of or feelings about leaving the newborn with a family member, or taking the newborn to live with family elsewhere, in deciding on work (re-)entry. |
| 2.2. Kindergarten or Creche | Within childcare, this code is used to indicate a mother's consideration of or feelings about taking the newborn to a creche or kindergarten. |
| 2.3. Nanny or paid professional | Within childcare, this code is used to indicate a mother's consideration of or feelings about leaving the newborn with a nanny or similar paid caretaker, in deciding on work (re-)entry. |
| 3. Competing interests between work and postpartum | This includes a participant's direct mention of competing interests that may act as barriers to work (re-)entry |
| 3.1. Baby's healthcare needs | This indicates a baby's unique needs that may act as barriers to a mother's work return, such as baby getting sick often, thus making job seeking a challenge. |
| 3.2. HIV and return to work | This will include the mother's considerations of her HIV treatment and care, and how this plays a role in her work (re)entry experience or considerations. |
| 4. Financial motivations for going to work | Financial Motivations: This will include the mother's financial reasons behind her decision to return to, delay or not return to work. It will be in terms the mother's financial status, and not |

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| | include the partner's financial (in)ability –which will be coded in the partner's indirect role in the mother's decision. |
| 4.1. Financial freedom or independence | Emerging code. This includes a mother's perceived financial independence as motivation for returning to work or looking for a job. . e.g. Participant 105 Interviewer: What motivates you to return to work? Participant: I would like to play a role of meeting my husband halfway but that doesn't mean he is unable to do everything on his own. I don't want to depend on him all the way. |
| 4.2. Need for baby support financially | Emerging code. Includes a mother's perceived need for the financial ability to take care her baby, and the perception of this need as a motivation for returning to work. |
| 5. Following policy recommendations | This code indicates a participant's mention of following clinic recommendations in the context of deciding on her work (return), whether these acted as barriers or facilitators to work return. |
| 5.1. Clinic recommendations about feeding | Within policy recommendations, this code indicates participants' mention of, or discussion about clinic recommendations regarding their feeding method. |
| 5.2. Seeking baby healthcare | Within policy recommendations, this code indicates participants' mention of, or discussion about clinic recommendations regarding seeking healthcare for the baby. |
| 5.3. Seeking healthcare for self | Within policy recommendations, this code indicates participants' mention of, or discussion about clinic recommendations regarding seeking healthcare, such as referral to different clinics, decision on follow-up dates, etc. |
| 6. Interpersonal relationships that affect decision to work | This indicates the people involved in the mother's work (re-)entry experience. It will involve three subthemes: Partner relationship, Family, and Friends |
| 6.1. Community and friends | Community and Friends: Includes the participant's other immediate support structures such as neighbours, close community members. e.t.c<br>e.g. P126 My plan was my mother to look after her, but she has got a job now. My baby's aunt is also available, but she lives in (location name removed) but I wouldn't like to take her to the aunt because I will also have to go stay there with them which I am not preparing to do. |
| 6.2. Family | This includes the participant's immediate family, as well as the partner's family, who are involved directly or indirectly in the mother's work (re-)entry experience<br>e.g. of active involvement: P126 Participant: There is another lady who stays in (location name removed) she said she is |

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| | available to look after my baby, but we haven't finalized this offer because she spoke with my mother.<br>e.g. of passive involvement: P108 Interviewer: You have mentioned that you would like to go back to work? |
| 6.3. Partner relationship | Includes both the active and passive involvement of the mother's intimate partner in her decision to go to work.<br>e.g of active involvement:<br>Interviewer: When would you like to go back to work?<br>P110: I had a conversation with my partner yesterday confessing how much I love my baby and I can't leave him (my baby) at all. I said I prefer to go back to work when he is one year old.<br>e.g. of passive involvement:<br>P103 Participant: No but the challenged I have faced w |
| 7. Mother's feelings about returning to work | Mother's feelings: this broad theme will explore the mother's feelings in relation to going (back) to work, how these influence her decisions, and how these play into her overall work (re-)entry experience |
| 7.1. Anticipation | Anticipation: Includes general feeling of worry, anxiety, stress, fear or panic. This may be related to the mother's HIV status, or just general worries about the baby |
| 7.2. Duty | Includes the mother's feeling of responsibility towards the baby, or to herself e.g. P104: Interviewer: What motivates you to return to work? Participant: I don't want to depend on others. |
| 7.3. Empowered | Emerging code. Includes a mother's feeling of empowerment (anticipated, experienced, or perceived) in regard to returning to work. |
| 7.4. Hesitation | Includes a mother's hesitation or apprehension when asked about their plan to return to work or look for a job |
| 7.5. Worry | Initially coded as trust. Includes feelings of worry about security when making a decision about the baby's care, and how it factors into the mother's work (re-)entry experience e.g. deciding on a creche vs getting a nanny vs a trusted family member |
| 8. Structural support for work (re-)entry | This code explores other forms of structural support which are intended to facilitate returning to work or to ease the work hiatus during the postpartum period. |
| 8.1. Maternity leave | This code indicates a participant's mention of, or discussion about maternity leave, whether paid or unpaid. |
| 8.2. Social grants | This code indicates a participant's mention of, or discussion about social grants received from the government, whether they are already receiving this grant. |

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| 8.3. Support for treatment adherence | This code indicates structural support that influences work return, but is primarily concerned with HIV treatment adherence, such as adherence clubs, counselling, etc. |
| 8.3.1. Adherence club | This indicates a participant's mention of their previous or current involvement with an adherence club. From the interviews, adherence clubs are a form of HIV retention intervention that enrols participants with a low viral load, and entice their continued adherence by providing quicker service, pre-packaged medication, and fewer follow-up demands. |
| 8.3.2. Social support groups and social workers | This includes any organized social support such as counselling and meeting with social workers. |

C. Interview guides – socioeconomic status

Interview guide at enrollment – Section 6

**6. Socioeconomic Status**

*This section of the agenda is intended to investigate how socioeconomic status (including employment and education) impacts access to HIV and other care during pregnancy, as well as, socioeconomic status as a stressor in anticipation of life postpartum.*

**LEAD QUESTIONS:** In addition to your personal and cultural beliefs, there are other things that impact how women access healthcare when they are pregnant, including money and transportation. Have you had any financial difficulties in getting HIV care?

**Follow-up Questions: Note to interviewer: reflect back on stories/narratives described previously to follow-up on these types of questions. i.e. You mentioned X previously, how does trying to maintain a job impact that?**

1. Do you currently have a job?
    a. How does this impact your ability to see the doctor?
    b. How does your job impact your ability to get or take you medications?
    c. Do the people in your life support your managing work along with your pregnancy? Tell me about a time when you felt supported in this.
    d. How do you think this will change once the baby comes?
2. Are you currently in school?
    a. How does this impact your ability to see the doctor?
    b. How does school impact your ability to get or take you medications?
    c. Do the people in your life support your managing school along with your pregnancy? Tell me about a time when you felt supported in this.
    d. How do you think this will change once the baby comes?
3. Does your family or partner provide any financial support?
    a. How do you they provide financial support? What does it go towards?
4. How do you feel about receiving financial support from your family or partner?
    a. Do you feel the need to repay your family or partner for the financial support they provide? If so, how do you repay them?
5. Aside from financial support, in what other ways do you feel your family or partner assist you in treatment or pregnancy? What about when the baby comes?
6. Is there any other experience you've had with reproductive or HIV health that you would like to share? Do you have any questions about your experience today at the clinic?

Interview guide at 4 – 6 months postpartum – Section 8

**8. Resources**

*The intention of this section of the interview is to inquire about the types of support participant feel they or other women living with HIV need.*

**LEAD QUESTION:** What help or support do you think you or other women need to assist with adjusting to life after baby? (Probe for community resources, clinical resources, family, etc.)

***Follow-up Questions:***

1. What help do personally you currently receive?
2. How do you wish things would be different?

**LEAD QUESTION:** What kinds of support do you think you or other women living with HIV need that you are not getting?

***Follow-up Questions:***

1. What is the hardest thing about being a new mother living with HIV?
2. If you could receive any kind of help with that challenge, what would it be?

**LEAD QUESTION:** Is there anything that we have not talked about today that you would like to talk about?