Teen Pregnancy in South Africa:

A literature review examining contributing factors and unique interventions

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EXECUTIVE SUMMARY

Background

Teen pregnancy is a global issue. It disproportionately affects young women around the globe on many levels, and may limit future opportunities for teens. Globally, the teen birth rate is declining; however significant regional disparities persist. Global adolescent fertility rates range from 121 per 1,000 in sub-Saharan Africa to 5 per 1,000 in Eastern Asia (WHO, 2011). Among the countries in Sub-Saharan Africa, which have some of the highest rates of teen pregnancy globally, South Africa’s rate is lowest and comparable to those in many middle-income countries (Macleod & Tracey, 2010). However, because young people under age 18 make up 50% of the population in South Africa (Reddy et al., 2010), teen pregnancy undermines future opportunities for many women in the population (Panday et al., 2009), and all young women who experience pregnancy may be subject to social disadvantages due to gender-based discrimination and violence as well as limited growth opportunities in education and occupation.

Aims/methods

This literature review – conducted mostly in 2013 – aims to describe the prevalence, contributing factors and consequences of teenage pregnancy in South Africa. Unless otherwise specified, “adolescents” will indicate young people age 15 to 19. English-language reports in peer-reviewed literature published after 1995 which focuses on a pre-selected set of criteria is included. The review attempts to balance literature that portrays teenage pregnancy as a social problem with literature that discusses teenage pregnancy from a human-rights perspective. This is critical given that early pregnancy is a choice for some young women. Finally, we provide a summary of recommendations for interventions that address teenage pregnancy.

Results

There are limited statistics on teenage pregnancy and fertility in South Africa (Panday et al., 2009), and considering the available data, there are inconsistencies in the teenage fertility rate. However, using the best available data, it is clear that teenage fertility in South Africa – approximated at 54 to 65 per 1,000 depending on the source – is lower than in most Sub-Saharan African countries, and it is declining.
The contributing factors for teenage pregnancy can be related to the individual herself, social/structural/environmental factors and the interaction between the individual and her social/structural/environmental situation. Sexual activity and contraceptive use (or non-use) are the two most immediate contributors. By age 17, half of all South African teenagers are sexually active (Rachel Jewkes et al., 2009). On average, males initiate sexual activity by age 16, and females initiate one year later, by age 17 (Panday et al., 2009). Early marriage is an important issue to consider and address when considering sexual activity; however, both married and unmarried adolescents become pregnant. In South Africa, extra-marital teen pregnancy is high, as the median age of marriage is 28 or 29 (Rachel Jewkes et al., 2009; Lam, Marteleto, & Ranchhod, 2008; Macleod & Tracey, 2010).

The contraceptive prevalence rate (CPR) in South Africa is one of the highest in Africa with 59.8% of married women using a modern form of contraception (Department of Health et al., 2007), and this rate appears to be increasing (Macleod & Tracey, 2010). However, the high rate can be misleading. It varies greatly according to region and education level, and younger, unmarried women are largely left out of this statistic. When all sexually active women (ages 15 to 49) are considered, contraceptive prevalence drops to 50% (Department of Health et al., 2007). In South Africa individual-level concerns and structural barriers prohibit many young women from using contraception; one significant barrier is health providers’ negative attitudes regarding adolescent sexuality.

Other major contributors to teenage pregnancy in South Africa include gender-based violence, poverty, and lack of access to high quality sexual education and comprehensive reproductive health services. Jewkes et al. (2001) found that pregnant teens in South Africa were more likely than their counterparts to have experienced intimate partner physical abuse and forced sex (Rachel Jewkes et al., 2001). The poorest teens in South Africa are Black African (Rachel Jewkes et al., 2009), and teens who become pregnant are more likely to be poor, Black African and Coloured (Mkhwanazi, 2010). Pregnancy during one’s school-going years can have significant negative effects such as: exacerbating poverty, disrupting or limiting educational and occupational attainment, and limiting future opportunities for the child (Department of Health et al., 2002, 2007; Karra & Lee, 2012; Marteleto, Lam, & Ranchhod, 2008; Panday et al., 2009; Richter et al., 2006). The overall impact of education on health and other outcomes is clear: women who have not exceeded grade five in school have the highest fertility rates and earliest age of sexual debut (Department of Health et al., 2007).

Finally, it is important to consider teenage pregnancy not just as a consequence of poor decisions or oppressive environments. Preston-Whyte suggested in the 1980s that, for some young women in communities marked by poverty, high unemployment and school drop-out, early
childbearing presented a route for upward social mobility (Mkhwanazi, 2010). This observation is still present today. For many young women, pregnancy may be seen as positive because a cultural value is placed on childbearing as marker of femininity and fertility. For some, becoming pregnant may be a rational and conscious decision made in light of particular circumstances rather, than merely something that happens (Mkhwanazi, 2010).

Discussion

Globally responses or interventions addressing teenage pregnancy vary greatly and differ in terms of their effectiveness. Many advocates promote structural interventions instead of interventions that focus on individuals because programs focused on individual behavior change (usually for adolescent girls), such as increasing contraceptive uptake, do not address the factors that adolescents cannot control. Structural interventions may focus on: changing cultural norms to allow women more power in family planning decision-making; reducing socioeconomic disparities; improving opportunities for schooling; reducing gender inequality and violence; and enforcing comprehensive policy and programming with “zero tolerance” approaches to sexual coercion (Leclerc-Madlala, 2008; Underwood, Skinner, Osman, & Schwandt, 2011). In South Africa, given the focus on schools as the vehicle for delivering “life orientation” training, improving the quality and effectiveness of this training is key.

In addition to structural interventions, many researchers also emphasize engagement of certain sectors of the population. Many highlight a lack of engagement with men as an issue to address in order to improve pregnancy and other reproductive health outcomes (Rachel Jewkes et al., 2009; Patricia Thuli Mngadi, 2003; Richter et al., 2006). Interventions including engagement with parents may also be helpful in terms of providing better health outcomes for adolescents. Finally, community involvement in all interventions is key.

Whether teen pregnancy is a social problem on its own or a symptom of many other social problems and disparities, “what we do know is that the high incidence of teenage pregnancy places great strain on the individual, her child, her family, and society as a whole,” (Cunningham & Boult, 1996, p. 697). Teenage pregnancy and early childbirth are concerning public health problems, and they deserve unbiased attention from health professionals, policy makers, educators, and community members (P.T. Mngadi et al., 2002).
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1. INTRODUCTION

Teen pregnancy is a global issue. It is also a complex social problem with many contributing factors that vary by region and require special, targeted interventions. It disproportionately affects young women around the globe on many levels, and may limit future opportunities for teens.

In 2008, an estimated 16 million young women age 15 to 19 gave birth (WHO, 2011). Many more young women were pregnant in 2008. There is an important distinction between pregnancy rates and birth rates. Birth rates are synonymous with fertility rates and refer to the number of pregnancies that result in live births per 1,000 women. Thus the 16 million figure does not capture teen pregnancies that ended in termination, miscarriage, or stillbirth (Kost & Henshaw, 2012; Panday et al., 2009).

The World Health Organization [WHO] defines “adolescents” as young people age 10 to 19 (WHO, 2006, p. 4). Pregnancy and birth among adolescents who are 10 to 14 years of age is rare in most countries. However, in some sub-Saharan African countries, 0.3% to 12% of adolescents give birth before turning 15 (WHO, 2011).

Globally, the teen birth rate is declining; however significant regional disparities persist. In 1990, the global fertility rate (births per 1,000 adolescents) was 60 per 1,000. In 2007 the rate decreased to 48 births per 1,000 adolescents. In 2008, 95% of teen births worldwide occurred in middle- and low-income countries. Global adolescent fertility rates range from 121 per 1,000 in sub-Saharan Africa to 5 per 1,000 in Eastern Asia (WHO, 2011). By comparison, the adolescent pregnancy rate (including births, stillbirths, terminations, and miscarriages) in the United States [U.S.] in 2008, although double the average adolescent pregnancy rate of other developed countries (Rowbottom, 2007) was 68 pregnancies per 1,000 adolescents, and 40 births per 1,000 adolescents age 15 to 19.

The average number of births per 1,000 women for the world’s least developed countries is five times the average adolescent fertility rate of more developed countries (Rowbottom, 2007). One third of adolescents give birth before age 20 in developing countries (Patel & Kooverjee, 2009; Rowbottom, 2007). In Sub-Saharan Africa, more than 50% of teens give birth before age 20, and in certain countries in the region, this figure is as high as 70% (Rowbottom, 2007).

Among the countries in Sub-Saharan Africa, which have some of the highest rates of teen pregnancy globally, South Africa’s rate is lowest and comparable to those in many middle-income countries (Macleod & Tracey, 2010). However, because young people under age 18 make up 50% of
the population in South Africa (Reddy et al., 2010), teen pregnancy undermines future opportunities for many women in the population (Panday et al., 2009), and all young women who experience pregnancy may be subject to social disadvantages due to gender-based discrimination and violence as well as limited growth opportunities in education and occupation.

2. AIMS

This literature review aims to describe the prevalence, contributing factors and consequences of teenage pregnancy in South Africa. Due to scarce data on adolescent pregnancy under age 15 (Rowbottom, 2007), this review will largely refer to teen pregnancy and birth among adolescents age 15 to 19. Unless otherwise specified, “adolescents” will indicate young people age 15 to 19. Data regarding the sexual behaviors of teenage males, age 15 to 19, and the role of older males in teenage pregnancy are included in the literature review to illustrate gender disparities. The review attempts to balance literature that portrays teenage pregnancy as a social problem with literature that discusses teenage pregnancy from a human-rights perspective. This is critical given that early pregnancy is a choice for some young women. Finally, we provide a summary of recommendations for interventions that address teenage pregnancy.

3. METHODOLOGY

Between March-July 2011 and December 2012 and February 2013, several research databases [Academic OneFile (Gale), Access World News, Africa Bibliography (Cambridge), Gender Studies Database (EBSCO), Health Reference Center (GALE), PsycINFO, and PubMed (Medline)] were used to locate articles for possible inclusion in the review. Appendix A provides detail regarding the specific search terms used. The first 100 citations retrieved per search term, per database were reviewed for eligibility. Article and report abstracts met the inclusion criteria if: 1) they were English-language reports in peer-reviewed literature 2) published after 1995, and 3) matched the pre-selected content areas listed in Appendix A. Articles that met these inclusion criteria were imported into an electronic library using the reference management software, Zotero [http://www.zotero.org].
Data from global and national studies and governmental and non-governmental sources are included. International and South African news media have been excluded, with a few exceptions, due to limited ability to analyze the content for reliability. Books and dissertations/theses were also excluded from this literature review. New and old literature libraries were merged to create the final literature library for this review. Please see the reference list at the end of this document for a complete bibliography of the literature included.

4. RESULTS

4.1 South African prevalence

South Africa has one of the lowest overall fertility rates of all sub-Saharan African countries with a rate of 19-22 births per 1,000 women age 15 to 49, depending on the source providing the data (Kaiser Family Foundation, 2012; Panday et al., 2009; PRB, 2012; UNFPA, 2010). By comparison, the fertility rate in sub-Saharan African ranges from 14 per 1,000 in Mauritius to 55 per 1,000 in Niger (UNFPA, 2010). Teenage fertility in South Africa is also lower than in most Sub-Saharan African countries, and it is declining. However, teenage fertility is much higher than fertility for women overall with rates varying between 54 and 65 per 1,000 – also depending on the source (this is addressed in detail below).

There are limited statistics on teenage pregnancy and fertility in South Africa (Panday et al., 2009), and considering the available data, there are inconsistencies in the teenage fertility rate. These inconsistencies may be attributed to variance in methodologies, study aims, and different populations studied at different time periods. The primary sources that are often cited are:

- the South Africa Demographic and Health Surveys [SADHS], which were conducted in 1998 and 2003 (Department of Health, Medical Research Council, & ORCMacro, 2002, 2007);
- two studies attributed to South Africa’s Department of Basic Education (EMIS, 2012; Panday et al., 2009; Richter et al., 2005);
- the 2003 Reproductive Health Research Unit survey on HIV and sexual behavior of youth (Pettifor et al., 2005); and
- the South African Youth Risk Behavior Survey 2008 conducted by the Medical Research Council (MRC) (Reddy et al., 2010).
Each source provides valuable information regarding the factors that contribute to the prevalence of teen pregnancy, however, the reliability of the data must be interpreted with caution, provided some data are more than fifteen years old. Also, for making comparisons over time, one must consider that these studies used different methodologies and may not actually be comparable.

SADHS data are often taken as the most reliable or used when international or chronological comparisons are necessary given that DHS methodology is the same across surveys and countries. However, 2003 SADHS data should be used with care. For this survey, there were reported fieldwork problems in KwaZulu-Natal that significantly impacted the reliability of the national fertility data; the survey found the overall fertility in the province to be about 25 percent lower than that observed anywhere in the world (Department of Health et al., 2007). The 2003 SADHS showed a 27% decline in adolescent fertility from 1987-89 (74 per 1,000) to 2003 (54 per 1,000) (Rachel Jewkes, Morrell, & Christofides, 2009). Given the problems with the 2003 SADHS data, Jewkes, Morrel and Christofides (2009) reviewed the issue and reported that even more conservative estimates confirm a significant decline in teenage pregnancy since 1998 (Jewkes et al., 2009, p. 678). The 2007 South African Community Survey census reported an adolescent fertility rate of 54 per 1,000 (Panday et al., 2009; United Nations Millennium Development Goals Indicators, 2012).

South Africa’s Department of Basic Education [DBE] also reported a decline in adolescent fertility over time from RSA census data and literature review. However, the DBE reports a slower decline than the percent decrease found by the DHS. In 2001, the census found a fertility rate of 65 births per 1,000 adolescents, which was a 16.6% decline from 1996 (78 per 1,000) census data (Panday et al., 2009, p. 21). The only data that indicates a trend of increasing teenage fertility in recent years (between 2004 and 2008) is derived from the Education Management Information System [EMIS], which is data representative of learners attending school. In 2004, the DBE, using data from the EMIS, found a rate of 51.42 per 1,000; this rate increased to 62.81 per 1,000 in 2008. However, the EMIS sample is not nationally representative, and the variant result may be from improved reporting or data capturing abilities (Panday et al., 2009).

The first and second MRC National Youth Risk Behavior Surveys (2002, 2008) surveyed a nationally representative sample of male and female adolescent learners in grades 8 to 11, and pregnancy rates in this learner population increased in the 5 years between surveys. The second MRC Youth Risk Behavior Study [YRBS] (2008) reported that 19% of participants had been pregnant or made someone pregnant (Reddy et al., 2010). The first YRBS (2003) found the prevalence of pregnancy was 16% (Reddy et al., 2003).
According to a literature review in the 2003 Status of the Youth Report [SYR], more than 40% of young women in the country have given birth by age 20 (Richter et al., 2005). The survey for the SYR report was a nationally representative study of 3,500 men and women age 18 to 35 from all provinces. Thirty percent of the respondents to the SYR (men and women) reported that they have children.

In 2003, Pettifor et al (2005) completed a nationally representative household survey of young South Africans, age 15 to 24 to collect information on HIV prevalence. The study found that nearly half (48%) of adolescents age 15 to 19 were sexually active, with no statistically significant difference in gender. Pettifor et al (2005) also found a higher proportion of prior pregnancy among 15 to 19 year olds (33%) than the DHS (16.4%) and the MRC (19.0%) (Department of Health et al., 2002; Pettifor et al., 2005; Reddy et al., 2010).

South African adolescent fertility rates vary by race; it is highest among African (71 per 1,000) and Coloured (60 per 1,000) teens, followed by Indian (22 per 1,000) and White (14 per 1,000 (Reddy et al., 2010). These differences may be accounted for by disparities in education, unemployment, health care access, and poverty experienced by teens in African and Coloured communities. Yet, even when those factors are controlled for, variances in fertility by race persist, “indicative of cultural differences with regard to pregnancy,” (Panday et al., 2009).

Fertility rates also vary by region in South Africa. According to the 2003 SADHS, a greater percentage of adolescents living in rural areas (14%) have become mothers than those adolescents living in urban areas (11%) (Department of Health et al., 2007). However, adolescent fertility is declining in both urban and rural locations. Comparing the 1998 SADHS to the 2003 SADHS, there has been a 15% decrease in adolescent fertility in urban areas, and a 34% decrease in adolescent fertility in rural areas. The DBE (2009) found the highest rates of learner pregnancies in KwaZulu-Natal, the Eastern Cape, and Limpopo, and the MRC found the highest rates of learner pregnancies in Limpopo (Panday et al., 2009; Reddy et al., 2010). Gauteng and the Western Cape have the lowest fertility rates (Reddy et al., 2010). The DBE suggests that the difference between urban and rural fertility rates is due to increased access to education, economic development, and more access to contraceptive services in urban areas (Panday et al., 2009).

4.2 Contributing factors and outcomes

The contributing factors for teenage pregnancy can be related to the individual herself, social/structural/environmental factors and the interaction between the individual and her
social/structural/environmental situation. This is illustrated by figure 1.0 below. In this section, we begin with those factors that must be considered for immediate action on teenage pregnancy - young women’s sexual activity and contraceptive use. We then discuss the social/structural/environmental factors and outcomes of early/teenage pregnancy.

Figure 1.0: Factors contributing to teenage pregnancy

Sexual activity, early marriage, men’s roles

Globally, adolescents have their sexual debut between age 15 and 19, with boys initiating sex earlier than girls (WHO, 2011). By age 17, half of all South African teenagers are sexually active (Rachel Jewkes et al., 2009). On average, males initiate sexual activity by age 16, and females initiate one year later, by age 17 (Panday et al., 2009). For sexually active youth, Pettifor et al. noted a difference between genders in terms of recent sexual activity; they found that 90% of young women, compared to 73% of young men reported that they had sex in the past 12 months (Pettifor et al., 2005). This finding was contradicted by the DHS in 2003, which did not find a gender difference among adolescents who reported that they had sex in the past 12 months (Department of Health et al., 2007).

In developing countries, adolescent girls often initiate sexual activity in the context of marriage, as a result of coercion, most often with older men (Leclerc-Madlala, 2010; Rowbottom, 2007; World

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Health Organization, 2011). A review of more than 40 studies from Sub-Saharan Africa found that there is an age gap of about five to ten years between adolescent women and their male partners (WHO, 2004). The South African DBE reports that teenage pregnancy was highest in schools with greater age diversity among the learners (Panday et al., 2009). Similarly, Jewkes et al. (2001) explored relationship dynamics and pregnancy risk in a case-controlled study in Cape Town, South Africa and found that pregnant or childbearing African teens under age 19 had partners that were significantly older (Rachel Jewkes, Vundule, Maforah, & Jordaan, 2001).

A majority of pregnant teens around the world are married (Rowbottom, 2007). The prevalence of early marriage varies by country and region. Data suggests that adolescent marriage is on the decline in most parts of the world, but the rate of decrease in prevalence is slow. The highest rates are found in West Africa, Asia, the Middle East, and Latin America (WHO, 2011).

Few studies have explored men’s perspective regarding age gaps in sexual relationships (Leclerc-Madlala, 2008). Studies on sexual relationships between adolescent girls and older men tend to focus on what motivates women to enter into such unions (Leclerc-Madlala, 2010). Throughout Southern Africa, many adolescent girls are encouraged to seek older men as husbands (Leclerc-Madlala, 2008). Many studies indicate that age gaps, including age gaps in child marriage, are driven by poverty and gender-based inequalities where women are seeking financial support from men to meet basic needs (Leclerc-Madlala, 2010; Nour, 2006). In addition to poverty and gender inequality, there is a complex web of cultural factors that influence the formation of younger woman-older man relationships (Leclerc-Madlala, 2010). There are assertions, not always substantiated in the literature, that girls enter into sexual relationships with older men for transactional sex in exchange for monetary gifts, clothing, school fees and entertainment (Leclerc-Madlala, 2010; Richter, Norris, & Ginsburg, 2006).

In some cultures, parents want to ensure that their children do not engage in sexual activity before marriage (Nour, 2006). Therefore, early marriage is sometimes seen as protective in maintaining virginity until marriage. As a result of limited power in the relationship to make decisions about family planning and safe sex, many young women marry older and more sexually experienced men, and are put at risk for STIs and HIV, as well as early pregnancy (WHO, 2004; Rowbottom, 2007). Clark, Bruce and Dude (2006) conducted a study using Demographic and Health Survey data from 29 countries in Latin America and Africa to make a case against child marriage because of the increased risk for HIV among married women age 15 to 19. This study found that, in South Africa, considering African female adolescents who did not desire pregnancy, more married teens (34%) than unmarried teens (18%) had unprotected sex in the past week (Clark, Bruce, & Dude, 2006). Another study found that, if they have
experienced forced sex, South African women are six times more likely to use condoms inconsistently, and they are at greater risk for unintended pregnancy, HIV and other STIs (WHO, 2004).

Early marriage is an important issue to consider and address; however, both married and unmarried adolescents become pregnant. In South Africa, extra-marital teen pregnancy is high, as the median age of marriage is 28 or 29 (Rachel Jewkes et al., 2009; Lam, Marteleto, & Ranchhod, 2008; Macleod & Tracey, 2010). In addition, whether married or unmarried, pregnant teenagers experience similar levels of stress and other adverse outcomes during or as a result of early pregnancy. A study that examined stress due to pregnancy among a convenience sample of married and unmarried adolescents in Lesotho found that both groups of adolescent mothers had high levels of stress due to pregnancy, and there were no significant differences between the groups (Yako, 2007). Thus, denial of adolescent sexuality (by not providing accessible, youth-friendly sexual and reproductive health services) has serious consequences for teens (Shaw, 2009).

**Contraceptive access and use**

Poor access to and low use of contraceptives is another major contributor to early pregnancy. In Southern Africa family planning is considered to be the woman’s responsibility (Leclerc-Madlala, 2010). The contraceptive prevalence rate (CPR) in South Africa is one of the highest in Africa with 59.8% of married women using a modern form of contraception (Department of Health et al., 2007), and this rate appears to be increasing (Macleod & Tracey, 2010). However, the high rate can be misleading. First, it varies greatly according to region and education level, and second, given South Africa’s tendency toward delayed marriage, younger women are largely left out of this statistic. When all sexually active women (ages 15 to 49) are considered, contraceptive prevalence drops to 50% (Department of Health et al., 2007).

“Unmet need” is another way to consider contraceptive use. It refers to currently married women who do not wish to have more children, or do not wish to have children for at least the next two years and who are not using a modern method of contraception. There is a higher unmet need for contraception among women living in rural areas and among women with only primary or no education. Many teenagers lack information about or access to modern forms of contraception (Rowbottom, 2007), and this is evident in their unmet need statistics. Adolescents age 15 to 19 have a higher prevalence of unmet need for contraception (17.7%) when compared to older women (11.7 - 16.8%) (Department of Health et al., 2007).

Ehlers (2003) conducted a study to evaluate why South Africa’s provision of legal and free contraceptives and emergency contraceptives have had limited effect on the utilization of services to
prevent unintended pregnancy. According to South African law, anyone 14 and older has the right to receive contraception without parental consent (Shaw, 2009). Contraception has been available for no cost at South African primary health care centers since 1974 (Panday et al., 2009). Ehlers (2003) used convenience sampling to obtain data from 250 mothers, age 19 and younger from 1999 to 2000. Forty-seven percent of participants indicated that they had used contraceptives (mainly injections, oral contraceptive pills, and condoms). Among the adolescent mothers in the study who did not report use of a contraceptive method, non-use was attributed to: concern about negative side affects; concern regarding parental disapproval; and fear about boyfriend disapproval. Other studies have reported that barriers to contraceptive use among young women include desire to prove fertility and womanhood, lack of access, fear of adult biases, perceived lack of risk, peer norms, concern for confidentiality, and power imbalance in relationship dynamics (Rachel Jewkes et al., 2001; Katz & Naré, 2002; Macleod & Tracey, 2010; MacPhail, Pettifor, Pascoe, & Rees, 2007; Panday et al., 2009).

In addition to individual-level concerns/barriers about contraception use, several structural barriers exist. An additional barrier highlighted in the Ehlers (2003) study was provider bias or attitudes. This has been shown in several instances. Harris (1999) and Ehlers (2003) reported that pharmacists would not advocate for the use of emergency contraception, even in cases when adolescents presented a prescription to the pharmacy (Ehlers, 2003 p. 238). Holt et al. (2012) found that in Soweto, South Africa one fifth of the health care workers reported that abstinence is the preferred method of contraception for young women (Holt et al., 2012). Wood and Jewkes (2006) conducted a qualitative study in Limpopo to investigate barriers to contraceptive access among adolescent girls age 14 to 20. Wood and Jewkes (2006) found that nurses acknowledged problems associated with teenage pregnancy, and still preferred to teach abstinence to adolescents who presented for contraceptive services (Wood & Jewkes, 2006). The authors noted that adolescent sex was highly stigmatized, and many adolescents reported experiences of harassment that was prohibitive to contraceptive use and continuation (Wood & Jewkes, 2006).

In addition, where providers may be friendly, method choice and counseling is poor. The injection is the most commonly used method of contraception in South Africa (Department of Health et al., 2007), and few other methods are available in many public sector clinics. Panday et al. (2009) reported that South African health care providers give insufficient counseling on a range of methods and tend to give preference to injectable methods (Panday et al., 2009). Holt et al (2012) found that The all health care workers in three public clinics in Soweto needed additional training on modern forms of contraception in order to be able to provide comprehensive family planning counseling (Holt et al.,
Poor counseling means that contraceptive users may be ill prepared for the potential side effects of their chosen method. Some girls report injectable method discontinuation due to side effects such as amenorrhea and weight gain. There is strong evidence that adolescents who use hormonal injectable contraceptives gain more weight than adolescents who use COC or no method of contraception (Beksinska, Smit, Kleinschmidt, Milford, & Farley, 2010).

Limited method availability and provider bias leaves little choice for young people. According to the 2008 National Youth Risk Behavior Study [YRBS], which sampled data from South African learners attending public school in grades eight to eleven, sexually active young people reported that condoms were the method of contraception they used most (Reddy et al., 2010).

Gender inequality, gender-based violence, coerced sex

Gender inequality and gender-based violence are significant contributors to early pregnancy. In many regions of the world, during adolescence, the power differential between girls and boys becomes evident. Boys may develop autonomy and have more occupational and educational opportunities available to them, while adolescent girls’ freedoms are comparatively limited (Rowbottom, 2007). In South Africa, studies cite unequal decision-making about sex among partners, where girls lacked autonomy, thus hindering the practice of safe sex (Harrison, Xaba, & Kunene, 2001; Varga, 2003). Making matters worse for teen mothers, they report that “young fathers” often deny paternity in order to have better future prospects in education and occupation. This compounds the challenges for young women as absent fathers often means greater economic burden and more societal stigma (Panday et al., 2009).

Regardless of whether young women are married or single, many pregnancies in Sub-Saharan Africa are the result of coerced sex or rape (Rowbottom, 2007). Jewkes et al. (2001) found that pregnant teens in South Africa were more likely than their counterparts to have experienced intimate partner physical abuse and forced sex (Rachel Jewkes et al., 2001). Adolescents whose first sexual intercourse is coerced are significantly more likely to get pregnant, report the pregnancy as undesired, and experience a sexually transmitted infection (Speizer et al., 2009).

Gender-based violence (GBV) is defined as violence between men and women, in which the female is usually the victim, as the violence originates from unequal power relationships between the sexes. It includes psychological, physical, and sexual harm that is perpetrated by individuals, groups, and may be condoned by institutions or governments (Borwankar, Diallo, & Sommerfelt, 2008). GBV is a pervasive public health and human rights problem throughout the world. Many studies have reported
that women are almost exclusively the victim/survivor of abuse or sexual coercion (Mosavel, Ahmed, & Simon, 2011; Rogan et al., 2010). One in three women have been physically abused or coerced into sex (Guedes, 2004).

GBV is extremely common in South Africa, in part due to historical structural inequalities that perpetuate discriminatory cultural norms (Mosavel et al., 2011). Violence is entrenched in private social environments and public institutions (Mosavel et al., 2011). As a protective measure, South Africa has a Domestic Violence Act (Act No. 116 of 1998) that permits criminal justice officials to arrest abusers without a warrant. Abusers may be convicted of rape if the couple is married, according to civil, customary, or religious law (DHS, 2001). While this Act symbolically empowers women, it does not always help women who are abused in private or in communities where GBV is normative (Rachel Jewkes, Levin, & Penn-Kekana, 2002). Where violence against women is a cultural norm, violent men are less likely to receive criminal charges (Rachel Jewkes et al., 2002).

Data from South Africa indicate that rape and sexual coercion often take place at school and in family homes, where abusers are peers, family members, and sometimes teachers (Mosavel et al., 2011; Panday et al., 2009). Coerced sex and violence happens within all socioeconomic categories and within shorter and longer-term relationships (Mosavel et al., 2011). Jewkes et al (2002) reported that worry about partner disapproval was a common theme heard from adolescent girls living in urban and peri-urban areas of Cape Town. Two thirds of the participants had experienced abuse by a partner. They reported that their partners objected to their desire for abstinence, and a majority reported that they had had sex against their will. Teens with prior pregnancy were more likely than never pregnant teens to cite fear of partner abandonment or persuasion (as opposed to love) as a reason for having sex (Rachel Jewkes et al., 2001).

It is important to remember that the effects of gender-based inequalities and violence reach beyond pregnancy. HIV prevalence in South Africa among girls between age 15 and 19 is more than twice that of teen males in the same age group (Rogan et al., 2010). GBV, HIV/AIDS, and teen pregnancy are linked because fear of violence affects women’s ability to advocate for condom use, HIV/AIDS counseling, and contraceptive use (Guedes, 2004).

**Poverty and economic disparities**

Poverty has many negative influences on health outcomes. Some of the consequences of poverty and economic inequality for adolescent women globally include an increased risk of: malaria, inaccessible contraception, unwanted pregnancy, unsafe abortion, HIV/AIDS and other sexually transmitted infections, and infant and maternal mortality (Shaw, 2009). In South Africa, both economic
and racial disparities are closely linked to teenage pregnancy. The poorest teens in the population are Black African (Rachel Jewkes et al., 2009), and teens who become pregnant are more likely to be poor, Black African and Coloured (Mkhwanazi, 2010).

Poverty is both a contributor and a consequence of early pregnancy. Teenage pregnancy is strongly associated with continuation of the “poverty cycle” (Mkhwanazi, 2010). According to focus-group discussions, narrative role-playing, questionnaires and in-depth interviews with rural and urban adolescents in KwaZulu-Natal, South Africa, teen parenthood is viewed as compromising financial ambitions by both sexes (Varga, 2003). However, research has shown that if girls and women are afforded educational and occupational opportunities to reduce their economic dependency on others, they are less likely to have an early pregnancy. Girls who have and keep a job are also better able to negotiate family planning with sexual partners and delay childbearing (Richter et al., 2006).

**Education, sex education, and economic attainment**

The YRBS reported that 70% of young people age 16 to 20 in South Africa are attending school (Reddy et al., 2010). School enrollment has increased since the 1970s (Panday et al., 2009; Richter et al., 2005), and trends have continued post-Apartheid. Black Africans were 29% of the total public school enrollees in 1988 and the African population represented 60% of total enrollments in 2000 (Richter et al., 2005). According to the 2003 SADHS, one third of the South African population completed grade 12 or higher (Department of Health et al., 2007). The 1998 SADHS reported that 7% of all South African women did not have any education. By 2003, the percent change was substantial (43%); just four percent of women had no formal education. However, due to data reporting problems in KwaZulu-Natal (with a 82% decrease in women with no education), one must interpret this decline with caution (Department of Health et al., 2007).

Pregnancy during one’s school-going years can have significant negative effects such as: exacerbating poverty, disrupting or limiting educational and occupational attainment, and limiting future opportunities for the child (Department of Health et al., 2002, 2007; Karra & Lee, 2012; Marteleto, Lam, & Ranchhod, 2008; Panday et al., 2009; Richter et al., 2006). South African policy allows pregnant adolescents to remain in school and return post-birth (Reddy et al., 2010). However, the process to re-enroll can be complicated. Some public secondary schools turn young women away despite the policy, and there is little advocacy on their behalf (Panday et al., 2009). In 2008, nineteen percent of learners in South Africa were pregnant or were the “father” involved with a pregnancy (Reddy et al., 2010). It has been estimated that just one third of adolescent girls return to school after giving birth (Grant & Hallman, 2008; Reddy et al., 2010), compared to 52% of women age 20 to 24...
(Grant & Hallman, 2008). However, these statistics may vary by region. Marteleto et al (2008) conducted a secondary analysis using data from the Cape Town Area Study and found that it was common for girls to continue school after having a child (Marteleto et al., 2008). Researchers attribute school continuation post-birth to having support at home and having the man involved with the pregnancy give paternal recognition of the child (Marteleto et al., 2008).

There are different perspectives on school dropout and pregnancy in the literature. The reason for school discontinuation at the time of pregnancy may be attributed to problems that occurred earlier in childhood. Early childhood factors that correlate to adolescent pregnancy and school dropout include: poverty, poor school performance, grade repetition, distance to school, safety and quality of primary school, cultural perceived value of education (Grant & Hallman, 2008; Marteleto et al., 2008; Mensch, Clark, Lloyd, & Erulkar, 2001; Panday et al., 2009; Reddy et al., 2010). Despite uncertainty regarding whether pregnancy itself always leads to dropping out, the overall impact of education on health and other outcomes is clear. Women who have not exceeded grade five in school have the highest fertility rates and earliest age of sexual debut (Department of Health et al., 2007). Mothers with more education are better able to care for the health of their children (Richter et al., 2005).

Providing women with sexuality education as well as the right to sexual and reproductive health information outside of the school environment will empower South African women to make informed decisions about childbearing (Shaw, 2009). There are different opinions regarding when it is best to provide such sexuality education. However, at a minimum, one must consider the average age of sexual debut and provide comprehensive sexual and reproductive health education programs prior to that time. South African schools have had varying levels of success implementing comprehensive sexuality education programs (Reddy et al., 2010). Life Orientation (LO) should be a part of every learner’s educational experience prior to graduation; however, the quality of LO services nationally varies greatly.

In addition to exposure to sex education, several studies demonstrate that adolescent-parent connectedness is correlated with a decrease in adolescent pregnancy. Adolescents report that it would be easier for them to avoid pregnancy if they felt comfortable discussing sexual and reproductive health with their parent(s) (Panday et al., 2009). A study in Dakar, Senegal, showed that 90% of women age 15 to 19 wanted more information regarding family planning, STIs and reproductive biology. Seventy-three percent of adolescents thought that information about family planning should be available in their home (even though they had never discussed sexual and reproductive health with their parents). Studies in Nigeria and South Africa found similar results with regard to teens’ desires to have family planning information available in their homes (Katz & Naré, 2002).
Despite young people’s desire for more information from their parents, in many communities in South Africa, there is a “culture of silence” with regard to sexuality, even if parents know that their child is sexually active or pregnant. Parents report that they would feel more comfortable discussing sex with their children if they have more education on various sexual and reproductive health issues (Panday et al., 2009).

**Pregnancy intention**

Pregnancy intention is an important factor to consider when discussing teenage pregnancy. Senanayake and Faulkner (2003) caution that unplanned teenage pregnancy should not always be taken to represent the negative aspects of young people’s sexual and reproductive health. The authors state that sexual activity is “a common and normal bridge to adulthood” (p. 118) and argue that the negative aspects of adolescent pregnancy may be a result of failing to protect the human rights of teens (Senanayake & Faulkner, 2003). Varga (2003) and Mkhwanazi (2010) refer to research by Preston-Whyte in the 1980s. Preston-Whyte’s findings suggested that, for some young women in communities marked by poverty, high unemployment and school drop-out, early childbearing presented a route for upward social mobility (Mkhwanazi, 2010). Pregnancy was considered to be positive because there was a cultural value placed on childbearing as marker of femininity and fertility, and early childbearing provided a way for a teenage girls to show that they were able to transition to ‘successful womanhood’ (Mkhwanazi, 2010). Based on these findings, Preston-Whyte argued that in some instances, becoming pregnant was a rational and conscious decision that a teenager made in light of her particular circumstances rather, than merely something that happened to her (Mkhwanazi, 2010).

The majority of all pregnancies among women under age 20 are reported to be unintended (Clear, Williams, & Crosby, 2012; Panday et al., 2009). However, obtaining accurate data on intended versus unintended pregnancy – for women of all ages – is difficult for several reasons (Macleod & Tracey, 2010). One must interpret rates of unintended pregnancy with caution because intention is based on attitudes pre- and post-conception, and attitudes are subject to change (Klerman, 2000). Pregnancy intention is a construct based on preconception planning, timing of the pregnancy, and desire for a(nother) child (Klerman, 2000; Stanford, Hobbs, Jameson, DeWitt, & Fischer, 2000), rather than a concrete measure. The concept of pregnancy intention is complex, because childbearing desires are influenced by a combination of women’s values, personality, environment, long-term goals, current life circumstances, and relationship status (Stanford et al., 2000).

Techniques do exist for estimating unintended pregnancy, and the best available data indicate that the global unintended pregnancy rate among women age 15 to 44 declined by 20 percent between
1995 and 2008 to 55 per 1,000 women (Singh, Sedgh, & Hussain, 2010, p. 245). In Africa, 39% of pregnancies among this age group were unintended, and one third of unintended pregnancies ended in abortion (Singh et al., 2010). About 14 million unintended pregnancies occur in Sub-Saharan Africa each year, and 44% of unintended births occur among 15 to 24 year olds (WHO, 2011). Hubacher, Mavranezouli and McGinn (2008) estimated the unintended pregnancy rate in Sub-Saharan Africa and found that over the 5-year period from 2005 to 2010, approximately 28% of all pregnancies across all reproductive-ages were unintended, totaling roughly 42 million (Hubacher et al., 2008).

The prevalence of unintended pregnancy remains highest in developing countries. In 2008, unintended pregnancy was especially high in the Caribbean (58%) and Southern Africa (59%); these were the only two regions across the globe where the prevalence of unintended pregnancy was higher than the prevalence of intended pregnancy (Singh et al., 2010, p. 248). In South Africa specifically, several studies show that most adolescent pregnancies are unintended (Department of Health et al., 2007; Panday et al., 2009; Pettifor et al., 2005; Reddy et al., 2010).

Whether adolescents experience intended or unintended pregnancy, teen pregnancy and parenthood is usually highly stigmatized. For some adolescents, however, pregnancy and motherhood is a sign of status, and it is preferable to infertility, irrespective of intention or the contributing factors that led to the pregnancy (Panday, Makiwane, Ranchod, & Letsoala, 2009).

**Access to health services**

South Africa began instituting programmatic initiatives specifically designed to meet the unique sexual and reproductive health care needs of teens in the late 1990s. Non-governmental organizations in South Africa implemented a sexual health campaign called “LoveLife” in 1999 to target 12 to 17 year olds and their parents for the prevention of STIs, HIV, and teen pregnancy with community outreach (Ashton, Dickson, & Pleaner, 2009).

LoveLife, which today is an independent NGO, was influential in the development, implementation, and evaluation of the National Adolescent-Friendly Clinic Initiative (NAFCI) in South Africa (Ashton et al., 2009; Panday et al., 2009). NAFCI aimed to: increase health care provider competencies and encourage accepting, non-judgmental approaches to health care provision; make health care environments more inviting for adolescents; increase accessibility of adolescent health care services; and facilitate public understanding and support of adolescent health needs (Ashton et al., 2009). However, the long term impact of NAFCI has been questionable. The DBE reports that the NAFCI has not sufficiently reduced the negative and stigmatizing attitudes of health staff (Panday et al.,
The DBE’s opinion is supported by literature that cites continued negative attitudes of health care providers as a barrier to the successful provision of local, provincial, and national sexual and reproductive health care programs (Alli, Maharaj, & Vawda, 2013; Ehlers, Maja, Sellers, & Gololo, 2000; Ehlers, 2003; Holt et al., 2012; Mkhwanazi, 2010; Panday et al., 2009; Shaw, 2009; Smith, Church, Milford, Harrison, & Beksinska, 2012; Varga, 2003).

Alli, Maharaj and Vawda (2013) explored barriers to accessing sexual and reproductive health care by interviewing university health center staff and clients (age 18 to 24) in KwaZulu-Natal. The concerns most frequently cited by clients were experiences of unfriendly and disrespectful staff, and feeling like the treatment was too brief. Clients reported that they did not have enough time to express their own health concerns, or ask questions/clarifications about the treatments they received during the visit. Health center staff acknowledged that their colleagues had judgmental attitudes, despite attending trainings on the provision of youth-friendly sexual and reproductive health services. The researchers also found that generational age gaps and gender differences between staff and clients hindered open communication about sexual health (Alli et al., 2013). Given these findings, health care provision may improve if trainings for staff shift focus toward interpersonal skills training, encouraging workers to build rapport with clients even in brief visits. The authors note that service provision would improve if clinic hours extended to allow for more time per visit so staff feel less rushed and clients have the opportunity to get all of their care needs met (Alli et al., 2013).

Racial and socioeconomic disparities are also a factor in barriers to accessing sexual and reproductive health services in South Africa (Burgard, 2004; Jewkes et al., 2009; Mkhwanazi, 2010). According to a study that examined the 1998 South Africa Demographic and Health Survey (SADHS), Non-White women were less likely than White women to have obtained antenatal care, or to have delivered babies in the presence of a physician, after controlling for demographic variances (Burgard, 2004). This finding is consistent with the 2003 SADHS data. White women had the highest percentage of pregnancies cared for by a doctor (82%), and the lowest percentage was among African women (23%). The percentage was even lower for African women living in non-urban areas (15%). When antenatal care does not occur, or occurs late in pregnancy, which is the case for most adolescents (Vundule, Maforah, Jewkes, & Jordaan, 2001), there is a strong correlation with high maternal and infant mortality rates (Magadi, Agwanda, & Obare, 2007a). To address this issue, the South African Department of Health states that it aims to monitor wealth disparities, and track the infant and maternal mortality rate as a way of measuring inequalities in child health and progress (Department of Health et al., 2007).
Maternal morbidity/mortality and other health outcomes

The negative health consequences of early pregnancy are 600 times higher in sub-Saharan Africa than in developed countries (Pettifor et al., 2005). Irrespective of the context in which women become pregnant, there are psychological, social, and physical risks associated with teenage pregnancy and childbirth, including morbidity and mortality. The WHO defines maternal mortality as death while pregnant or within 42 days after a pregnancy. Maternal mortality can be classified as “direct” (death during birth or six weeks post-delivery), “indirect” (death due to pregnancy-aggravated disease), and/or “late” (deaths that occur up to one year following childbirth) (WHO, 2006). The five leading causes of maternal mortality globally are hemorrhage, infection, high blood pressure, obstructed labor, and unsafe abortion. Maternal mortality from all five leading causes is five times higher for girls under 15 years of age, and it is doubled for girls age 15 to 19 as compared to women over age 20 (Nour, 2006; Shaw, 2009).

Some of the serious health complications that adolescents experience as a result of pregnancy are similar to the main maternal mortality causes. They are: pre-eclampsia, infection, postpartum hemorrhage, obstructed labor, fistulas [as high as 88% for girls age 10 to 15 (Nour, 2006)] and unsafe abortion (Gant, Heath, & Ejikeme, 2009; P.T. Mngadi, Thembi, Ransjo-Arvidson, & Ahlberg, 2002; Nour, 2006; Panday et al., 2009). Pregnant adolescents giving birth for the first time are more likely to die in childbirth (WHO, 2006). Investigators in a study conducted by the Africa Centre Study (2012) assessed mortality risk for African teen mothers in KwaZulu-Natal over the course of a decade (2000-2010). Their findings suggest that adolescent fertility is strongly associated with a higher risk of mortality before age 30 (Karra & Lee, 2012, p. 4).

There is debate in the literature regarding whether the maternal health risks associated with teenage childbearing and teen pregnancy are due primarily to biological immaturity, or if the risks are primarily associated with other sociocultural demographic characteristics (R Jewkes, Vundule, Maforah, & Jordaan, 2001; Magadi et al., 2007a; Panday et al., 2009). In a study that compared the obstetric outcomes among adolescents (age 13 to 18) and adults (age 19 to 21) in rural South Africa, there were no significant differences in pregnancy complications between the age groups. However, the socioeconomic conditions were worse for adolescents (Hoque & Hoque, 2010).

Environmental factors contribute to the health complications associated with early childbearing. The 2007 UNFPA report on adolescent pregnancy cites environmental factors that delay care and worsen pregnancy outcomes for first-time young mothers. Adolescents are less likely than older women
to have prenatal care (Burgard, 2004; Chaibva, Ehlers, & Roos, 2010; Magadi, Agwanda, & Obare, 2007b; Panday et al., 2009; Rowbottom, 2007; WHO, 2006). Therefore, teens may be slow to recognize symptoms associated with pregnancy complications, and may not know of a health care facility to go to in emergencies. During an emergency, “[relatives] among poor families may not want to pay to take a young girl to the hospital” (Rowbottom, 2007, p. 1333). Upon arrival at a health care facility, adolescents may encounter judgmental attitudes by health professionals, especially if the teens are unmarried (Panday et al., 2009; Rowbottom, 2007).

In addition to health risks for young mothers, the literature consistently reports health risks for infants and children born to adolescent mothers (Panday et al., 2009). The infant mortality rates in Sub-Saharan Africa are more than three times the global rates (Gant et al., 2009). In South Africa, child mortality increased from 1990 to 2000, from 65 per 1,000 live births to 95 per live births (Panday et al., 2009), and this is despite economic and medical advancements. Mortality rates are 73% higher for infants born to mothers under 20 (Nour, 2006). There is also a higher incidence of low birth weight among infants born to teens (Boult & Cunningham, 1995; Magadi et al., 2007b; Nour, 2006). Infant mortality is consistently higher in rural areas of South Africa (Department of Health et al., 2002, 2007).

Unsafe abortion

Adolescent unintended pregnancy is associated with increased levels of abortion. Forty percent of all unsafe abortions worldwide occur in sub-Saharan Africa, and adolescents are treated for 39-79% of abortion-related complications (Ahman & Shah, 2011; Rowbottom, 2007). In 2008, about three million 15 to 19 year olds had unsafe abortions in developing countries (WHO, 2011). According to the WHO report, “Unsafe abortion; Global and regional estimates of the incidence unsafe abortion and associated mortality in 2008,” Cambodia, Ethiopia, Guyana, Nepal, and South Africa have a high prevalence of unsafe abortion, despite being countries that have less restrictive abortion laws (Ahman & Shah, 2011). All of these countries changed their abortion policies within the last 10 to 15 years.

In 1996, South Africa passed the Choice on Termination of Pregnancy Act (CTOPA) in an attempt to address maternal mortality from unsafe abortion. South Africa’s abortion policy is liberal compared to many other developing and developed countries. Abortion is available on demand up to 12 weeks and in a range of conditions (rape, incest, threat to the mother’s health, socioeconomic hardship) up to 20 weeks. Evidence suggests that the CTOPA has reduced deaths from unsafe abortion significantly (Rachel Jewkes et al., 2009; Panday et al., 2009)

Another special feature of abortion services in South Africa is that adolescents are not required
to obtain parental consent in order to have access to abortion services (Act No. 92 of 1996) (Department of Health, South Africa, 1996). The 1983 South African Child Care Act (Act No. 74 of 1983) states that teenagers 14 years and older may consent to medical treatment without parental consent. Surgical procedures require parental consent for adolescents under age 18, except in the case of abortion (DHS, 2001). The purpose of this exception in the Child Care Act was to acknowledge the potential for incest and rape by parents/guardians and to permit teens (14 and older) to care for their own sexual and reproductive health (DHS, 2001; Rachel Jewkes et al., 2009).

Globally, women of all ages choose to terminate pregnancies, however, particularly high rates of pregnancy termination are seen among adolescents (Varga, 2003). Adolescents in Sub-Saharan Africa are at high risk for resorting to unsafe abortion provided by clandestine means (Varga, 2003). The high prevalence of unsafe abortion can be attributed to lack of information about the right to access safe and legal abortion services, barriers to access, and social and cultural beliefs regarding the provision of legal abortion services. The WHO found that 54% of South African women did not use legal abortion services in 2000 [four years after implementation of the Choice of Termination of Pregnancy Act]. Some women reported that they did not know abortion was legal. Of the women who were informed of South African policies on pregnancy termination in 2000, 15% of women were not aware of a facility that provided legal abortions. Some women knew where to access legal services, but “feared rude staff or breaches of confidentiality.” Other women reported that they could not access legal abortion services before they were past the legal gestational limit, and thus could not comply with the law (Ahman & Shah, 2011, p. 8). Seventy-eight percent of the adolescent mothers who participated in the Ehlers (2003) study reported that they did not wish to terminate their pregnancy. However, of the teen moms who inquired about termination (8%), none of the teens were able to obtain an abortion at the clinics they went to, even in cases of rape (Ehlers, 2003).

Varga (2003) used methodological triangulation (focus-group discussions, narrative workshops, role-playing, surveys, and in-depth interviews) to explore the role of abortion among Zulu young people (age 11 to 24) living in rural and urban KwaZulu-Natal, South Africa. The study found that 83% of teens living in urban areas that participated in the study identified abortion as legal, compared to 53% of teens living in rural areas. Less than half of all study participants identified abortion as a free procedure if performed in a public health facility. Teens referred to clandestine abortion as preferable to abortion performed in a clinic because of confusion over whether there was a fee associated with pregnancy termination. Forty-five percent of rural teens and 64% of urban teens believed that pregnant girls their age would choose to terminate their pregnancies, and most teens who wanted to end a
pregnancy were likely to do so using clandestine (or “backstreet”) means. Less than one third of respondents reported that they knew someone who had an abortion. Some teens referred to societal stigma and the need to keep abortion a secret, or in the “home” (Varga, 2003, p. 288).

Many young people from KwaZulu-Natal perceived or enacted abortion stigma (Varga, 2003, p. 289). Varga (2003) reports that young people viewed abortion as a “sin,” an “irresponsible” act, or “consequence of poor morals,” and related abortion to murder and promiscuity. However, many other young people who participated in the study voiced a need for safe, legal, and available abortion services, regardless of acceptability (Varga, 2003).

4.3 Interventions

Globally responses or interventions addressing teenage pregnancy vary greatly and differ in terms of their effectiveness.

Advocates who are engaged in efforts to prevent the prevalence of child marriage, a major contributor to teenage pregnancy, believe that the first-line response must be community engagement with local religious leaders and parents. Additionally, community members and law enforcement must help implement policies that do not permit marriage until adulthood. The Universal Declaration of Human Rights states that individuals must enter marriage “freely” at “full age” [over age 18] and with “full consent” (Nour, 2006).

Considering teenage pregnancy specifically, many advocates promote structural interventions instead of interventions that focus on individuals because programs focused on individual behavior change (usually for adolescent girls), such as increasing contraceptive uptake, do not address the factors that adolescents cannot control. Many advocates suggest that teenage pregnancy prevention efforts should focus on: changing cultural norms to allow women more power in family planning decision-making; reducing socioeconomic disparities; improving opportunities for schooling; reducing gender inequality and violence; and enforcing comprehensive policy and programming with “zero tolerance” approaches to sexual coercion (Leclerc-Madlala, 2008; Underwood, Skinner, Osman, & Schwandt, 2011). Supporting the need for broad-based structural interventions, Gant et al. (2009) suggest that communities in Sub-Saharan Africa with high rates of infant mortality, teen pregnancy, HIV/AIDS as well as low-life expectancy are communities in which people have several children in order to ensure a “next generation of survivors.” Thus, the researchers suggest initiatives to increase opportunities for better living conditions, as opposed to initiatives targeted at one particular aspect of the public health problem (Gant et al., 2009).
In South Africa, given the focus on schools as the vehicle for delivering “life orientation” training, improving the quality and effectiveness of this training is key. Panday et al. (2009) examined characteristics that were common among successful sex education programs. They found the following characteristics to be consistent among successful sexual education programs in South African public secondary schools:

- The Department of Health, the school district, and community organizations supported the program;
- Multiple interdisciplinary experts participated in curriculum development and teachers received comprehensive training prior to implementation;
- Programs were tailored to community values and accounted for resources that were (and were not) available; and
- Programs were pilot tested and had clear aims (prevention of pregnancy, STIs, HIV) (Panday et al., 2009).

In addition, findings from the YRBS suggest that educational programs would improve if they specifically addressed situations when sex occurs, such as forced sex and sex while taking drugs and alcohol (Reddy et al., 2010). Finally, young men and women need to be informed of their rights within the school system, especially regarding their ability to return to school after childbearing (Panday et al., 2009).

In addition to structural interventions, many researchers also emphasize engagement of certain sectors of the population. Many highlight a lack of engagement with men as an issue to address in order to improve pregnancy and other reproductive health outcomes (Rachel Jewkes et al., 2009; Patricia Thuli Mnqadi, 2003; Richter et al., 2006). A shift in social norms, community engagement, and expectations regarding men’s involvement in parenting may be socially beneficial because paternal involvement ensures more positive health outcomes for infants and more advantageous educational and occupational opportunities for women (Rachel Jewkes et al., 2009; Panday et al., 2009).

Interventions including engagement with parents may also be helpful in terms of providing better health outcomes for adolescents. Teens have significantly better social and health outcomes if they have consistent prenatal care and strong family supports (Cosey & Bechtel, 2001), and teens are more likely to go to their parents for advice about family planning and seek support during the antenatal and postpartum period if parents open a dialogue about sexuality, rather than continue to engage in the culture of silence about sex (Nour, 2006; Underwood et al., 2011). Communication among parents and their children should be encouraged through community education programs in
order to foster parenting styles that decrease adolescent pregnancy (e.g. greater support, rule enforcement, behavior monitoring) and increase postpartum support to help teens return to school (P.T. Mngadi et al., 2002; Panday et al., 2009; Reddy et al., 2010).

Finally, community involvement in all interventions is key. In South Africa, Holt et al (2012) explored health care workers’ attitudes regarding sexual and reproductive health services [SRHS] at primary health clinics in Soweto. The authors found that many providers do not think adolescents should engage in premarital sex. Holt et al. (2012) found that health care workers believe it is parents’ responsibility to talk to their children about sex, meanwhile, parents are not engaging with their teens about sexuality, family planning, and sexually transmitted infections (Holt et al., 2012). These gaps leave adolescents without resources for addressing their sexual and reproductive health needs, and reinforce the culture of silence around teenage pregnancy. It is imperative that health care providers, adolescents, and community members freely engage in discussion about sex to be informed of risk factors and preventative measures to reduce teenage pregnancy and sexually transmitted infections.

4. DISCUSSION

Delegates at the 1994 International Conference on Population and Development [ICPD] agreed that global empowerment of women is a priority through individual, social and economic efforts. The ICPD asserted that women’s right to comprehensive reproductive health care and gender equality is central to women’s empowerment. Following on the ICPD, in 2000, national leaders from developed and developing countries met to agree on humanitarian objectives for the year 2015, i.e. the “Millennium Development Goals” [MDGs]. MGD 5 sets targets for improving maternal health through universal access to reproductive healthcare. The two indicators for measuring progress focus on countries’ adolescent birth rate and unmet need for contraception (United Nations Millennium Development Goals Indicators, 2008). Several other MDGs that are not specifically related to maternal health will still have positive effects on adolescents’ sexual health and wellbeing. Goals toward working to end poverty and hunger and providing access to universal education will equip teens with more resources and empowerment to make informed choices regarding their sexual health and negotiate safer sex (United Nations Millennium Development Goals Indicators, 2008).

Shaw (2009) emphasizes the importance of providing comprehensive sexual and reproductive health services to prevent unintended pregnancy, unsafe abortion, and maternal mortality (Shaw, 2009).
In South Africa, improved access to and utilization of comprehensive sexual and reproductive health care for adolescents would significantly improve a range of health outcomes. Specifically there is an immediate need for more widespread funding for, availability and use of implants and other longer term family planning methods to improve the country’s contraceptive method mix and increase prevention of unintended pregnancy among young women (MacPhail et al., 2007). The 2003 SADHS states that the DOH has a goal of increasing access to contraceptive access and use (Department of Health et al., 2007); however, having the goal is just the beginning. Young people also need accessible health care providers, teachers, and peer educators who provide nonjudgmental assistance on a range of sexuality and sexual health issues. Reducing the level of violence in the country and creating more opportunities for employment or economic independence for young women may be longer terms goals, but they are no less important.

The negative health consequences of early pregnancy are 600 times higher in sub-Saharan Africa than in developed countries (Pettifor et al., 2005). South Africa’s rate is not as high as other countries in the region, but it is a major concern. Inequalities in race, gender, and socioeconomic status inhibit teenagers’ ability to control their environment and navigate access to resources when exploring their sexuality (Rachel Jewkes et al., 2009). Whether teen pregnancy is a social problem on its own or a symptom of many other social problems and disparities, “what we do know is that the high incidence of teenage pregnancy places great strain on the individual, her child, her family, and society as a whole,” (Cunningham & Boult, 1996, p. 697). Teenage pregnancy and early childbirth are concerning public health problems, and they deserve unbiased attention from health professionals, policy makers, educators, and community members (P.T. Mngadi et al., 2002).

5. REFERENCES


APPENDIX A

Search Terms

- South Africa and Teen* Pregnan*
- Sub-Saharan Africa and Teen* Pregnan*
- South Africa and Teen* Pregnan* and Interven*
- South Africa and Early Marriage
- South Africa and unintended pregnan*
- South Africa and Sex* Education
- South Africa and Contraception
- South Africa and Learner* and Sex*
- South Africa and Pregnan* and Health Outcomes
- South Africa and Gender Based Violence
- Teen Pregnan* and interven*
- Teen pregnan* and attitude and South Africa
- Teen pregnan* and attitude and Africa
- Teen pregnan* and women* right* and / or South Africa
- Feminis* and teen pregnan*

Pre-selected content areas

- Global and national prevalence of teenage pregnancy
- Pregnancy intention and termination of pregnancy
- Health: SRHS delivery and quality; provider attitudes; maternal and child morbidity and mortality
- Disparities associated with teenage pregnancy: gender, region, race, culture, wealth/poverty, educational attainment; violence; early marriage
- Global and national policy associated with adolescent sexual and reproductive health