

# **A Review of Teenage Pregnancy in South Africa – Experiences of Schooling, and Knowledge and Access to Sexual & Reproductive Health Services**

**'Girls subordinate position in the gender and social hierarchy contains their ability to make real choices around pregnancy.'**

**(Jewkes, Morrell and Christofides, 2009:675)**

**Teenage mothers who had support from their mothers were the most likely to return to, and remain at, school.**

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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AYFS	Adolescent and Youth Friendly Services
CAPS	Cape Area Panel Study
CEDAW	The UN Convention on the Elimination of All forms of Discrimination Against Women and Girls
CSE	Comprehensive Sexuality Education
CSG	Child Support Grant
CToP	Choice on Termination of Pregnancy
DoBE	Department of Basic Education
DoH	Department of Health
EC	Emergency Contraceptive
EMIS	the Education Management Information System
HCT	HIV Counselling and Testing
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
ICPD	the International Conference on Population and Development
ISHP	Integrated School Health Policy
JHHESA	Johns Hopkins Health and Education in South Africa
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
LO	Life Orientation
MDGs	Millennium Development Goals
MMC	Medical Male Circumcision
MPMLP	Measures for the Prevention and Management of Learner Pregnancy
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
PSH	Partners in Sexual Health
RHRU	Reproductive Health Research Unit
SADHS	South African Demographic and Health Surveys
SALDRU	Southern African Labour and Development Research Unit
SASA	South African Schools Act (Department of Education no 84 1996)
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UCT	University of Cape Town
WHO	World Health Organisation
UN	United Nations
UNGASS	UN Special Assembly on HIV/AIDS
YFHS	Youth-Friendly Health Services
YRBS	Youth Risk Behaviour Surveys

## Executive Summary

Approximately 30% of teenagers in South Africa report ‘ever having been pregnant’, the majority, unplanned (Jewkes, Morrell and Christofides, 2009; Lince, 2011; Flanagan et al, 2013; Pettifor et al., 2005; Reddy et al., 2008 and Holt et al., 2012; Ardington, 2012). While this number has decreased over the past few decades, it is still unacceptably high. The figure is for all teenagers. (13-19 years old), but motherhood for an 18 or 19 year old has very different implications than for a young teenager, one aged 15, for example. Therefore this report tries, where possible, to be mindful of differing experiences of pregnancy and motherhood across the teen years.

Of all teenage girls who fall pregnant only around a third stay in school during their pregnancy and return following childbirth, with the highest return rate among those in Grade 12 (Grant and Hallman, 2008). Even so for the majority of teenage girls, falling pregnant has a devastating effect on their secondary schooling, with consequent negative impacts on their lives.

Teenage pregnancy in South Africa is driven by many factors including: gender inequalities; gendered expectations of how teenage boys and girls should act; sexual taboos (for girls) and sexual permissiveness (for boys); poverty; poor access to contraceptives and termination of pregnancies; inaccurate and inconsistent contraceptive use; judgmental attitudes of many health care workers; high levels of gender-based violence; and poor sex education (Jewkes, Morrell and Christofides, 2009; Panday et al., 2009; Chigona and Chetty, 2007; Bearinger, 2007; Pettifor et al., 2005).

When exploring knowledge, access to, and use of, contraceptives we found that many teenagers have a basic knowledge about contraceptives and protection from unplanned pregnancies, STIs and HIV. However, many report insufficient contraceptive knowledge and not using contraceptives correctly and consistently, as well as limited reproductive knowledge about fertility and conception. In the words of one of our respondents:

Yes, we were informed about condoms, but never really had access to them and also couldn't use them even if we had them because nobody took the time to show us the right way. We were not able to use the knowledge we gained in class as it was not enough to give us a picture of the right way (Thembi, teenage mother, 16 years at birth, who returned to school after one year).

Most teenage mothers reported limited contraceptive use prior to falling pregnant and following pregnancy almost all girls began using the hormonal injection. While this is positive in terms of preventing future unplanned pregnancies, it does not assist in preventing STIs or HIV, and there was very little consideration given to this, by either teenagers or health care workers. Access to contraception was reported as a significant barrier, with many teenagers reporting that the attitudes of health care workers and clinic access often stopped them from accessing contraceptives.

Given these multiple and complex drivers of unplanned teenage pregnancy, it is imperative that South Africa address unplanned teenage pregnancy at both an individual and structural level. Responses should focus on a number of areas including: gender equality programmes across communities and schools; comprehensive sex education to include elements of gender awareness, gender equality, women's rights etc; clinics which are adequately staffed, accessible

and supplied with a full range of contraceptive options; appropriately trained health care workers (on the range of modern contraceptives, the need for dual protection and to reduce ‘moralising’ attitudes) and scaled up, accessible, appropriate and acceptable to teenage users family planning initiatives. Holt et al., (2012) noted that:

The availability, accessibility, and acceptability of health care services for young women significantly impact their use of prevention methods, which in turn influences their risk for pregnancy and HIV (Holt et al., 2012: 284).

Bearinger et al. (2007:1220) went on to say:

...effective approaches are multifaceted. All adolescents need access to quality youth-friendly services provided by clinicians trained to work with this population. Sex education programmes should offer accurate, comprehensive information while building skills for negotiating sexual behaviour. Girls and boys also need equal access to youth development programmes that connect them with supportive adults and with educational and economic opportunities.

A major concern of this report is to examine ways in which all pregnant teenagers and teenage mothers be supported to remain in school and, for those that do remain in, and return to school how can they be supported in their dual role and responsibilities as both learner and mother?

The literature, and the interviews we undertook, highlighted that the most important factor for determining whether a teenage mother would return to school was whether she had family support (in particular from her mother) to assist her with child-care responsibilities, and/or money to pay for childcare. Supporting a teenage mother with daily childcare responsibilities seems to be the most critical factor that will enable her to return to school. As one of our respondents, who returned to school one week after giving birth and achieved well academically, noted, support from her family was critical in enabling her to return to school:

They [my parents] encouraged me to go back to school although I did not want to and felt it would be too much for my parents to support me and my baby. They bought us food and clothing, they did everything for us (Buhle, teenage mother, who was 16 years at the birth, and returned to school one week after childbirth).

Another important factor is previous academic performance; girls who did well prior to falling pregnant tend to be able to continue succeeding academically as both mothers and learners. While teacher support is desirable, the evidence shows that it is not critical to mothers returning, supportive teachers make the schooling experience better, and yet many teenage mothers who have returned to school report unsupportive teachers and principals, and that they continued despite this.

The critical barriers to pregnant girls remaining in school and returning following pregnancy again relate to childcare, whether they have financial means to pay for childcare or someone, usually the maternal grandmother, who can care for the baby during school hours. Where girls do not have childcare support from their family and in particular her mother, many have no choice but to stay home and care for the baby. Other issues such as stigma from peers and teachers; unsupportive teachers; poor academic performance prior to pregnancy; balancing being a learner and a mother all contribute to her not returning, but to a lesser extent than support for childcare.

Another important issue, which is seldom addressed in the literature, is the question of the role of the school in supporting a teenage mother as both a learner and a mother. The evidence overwhelmingly shows that childcare responsibilities are gendered and fall to the teenage mother. Yet at the same time South Africa is committed to gender parity in schools, assisting girls to realise their right to education and keeping teenage mothers in school. This provides a strong argument that a school's role is to support a mother both as a learner and as a mother, and as such, if she chooses to exclusively breastfeed or express milk, the school should provide a space for her to do so. Schools could have childcare facilities attached to them to support all mothers of young babies - whether the mothers are learners or teachers. This would significantly assist teenage mothers who do not have childcare support at home, and reduce the burden of purchasing formula, which is critical in poorer households.

The South African policy environment creates a relatively progressive space around teenage sexuality, teenage pregnancy and motherhood. Teenagers' rights to access sexual and reproductive health (SRH) care are guaranteed in the South African Constitution (1996) and a series of laws thereafter enable teenagers to access contraceptives, terminations of pregnancies and SRH services. They are also protected from sexual violation by equally strong laws. However, implementation presents a severe obstacle, with many teenagers reporting difficulties in actually accessing SRH services, and feeling judged by health care workers and teachers for being sexual. Furthermore, the high levels of sexual and physical violence and poor implementation of progressive policies also undermine laws around sexual violence. As is commonly seen there is appears to be a disconnect between the progressive policies and the environment in which implementation occurs.

South African law is also supportive of pregnant teenagers and teenage mothers completing their schooling. The South African Schools Act (1996) permits pregnant teenagers and teenage mothers to stay in school while pregnant and to return to school after childbirth. Jewkes, Morrell and Christofides (2009) note that while the policy focus is primarily on preventing pregnancies, it does create an environment for girls to continue schooling. However, again implementation remains a challenge. In this case implementation is often dependent on attitudes of the principal, teachers and governing bodies, and as such is not always undertaken in the best interests of the teenager. As Bhana et al. (2010:880) found: 'How teachers construct the policy and practice of permitting pregnant pupils and mothers to attend school varies in schools and across schools.'

This report explores the drivers of teenage pregnancy, in particular: gendered norms, knowledge, access and use of contraceptives and the barriers and facilitators to returning to school. The literature review included academic, grey and policy literature over the past 12 years, primarily focused on South Africa. We also undertook four in-depth interviews with teenage mothers, these were intended to give a 'face' and 'voice' to the research and to create a space for teenage mothers to share their experiences. This study was commissioned to provide a strong evidence base from which to develop advocacy strategies around reducing unplanned teenage pregnancy and ensuring teenage mothers realise their right to schooling.

## Introduction

In the past few decades South Africa has seen a decline in teenage fertility; and yet rates still remain high with around 30% of 15-19 year olds reporting having ever been pregnant, with the majority of these pregnancies being among 18 and 19 year olds. Distinguishing between whether these pregnancies are among older or younger teenagers is important as the impact for a 19 or 15 year old will be very different. Furthermore, only around one third of teenage girls return to school following childbirth. Importantly, while a large number of pregnant teenagers and teenage mothers are not in school, a significant proportion of girls had dropped out from school *before falling pregnant*.

Unplanned teenage pregnancy is driven by a number of issues including: unequal gender relations; gendered expectations of boys and girls; taboos around teenage sexuality making discussions around the topic difficult and fuelling stigma towards pregnant teenagers; poor access to contraceptives; judgemental attitudes of health care workers (HCWs), teachers and community members; low rates of consistent and correct contraceptive usage, and very little dual protection to protect against both unplanned pregnancies and STIs and HIV.

This report will highlight teenage pregnancy and teenage motherhood as a critical issue needing attention in South Africa. Not because teenage sexuality should be taboo, nor because teenage girls cannot and should not be mothers, but rather because a significant majority of these pregnancies are unplanned. The consequences of unplanned pregnancies can be devastating for teenage girls, and this report will show that for the majority of teenage girls unplanned pregnancy often leads to a number of negative consequences, in particular non-completion of secondary school, indeed of the one third of teenage mothers who return to school many battle to balance motherhood and schooling. And yet for teenage girls who receive support, (childcare, emotional and financial), teenage pregnancy and motherhood can sometimes be balanced with continued schooling, showing that with supportive interventions unplanned teenage pregnancy does not necessarily disrupt a girl's future.

Reducing unplanned teenage pregnancies and assisting teenage mothers to return and stay in school needs a multi-pronged response. Unplanned teenage pregnancy is not merely a reproductive health matter. Simply making more contraceptives available at clinics or schools will not necessarily reduce unplanned pregnancies. Given the multiple drivers of unplanned pregnancies the response needs to address all drivers: from the social, the structural through to individual behaviours, all of which can empower girls to make choices about their sexuality.

As the powerful report authored by Panday et al. in 2009<sup>1</sup> noted:

Given the inextricable links between adolescent motherhood and poverty and socio-economic disadvantage, efforts to empower young women through skills development and opportunities for developing sustainable livelihoods may assist in minimising tradeoffs between health and economic security (Panday et al., 2009:18).

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<sup>1</sup> This report was undertaken by the Human Sciences Research Council on behalf of the Department of Basic Education, and was tabled for extensive discussion in Parliament in 2009. The findings and recommendations within this report are widely known and discussed, and appears to be very influential.



This report is based on a desktop literature review, supplemented by in-depth interviews to enable us to hear from teenage mothers themselves. It explores the drivers of teenage pregnancy, and the impact of teenage pregnancy and teenage motherhood on girls' secondary schooling experience in South Africa. In particular the review considered: data on teenage pregnancy and adolescent fertility; the estimated numbers of teenage mothers who return to school; teenage girls knowledge, access to, and use of, contraceptives; the role of gendered norms and gender inequalities in driving teenage pregnancy; the barriers and facilitators that teenage mothers experience in returning to school and the related policy environment. This information will assist in creating an evidence base for advocacy campaigns carried out by organisations working on teenage pregnancy, to assist in reducing unplanned pregnancies and support pregnant teenagers and teenage mothers realise their right to education.

When reviewing teenage pregnancy, teenage mothers and educational dropout, this report considers three key areas of concern for pregnant girls:

- Teenage girls' experiences at school during pregnancy (pregnant learners);
- Teenage girls' experiences as mothers at school (parent learners);
- Teenage motherhood at school, do schools support them as mothers, and can they parent at school?

As with every report this review has not been able to cover everything and we are acutely aware that we have not been able to address a number of key marginalised teenage populations such as: teenagers living with HIV; teenagers living with disabilities; those not in school or teenagers who are lesbian, gay, bi-sexual, transgender or intersex (LGBTI). The scope of the review simply was not wide enough to cover the particular experiences and needs of these populations, however, we strongly advise a separate piece to explore teenage pregnancy and these marginalised teenagers.

Throughout the literature review no clear definition of three key concepts could be found, namely: '*school dropout*', '*not yet returned to school*' or '*temporarily absent from school*'. In other words how long does a pupil need to be away from school in order to be considered a 'school dropout'? Equally if s/he returns at any point is the period of absence simply considered a 'temporary absence from school' because they have now returned, no matter how long they were away – even if they had been counted as 'dropped out' until that point? The literature was not clear

In following this up I then had a personal communication with Prof Robert Morrell (UCT) to hear his views; he noted that despite extensive work in this area he is not aware of any definition, beyond the legal definition which states that all children under 16 years must be in school, and if not, they are considered as having 'dropped out'. He noted that following 17 years it becomes very unclear as legally no one is compelled to be in school, and it becomes unclear how to establish dropout. In summary, it appears there is no simple definition of how these terms are used in the context where a teenager may leave school for a while, and may or may not return. If s/he does return at some point it seems that s/he may move from being considered as having dropped out of school, to instead having had a 'temporary absence from school'. For the purposes of this literature review we are assuming that any teenage mother who does not return to school following childbirth has 'dropped out of school', if she returns at some point she becomes a teenager who was 'temporarily absent from school'.



## Methods

This study involved both a literature review and qualitative in-depth interviews with a small number of teenage mothers. The literature review included academic, grey and policy literature over the past 12 years, primarily focused on South Africa. However, a small amount of literature from beyond South Africa was included to provide broader context and to learn from other experiences. While this was not a systematic review, the process included:

- Searching for literature on Google Scholar
- Contacting a number of key academics and practitioners in the field for suggested readings
- Reviewing and following reference lists of publications

The qualitative interviews that we undertook are not intended to provide a representative study of teenage mothers' experiences, the purpose was to speak to a few young mothers to understand some of the subjective experiences that they face in different settings, and to provide detailed in-depth understandings of these teenage mothers' experiences. Their voices have been used to either support or contrast the findings of the literature review and despite not being a sample or even a large number they provide rich insights in exploring the issues.

A second key purpose for interviewing a few teenage mothers was to give young women voice within the literature and campaigns, particularly concerning returning to secondary school, in order to provide perspectives other than the ones dominant within the literature, namely: educators, school principals and community leaders.

The qualitative interviews were conducted among a small group of four teenage mothers, two of whom had returned to school following childbirth and two who had not returned to school. The interviews were undertaken by field staff at two Partners in Sexual Health (PSH) partner organisations who work in the area of teenage reproductive health and sexuality. Participants were purposively selected by the interviewers. Interviews were conducted in Pietermaritzburg, KwaZulu-Natal and Khayelitsha in the Western Cape

All interviews followed standard protocols, with written informed consent obtained in advance of the interviews. For those under 18 years written informed consent was obtained from their parent/guardian before the interviews were undertaken. The qualitative data was then analysed using thematic analysis, which provided a flexible and useful tool to identify and organise key themes from qualitative data. Full ethical approval was granted for this research by the University of KwaZulu-Natal's Human and Social Science Research and Ethics Committee in November 2012, reference renumber: HSS/1269/012.

Of the four teenage mothers we interviewed, two had returned to school and two had not. Of the two that returned one returned a week after childbirth and the other after a year. The youngest was 16 years old at the time of giving birth, the next was 16 years five months, and the others two were both 17 years old at the time of childbirth – non were very young teenagers when they gave birth, although all four are considered to still be on the 'young side of teenage-hood'. All four of the teenage mothers still lived at home with their mothers, and two were the primary caregivers of their children caring for them during the daytime and evenings, while two were sent to crèche. All were resident in urban areas.

## Limitations of the study

The terms of reference of the study were amended halfway through the study to also include reflections on the reasons for unplanned teenage pregnancies and teenage girls access to SRHR services. This addition was appropriate to ensure maximum usefulness of the report, however, unfortunately the added issues were not able to receive the same attention as issues around schooling – and as a result the reader will note more discussion around schooling and teenage pregnancy. A second limitation was that while we undertook seven interviews in total for a number of reasons were not able to use three of them.

## South African policy environment

There are a multitude of international commitments addressing women and girls' sexual and reproductive health and rights, and South Africa is signatory to all. Although these are not necessarily translating to change for women and girls on the ground, they do nonetheless play a critical role in: applying pressure to governments; recognising sexual and reproductive health and rights (SRHR's) as human rights; as monitoring and accountability tools for civil society and international agencies and providing citizens with clear commitments and targets to aspire towards. These commitments include among others: The UN Convention on the Elimination of All forms of Discrimination Against Women and Girls (CEDAW, 1979); the International Conference on Population and Development (ICPD, 1994); the Fourth World Conference on Women in Beijing (1994); the UN Special Assembly on HIV/AIDS (UNGASS, 2001); the Millennium Goals 3, 5 and 6 (MDG's)<sup>2</sup>; the Maputo Plan of Action (African Union, 2006) which considers how to implement SRH rights and services in Africa and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Gerntholtz et al., 2010; Bearinger, 2007; MIET; 2011).

### *What do the relevant policies say?*

South Africa has a relatively progressive legislative response to teenage pregnancy and motherhood, with some even suggesting it has a 'feminist influence' (Bhana and Clowes, 2008). The South African Constitution (1996) 'protects the right (of all citizens including children) to make decisions regarding reproduction and the right to access health care services, including reproductive health care'<sup>3</sup>(Hoffman-Wanderrerr, 2013:4). Since 1996 a number of laws have been passed to actualise these rights, and some are discussed below, of particular relevance is: the Choice on Termination of Pregnancy Act, the South African Children's Act and the Sexual Offences Act (Hoffman-Wanderrerr, 2013).

*The Choice on Termination of Pregnancy (CToP) Act* (No. 92 of 1996) uses a rights-based framework to introduce the legalisation of termination of pregnancy. It allows that any pregnant women or girl can have a pregnancy terminated on request up to 12 weeks of gestation<sup>4</sup>, provided by a certified midwife or doctor. And terminations can also be performed from 13-20 weeks in cases where the pregnancy poses a risk to the women's social, economic or psychological well-being. After 20 weeks terminations will only be performed to save the mother's life (Cooper et al., 2004

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<sup>2</sup> MDG 3 to promote gender equality; MDG 5 to improve maternal health and MDG 6 to combat HIV/AIDS, malaria and other diseases.

<sup>3</sup> Sections 12(2), 27(1)(a) of the South African Constitution.

<sup>4</sup> Section 2(1)(a) of the CTPA

and Jewkes et al., 2005). Importantly this applies to ‘any person of any age’<sup>5</sup> and can be performed without parental consent, so long as the child is deemed able to provide informed consent. Children under 18 years are advised to seek counselling before doing so, but they are not obligated to do so (Hoffman-Wanderrerr, 2013:4). The Act allowed for surgical terminations to be performed by a doctor or trained midwife in designated facilities, whereas medical terminations can be performed anywhere. In 2003 an Amendment was introduced in an attempt to broaden access to abortions (in light of ongoing high numbers of ‘illegal abortions’), the critical change was to allow any health facility with a 24-hour maternity facility to offer abortions for the first trimester; and for any nurse who has completed the ToP training to undertake first trimester abortions, not only midwives (Cooper et al., 2004).

*The South African Children’s Act (2005)* (as amended by the Children’s Amendment Act, No. 41 of 2007) came into effect, with regulations, on 1 April 2010. It allows those over 12 years to ‘access health care services, including HIV testing, contraceptives and termination of pregnancy (TOP) services, without parental consent’. The Act stipulates that: ‘contraceptives other than condoms [and also including condoms] may be provided to a child on request by the child and without parental consent of the parent or care-giver of the child if the child is at least 12 years of age.’ (Hoffman-Wanderrerr, 2013:7).<sup>6</sup>

*The Criminal Law (Sexual Offences and Related Matters) Amendment Act (Sexual Offences Act) (2007)* protects children and adults from non-consensual sex, it states that children can only consent to sex once they are 16 years old.<sup>7</sup> This means that even consensual sex between a child under 16 years and those over 16 would be considered non-consensual and statutory rape (Hoffman-Wanderer, 2013:9). It had also criminalised consensual sex between two children where both parties are between 12 – 15 years of age, this has been taken to court and on 14 January 2013 ‘Judge Pierre Rabie found that sections of the Sexual Offences Act, which made consensual sex between teenagers a crime, were unconstitutional’ (Parker, 16 January 2013).

The introduction of *the Child Support Grant* has been critical to provide support to mothers of young children, children from 0 -18 years are now eligible for the grant, and the primary caregivers receive R280 per child per month, to be increased to R300 by October 2013.

In terms of schooling and teenagers’ rights, *the South African Schools Act (SASA) (1996)*<sup>8</sup> permits teenagers to stay in school while pregnant and to return to school after childbirth. In addition, *the Promotion of Equality and Prevention of Unfair Discrimination Act* (No. 4 of 2000) stipulates that school learners who become pregnant should not be unfairly discriminated against (Lince, 2011). Bhana and Clowes (2008) noted SASA appears to only apply to mothers, and not fathers, which further perpetuates gendered norms around women carrying the burden of childcare.

In 2007 the Department of Education (DoE) released *Measures for the Prevention and Management of Learner Pregnancy* (MPMLP), it was intended to address the issue of an ‘implementation vacuum for SASA’ through providing assistance around implementation with a dual focus on prevention of pregnancy and management of pregnancy where it does occur. However it has been heavily critiqued for having some conservative language such as: ‘strongly advocating abstinence’ (Chohan, 2010) and for having some recommendations which do not seem to support girls

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<sup>5</sup> Section 1 of the CTPA

<sup>6</sup> Section 134(1)(a) of the Children’s Act

<sup>7</sup> Sections 15 and 16 of the Sexual Offences Act

<sup>8</sup> Department of Education no 84 of 1996

returning to school and realising their right to education. In addition, it states that a girl may not return to school in the same year she gives birth, and recommends that a mother should take a two-year break from school (note the latter is only a recommendation and not compulsory). These clauses are very difficult as they are primarily driven by the rights of child (which are of course critically important), however some have argued that this undermines the teenage mothers' right to continue education. It shifts the caregiving solely to the girl and the family rather than attempting to make the school a supportive space for both mothering and learning.

The Departments of Basic Education (DoBE) and Health (DoH) launched the joint *Integrated School Health Policy* (ISHP) in October 2012. This Policy is currently being viewed by many as an opportunity to ensure that sexual and reproductive health services and rights are addressed within schools; it outlines a number of critical spaces in which this can be done. For example Life Orientation has been widened to include a number of areas including: 'Abuse (sexual, physical and emotional abuse, including bullying and violence); sexual and reproductive health; menstruation; contraception; sexually transmitted infections (STIs) including HIV/AIDS; male circumcision; teenage pregnancy, Choice of Termination of Pregnancy (CToP), PMTCT; HIV Counselling and Testing (HCT) and stigma mitigation.' It goes further to note 'For sexually active learners, this should include the offer of provision of dual protection contraception and HCT, and screening for STIs. Where required, the school health nurse can provide these services on-site or refer the learner to a health facility where he/she should receive the service' (ISHP, 2012: 12-13), and it also addresses the importance of training and re-orientation for all staff who are involved in implementing the policy. This policy is new, and roll-out is still in planning phase. Like most policies it provides an opportunity and space to call for delivery within schools.

The end of 2012 saw the National Department of Health (NDoH) launching updated and revised *National Contraception Policy Guidelines*. The Guidelines state that: 'The need for the policy update was prompted by: changes in contraceptive technologies; the high prevalence of HIV in South Africa; and the need to ensure linkages and alignment with other related national and international policies and frameworks.' Among the many aims an important additional point was highlighted: 'to make available and promote wider contraceptive choice and method mix in public sector facilities' (National Contraception Policy Guidelines, 2012: 7). These guidelines seem very all-encompassing and recognise the need for improved service delivery, health care provider training and ensuring user-friendly clinics – all of which are critical for the success of these guidelines.

The Department of Health also launched a booklet for teenagers in 2012, entitled 'Preventing Teenage Pregnancy'. It appears to be a comprehensive and accessible booklet which aims to assist teenagers to learn about and avoid teenage pregnancy 'through empowering them with knowledge.' The approach is interesting, it avoids moralising and does not simply say 'abstain', but rather says if one is going to have sex be responsible and protect oneself from pregnancy, STIs and HIV. Nonetheless it still includes a push for 'abstinence, faithfulness and condoms'.

Hoffman-Wanderer, (2013) and the 2011 Ibis workshop of key government and civil society actors, both highlighted concerns about conflicting government policies. These include the Children's Act, the Sexual Offences Act and the Termination of Pregnancy Act which either contradict each other, or which appear contradictory. These contradictions and confusions arise because legally children can access contraceptives from 12 years, can obtain terminations of pregnancy and yet are only allowed to engage in sex from 16 years onwards (except for the recent ruling allowing for sex between consenting teenagers 12-15 years). Not only does it create confusion for educators and HCWs when counselling and providing information and services

(indeed many in the Hoffman-Wanderer study reported inaccurate understandings of the laws), it also provides an ‘excuse’ for those service providers who do not wish to support children’s right to their sexuality, contraceptives, terminations etc to ‘hide’ behind the confusion. Furthermore, the Hoffman-Wanderer (2013) report highlighted the difficulties experienced by some health care providers where they are being asked to ‘police’ teenage sexuality rather than supporting teenagers in their rights to safe sex.

### ***How effectively are policies being implemented?***

Despite progressive policies supporting teenagers in their rights to: autonomous sexual choices; comprehensive sexuality knowledge; a range of contraceptive options from the public sector; access to terminations of pregnancies and HCWs and educators that support them in their sexual choices, much of the literature spoke in detail of how teenagers are not able to realise these rights. This will be explored in detail further in the paper, suffice to say that policy is failing many teenagers, both girls and boys, and not enabling them to be in control of their sexuality.

While the policy arena is broadly supportive of enabling teenage girls to remain in school while pregnant and return as mothers, again implementation seems to remain a significant barrier, since as Morrell, Bhana and Shefer (2012:19) noted: ‘The legislative environment is not an automatic driver of gender equality in schools.’ There are insufficient consequences for schools, principals and governing bodies if the policies are ignored.

Within schools policies are interpreted and implemented by principals, governing bodies and teachers, often influenced by communities and families – and this allows ‘space’ for people to apply their own morals and values to implementation. Implementation is filtered through people’s own views on teenage sexuality, and beliefs about ‘appropriate girls and boys norms’ – and this has led to many violations of these policies (Chigona and Chetty, 2008; Morrell, Bhana and Shefer, 2012 and Panday et al., 2009). Panday et al. (2009:99) ‘...this practice [of expelling pregnant girls] persists. Anecdotal reports through the media... indicate that girls continue to be expelled when they become pregnant.’ This was seen again with yet another case taken to the Constitutional Court in March 2013, the case is opposing two schools in the Free State that tried to keep pregnant teenagers and teenage mothers away until the year after their babies are born (The Mercury, 6 March 2013).

The literature had numerous examples of teachers and principals violating the law extensively. Indeed in 2000 the Commission on Gender Equity received numerous complaints from teen mothers not allowed to return to school (Chigona and Chetty, 2008:265). Chigona and Chetty (2008) also noted many examples of teachers refusing to support girls who had missed classes because of childcare responsibilities.

Morrell, Bhana and Shefer (2012) noted that while some girls are still being expelled (illegally) this is decreasing, however discrimination, stigma and pressure to leave is still experienced by many girls. Shefer et al. (2012) also noted that girls experienced increased pressure to withdraw from school in the third trimester when the pregnancy was more visible.

Our interviews also reflected ignorance about the SASA policies, indeed, none of our respondents knew of the law enabling them to continue at school. However, Buhle, who was 16 years at the birth and returned to school one week after childbirth, was informed about it by her teacher, once pregnant. Both of the teenagers who left while pregnant reported that they left



under duress from school teachers and principals, and reiterated that they were unaware of the law.

Chigona and Chetty (2008) noted that in many cases the violations were not only about moral objections to the policies or ignorance of them, in some cases principals and teachers did not know how to implement them, even when they wished to do so. Some teachers noted the lack of training and professional help available to them as teachers to assist them in supporting the girls.

The Child Support Grant (CSG) appears to be a useful support to mothers, however uptake among teenage mothers is very low. A study by Makiwane and Desmond (2006) exploring whether these grants had become an ‘incentive for teenage pregnancy’ found that this was not the case, and in fact only 20% of teenage mothers were accessing a social grant in the mid 2000s. They went on to note: ‘that below age 30, there are fewer CSG beneficiaries than women who gave birth in the year, whereas for those above age 30 there are more beneficiaries. This is in line with patterns of childcare in South Africa, where older persons take on the care of children of young women and thus qualify to receive a CSG in respect of those children’ (Makiwane and Desmond, 2006:12). Another study by Steele and Geospace (2006) found that teenager mothers represented only 5% of all CSG recipients registered in 2005, which was considerably lower than the proportion of teenage mothers in the South African population (Morrell, Bhana and Shefer, 2012: 12).

## Unplanned teenage pregnancy in South Africa

Teenage pregnancy and being a teenage mother is not simply about teenagers having unprotected sex, it is wrapped up in gendered norms, sexual taboos (especially around teenage sex) and gender inequalities within our societies which influence **how, when and why teenagers have sex**. As Jewkes, Morrell and Christofides (2009:676) noted ‘teenage pregnancy is not just an issue of reproductive health and young women’s bodies but, rather one in its causes and consequences that is rooted in women’s gendered social environment.’

Panday et al. (2009) presents an excellent summary of the critical drivers that place teenage girls in South Africa at heightened risk of early pregnancy. Factors include:

- Young girls dropping out of school early on, often because of economic barriers and poor school performance;
- Young girls growing up in areas of entrenched poverty;
- Not many opportunities to discuss sexuality where high levels of stigma about adolescent sexuality abound, leading to gaps in knowledge and access to contraceptives;
- Men making decisions about sex in situations where for instance young women are involved in relationships of unequal power often resulting in unprotected and coerced sex;
- Young women who are poor having often to make ‘trade-offs’ between health and economic security, which can lead to staying in abusive relationships, inter-generational relationships and multiple partners; these situations usually reduce a young women’s ability to negotiate when and how to have sex.

Conversely, Panday et al. (2009) note that for a young woman when both parents, in particular the mother is at home, risk of early pregnancy is decreased. Jewkes, Morrell and Christofides (2009: 685) went on to add that:

Teenage pregnancy is a deeply embedded social phenomenon. While teenage women contribute to shaping it, their attitudes and actions are critically shaped by the environment in which they are socialised and the relationships that they develop... reducing teenage pregnancy we suggest...lies in paying more attention to the gendered features of sexuality and the terms and conditions under which they have sex (Jewkes, Morrell and Christofides, 2009:685).

Sexual activity among teenagers is 'a common and normal bridge to adulthood' (Senenyake and Faulkner, 2003; Flanagan et al, 2013: 19), and it should not be stigmatised nor condemned but rather, teenagers should be recognised as moving into a period of sexual discovery and be supported to ensure they are informed to be able to have healthy, safe and satisfying sex. Nonetheless one does need to be mindful of the different experiences of young teenagers (under 17) and those 17 and older because, as mentioned earlier, falling pregnant and becoming a mother have very different impacts for a young teenager as opposed to an 18 or 19 year old, and our responses need to take account of this nuanced reality.

Despite common assumptions that sexual debut in southern Africa is high, the highly acclaimed study by Pettifor et al. (2009) indicated that 'age at first sex is fairly consistent worldwide; for most young women in Africa, sexual debut occurs at ages 17-20. The mean age at first sex among young men and women in South Africa ranges from 16-18 depending on the age and type of sample' (Pettifor et al., 2009: 82). In terms of those having sex at a younger age, they found that '18% of young men and 8% of young women said they had sex for the first time at age 14 or younger' (Pettifor et al., 2009: 83) They also noted that women's first partners were generally 1-4 years older than them and most reported that their first sex was with a main partner. And while 7% of 15-19 year olds reported their first sex as coerced, when asked 'whether they had been willing participants in their first sex' only three in five reported they had been willing. They also noted that 'Young women who had had their first sexual debut at an early age were more likely than other women to report that their first partner had ever physically forced them to have sex' (Pettifor, 2009: 87). Jewkes, Morrell and Christofides (2009) reported that by 17, half of all teenagers were sexually active.

Furthermore, although most teenage pregnancies in South Africa are unplanned (DoH et al., 2007; Panday et al., 2009; Pettifor et al., 2005; Reddy et al., 2010; Flanagan et al, 2013), one must be cautious about seeing all pregnancies as unplanned. Indeed, Pettifor (2007), [reported in Ashton et al. (2009)] found that 34% of 15-19 year olds in South Africa who were pregnant ***did NOT report these pregnancies as 'unplanned'***. Cooper et al. (2004) found that 53% of pregnancies were unplanned or unwanted. In Ehlers (2003) study she found 13.6% of the adolescent mothers had planned their pregnancies. Neloufar Khan reflecting on the Department of Social Development's current study on teenage pregnancy<sup>9</sup> noted that when teenage mothers were asked about their reasons for falling pregnant some clearly had agency, and said that it was planned. Panday et al. (2009:56) also noted that in a 2006 survey 28% of young women reported that she fell pregnant because 'I wanted a baby'. Moving from a women's rights perspective it is important to recognise that not all teenage pregnancies are unplanned and unwanted and secondly, not all teenage mothers are 'victims in need of rescuing', their right to choose to

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<sup>9</sup> This data was presented at the Ibis-hosted meeting on Teenage Pregnancy on 26 February 2013, the raw data and reports are not yet available.



become pregnant needs to be respected and balanced with a clear need to be reducing the number of unplanned pregnancies in the country.

Irrespective of whether a teen pregnancy is planned, it is important to recognise that teen pregnancies among young teenagers can be medically dangerous for the mother. Indeed, maternal mortality remains one of the biggest killers of teenage girls in Africa (World Population Foundation); girls in their teens are twice as likely as older women to die from pregnancy and childbirth-related causes (Save the Children, 2004), and further, young girls between the ages of 10 and 14 are five times more likely to die during delivery than mothers who are between 20 and 24 (Save the Children, 2004).

Ehlers (2003) went on to note that babies of teenage mothers had poorer neonatal outcomes and low birthweights. Ardington (2012:3) supported this noting that: 'The urban survey<sup>10</sup> showed that teen childbearing had a negative impact on the nutritional status of children who were 10 percentage points more likely to be underweight at birth, and 18 percentage points more likely to be stunted.' They went on to note negative educational impacts 'children of teenage mothers ...had poorer educational outcomes than their peers. Children born to younger teenagers were most at risk – especially in rural areas. The younger the mother the higher the child's schooling deficit. Children born to older teenagers in urban areas were not lagging behind in grade attainment compared to peers born to older mothers' (Ardington, 2012:3).

Much has been written about 'teenage mothers not coping with being parents'; however some of the literature highlighted young women embracing motherhood and being 'good mothers'<sup>11</sup>. Our interviews supported this - all our respondents were actively parenting and supporting their babies, and those who had returned to school were balancing school and motherhood very effectively.

Mainstream literature, researchers and some South African leaders tend to highlight the issue as a 'crisis that hinders teenage girls' educational opportunities'. Indeed, Jewkes, Morrell and Christofides (2009) and Clowes and D'Amant (2012) both noted judgemental attitudes from President Zuma towards teenage mothers, where Zuma suggested in the media that the 'policy [on teenage pregnancy] has been too permissive, teenagers too indulged and that solutions require "tough love" (Jewkes, Morrell and Christofides, 2009:676). Zuma went further to say that: 'schoolgirls who fall pregnant should be separated from their babies until they have completed schooling' (Clowes and D'Amant, 2012:35). These views are found across the literature, as Ngabaza (2011:44) noted: 'mainstream discourse on teenage pregnancy is generally that of moral outrage and patronising concern for young people and their children.'

Numerous authors critiqued this attitude of 'moral outrage and panic' arguing that 'the moral panic is unfounded' (Panday et al., 2009:12) and that many teenage mothers made conscious choices to keep their babies, embraced motherhood, managed their pregnancy well, continued to succeed at school and were very 'good mothers' (Panday et al., 2009; Chohan, MacLeod, Ngabaza, 2011; Mokgalabone in Chigona and Chetty, 2008:264; Morrell, Bhana and Shefer, 2012). Furthermore, Bhana and Clowes (2008) found that many teenage girls who fell pregnant had exercised sexual agency and had engaged in consensual sex, noting that such sexual agency is nonetheless operating within the confines of gender inequalities.

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<sup>10</sup> Drawing on 2001-2009 data from the Africa Centre Demographic Surveillance Area

<sup>11</sup> The term 'good mothers' is used advisedly to critique the very notion of 'good motherhood', the critique will follow later.

The literature went further to challenge the frequent assumptions and labelling around notions of 'good mothering' and what 'good mothers' are (MacLeod and Chohan, 2010; Ngabaza, 2011; Bhana and Clowes, 2008; Chohan, 2010). For example Chohan (2010:20) noted the common belief that good mothers are: 'skilled, mentally mature, more responsive, knowledgeable, physically and psychologically equipped to deal with motherhood', this is set up as a 'gold standard' that teenage mothers cannot meet, with many proponents of this framing of 'good mothers' arguing that teenage mothers are not physically and psychologically equipped to achieve these ideals. Macleod (2001:499) argues both that this 'romanticised portrayal of good mothering' is in itself a false construction resulting from a patriarchal lens and secondly that many teenage mothers do not battle with becoming mothers and the necessary changes that accompany this. Moore (2013) undertook a critical study of three generations of mothers where she noted that ideas of mothering and 'good mothering' have shifted significantly in South Africa over the last decade, with many mothers now expressing very different views on the timing of marriage, role of fathers and 'ways of mothering'. This shifting view of mothering included the recognition of the importance of being a mother as well as 'nurturing the self' (for which she needed support): 'The mother in the younger generation, however, required support from kin caring for her children so that she could work on the "project of the self"' (Moore, 2013:168). This 'project of the self' is a more modern shift, which often involves furthering her education and career while having young children, both for her own empowerment and the benefits of her children.

Many studies highlighted both the challenges and rewards of teenage pregnancy and motherhood, as experienced by teenage girls. Chohan's (2010) research<sup>12</sup> highlighted that the young mothers in her study acknowledged that motherhood was demanding and challenging, especially when the baby was sick or they had a lot of school work, in fact many of her participants started their day three hours earlier than their peers to prepare themselves and their baby. However, they had all returned to school and were achieving academically. In addition, many felt caught in a double-bind, they wanted to stay home and care for their babies, which would reinforce the attitudes of 'teenage mothers as reckless because they don't return to school'. But they also wanted to return to school, however this would feed into the notion that 'teenage mothers are not good mothers' as they are accused of prioritising their education over their babies well-being.

Nonetheless despite most young mothers being competent, loving mothers, and the moral outrage being misplaced, one still needs to reflect on whether motherhood as a young teenager (under 17 years) is desirable, whether it limits opportunities for young teens and the potential negative impact for the children – in other words – are the young teenage years an optimal period to become a mother?

## Teenage fathers

Much of the literature noted the absence of research and commentary on the teenage fathers, and even the South African Schools Act (SASA) appears to be intended for the girl only. This in many ways reflects societal, gendered prejudices that responsibilities for 'falling pregnant' and being a 'teenage parent' lie with the girl, and further that the role of parenting should be born almost exclusively by the mother. However, a few studies are showing that some of this is changing, and indeed expectations from both mothers and fathers is slowly changing – many of

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<sup>12</sup> Chohan undertook qualitative interviews with eight teenage mothers, all of whom had returned to school, the school was in an inner-city area.

today's mothers are expecting more involved fathers, and an increasing number of fathers are trying to be more involved.

The limited research on fathers showed that some felt their primary role should be in providing economically, and not actually undertaking care-work, while others wanted to be involved fathers and others also noted that it was important to acknowledge paternity. Panday et al., (2009) referencing the work of Swartz and Bhana (2009:77), noted that:

While most teenage boys involved in the study were not ready for fatherhood, they expressed a deep sense of responsibility for the child and a willingness to be actively involved in the child's life. Unlike reports from the perspectives of young women, few men spoke of denying paternity...the key motivation to be present and to participate in their children's lives is the absence of their own fathers.

Moore (2013) undertook interesting qualitative research exploring changing conceptions of motherhood and marriage with three generations of mothers in six families in Cape Town. She noted that:

Findings from the largely qualitative studies of the last two decades have also suggested that black African women opted out of marriage in the interest of empowerment. Evidence for the uncoupling of marriage and motherhood, as argued by (Cherryl) Walker, can also be seen in the rise in female-headed households and the decline in the stigma attached to single motherhood, suggesting that many 'women look upon it (single motherhood) as a preferable option to marriage'... ***African women... still valued marriage as an ideal but remained sceptical about its actual feasibility in their own circumstances*** (Moore, 2013: 155).

This critical work helps us to explore the changing expectations and roles of fathers. Many teenage girls are probably not expecting marriage, but still value father's involvement in the baby's life. Moore (2013) also reported that in 1996, 44% of African women between 30-34 years had never married, and by 1997 this figure had increased to 51%. As stressed above this is not simply due to not believing in marriage, but rather: 'The majority of African women believe that marriage should take place after one has achieved a certain level of educational attainment and financial independence' (Moore, 2013: 161). Similarly, the younger generation of mothers saw providing financially for their children as a critical role of mothering, which often meant sending the child to the maternal grandmother while the mother studied and worked to ensure better earning potential. Indeed, Moore found that none of the younger generation of mothers that she interviewed were married and only one was living with her long-term partner (these women were all between 20 and 30 years).

Moore's study of Ndecka (younger generation mother) and her mother and grandmother highlighted the changing expectations around the role of the father. In Ndecka's case:

Nomsa (great-grandmother) regarded the father as a 'good worker', while Xoliswa (grandmother) regarded him as a 'responsible father', but although Ndecka (mother) accepted that her former partner 'cared about' the baby, she expected him to '**care for**' the baby, too. His conduct in taking another girlfriend when he heard about Ndecka's pregnancy did not match her expectations of 'good fatherhood' (Moore, 2013: 169).

Ndecka felt that despite the father phoning on a weekly basis, and occasionally buying things for the baby his decision to leave his relationship with her and his lack of meaningful engagement in caring for the baby meant he was not a 'good father', she clearly expected more than financial

support. These changing expectations may be confusing for young fathers, but are also exciting as they represent new opportunities for fathers to be challenged to be ‘present and engaged’ as fathers.

Of the four mothers that we interviewed none were living with the baby’s father and two fathers were involved to different degrees with their babies. In both cases the teenage fathers left school to find work to support the baby, in one case the fathers’ decision to leave school and seek work supported the mother, Buhle, to be able to return to school. In Buhle’s case the father is very involved in caring for the baby – he takes the baby to and from crèche creating more space for the mother to study. In the other case despite the fathers decision to leave school and seek work to support his baby, he cannot provide enough money and the mother, Nonhlanhla (who was 17 years at the birth) had to leave school to care for the baby. This interesting finding highlighted that among this particular small number of individuals while the involvement of the father is important, and desirable, there was not always a link between the father providing financial support and the mother returning to school. Indeed, in Buhle’s case where the father was involved in caring for the baby *and* assisting financially this supported the girl returning to school, however financial support alone was not enough for Nonhlanhla to return to school.

## **Link to HIV**

Teenage pregnancy is a marker of unprotected sex, and therefore high rates of teenage pregnancy alert us to the high-risk nature of many sexual encounters among teenage girls. This is of particular concern as South Africa has one of the highest HIV prevalence figures globally, 30.2% of 15-49 year old women were living with HIV in 2010 (The South African Department of Health Study, 2010) (Panday et al., 2009; Morrell, Bhana and Shefer, 2012; Bhana and Clowes, 2008; Jewkes and Morrell, 2009; Bearinger, 2007). Pettifor et al. (2009) also noted that early sexual debut heightens HIV risk, and further that ‘sexual behaviours at the time of early coital debut (e.g. non-use of condoms) may set a precedent for future behaviours that elevate HIV risk’ (Pettifor et al., 2009: 82).

Panday et al. (2009:16) noted further that: ‘incomplete schooling is a risk factor for both pregnancy and HIV in South Africa.’ This is a sobering reminder of the inter-connectedness between unprotected sex, teenage pregnancy, HIV and school dropout and the many vulnerabilities that teenager girls in South Africa face. As such intervening to decrease unwanted pregnancies, though addressing both structural issues and individual behaviour change, will also impact on reducing STIs and HIV and leading to improved health outcomes: ‘investing in the health of adolescents not only improves the health of adolescents today, but also ensures that the next generation of children is healthier’ (MIET, 2011:7).

Given this dual crisis of both high levels of unplanned teenage pregnancies and high levels of HIV among teenagers in South Africa, many are advocating for stronger messages around consistent, dual protection for all sexual encounters - in other words using a hormonal contraceptive plus a condom every time one has sex. As MacPhail et al. (2007:7) noted, often in longer-term relationships young women battle to retain condom use, and prevention work needs to recognise this particular experience of young women and assist them to retain ongoing, consistent, dual protection. As they went on to note: ‘Now, more than ever, there is a need to continue efforts to better integrate family planning and HIV prevention services.’

## Fertility and pregnancy rates

It is challenging to offer accurate, comparable figures over time on teenage fertility and pregnancy. These obstacles stem from a number of problems, firstly: ‘South Africa does not collect vital statistics on fertility, pregnancy and abortion. While trends in fertility [measure of live births] can be reliably estimated from national datasets, pregnancy rates [that include abortions and miscarriages] cannot be reliably estimated’ (Panday et al., 2009:113).

Secondly, in some areas data collection methods have improved and so it is difficult to assess trends over time. The Education Management Information System (EMIS) is a good example of improved data collection methods, it measures the ‘number of female learners (that schools are aware of) that fell pregnant over the previous year’. The assumption is that the increase in EMIS figures are actually as a result of improved data collection and not an actual increase in pregnancies. Thirdly, the introduction of the Choice of Termination of Pregnancy Act in 1996 has made pregnancy rates harder to measure for two reasons: it is unknown whether terminated pregnancies are captured in survey data and the EMIS system, and secondly there is no comprehensive national register of abortions performed (Panday et al., 2009:105).

The distinction between fertility (live births) and pregnancy (live births plus abortions, miscarriages and stillbirths) is important to bear in mind when analysing this data. It is also important to note that some data is presented as ‘teenagers who were ever pregnant’, which measures whether a teenager fell pregnant over any of her teen years, a second set of data looks at whether teenagers were ‘pregnant in the previous year’, the second set of data obviously presents different, lower figures.

Although South Africa has seen a slow decline in teenage pregnancy since the 1980s Jewkes, Morrell and Christofides (2009) with one of the lowest teenage pregnancy levels in the region comparable to many middle-income countries, pregnancy rates remain high, **with around 30% of 15-19 year olds reporting *having ever been pregnant*** (Lince, 2011; Flanagan et al, 2013; Pettifor et al., 2005; Cooper et al., 2004; Reddy et al., 2008, Holt and Lince, 2012). Ardington, (2012) revealed one of the lowest figures, showing that teenage childbearing has decreased from 30% in 1984 to 23% in 2008. The South African National Strategic Plan for HIV, TB and STIs (2012 – 2016:40) notes higher figures, that 39% of 15-19 year olds have ever been pregnant. The Panday report (2009: 11) noted a ***decline in teenage fertility by 10% between 1996 (78 per 1000) and 2001 (65 per 1000), and a further decline was reported in 2007 (54 per 1000)*** in the 2007 Community Survey.<sup>13</sup>

However, this report believes it is important to re-iterate that ‘There is a significant difference between a girl of 15 and a young woman of 19.’ (Ardington, 2012:1) Indeed, pregnancy and motherhood may not be particularly problematic nor uncommon for an 18 or 19 year old, however, for a younger teenager (under 17 years) the implications may be very different.

Ardington (2012) showed that ‘there was a decrease in the proportion of children born to teenagers under 17 since 1984, and a corresponding increase in children born to older teenagers (17-19 years). Only 5% of children were born to mothers under the age of 17 in 2008, down from 13% in 1984’ (Ardington, 2102: 1).

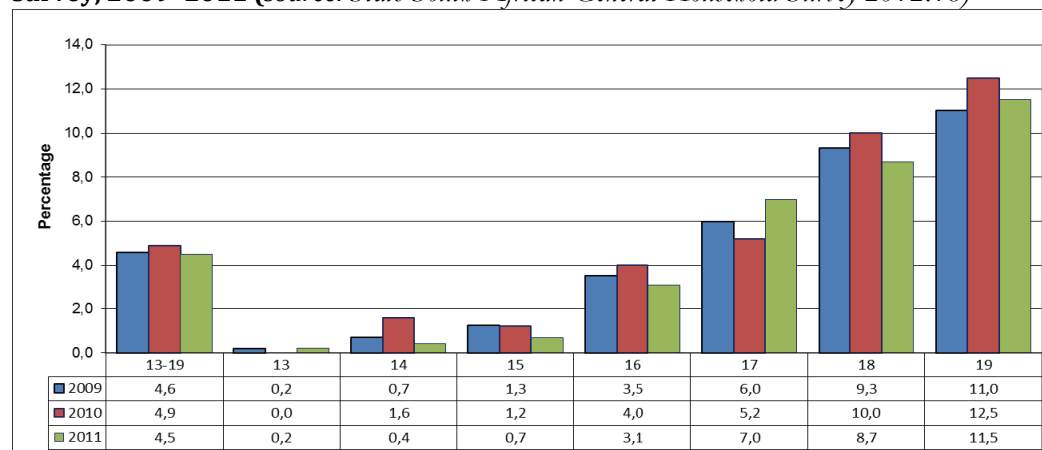
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<sup>13</sup> The Community Survey is the largest survey to be conducted by Stats SA. The survey, conducted in 2007, collected information on population dynamics (population size, composition and distribution; and fertility, mortality and migration), disability and social grants, school attendance and educational attainment, labour force and income.



Table 1 shows another source of information disaggregated by age, the *Statistics South African General Household Survey 2012*, which indicates the percentage of teenage girls who *were pregnant in the past year*, over three years, 2009, 2010 and 2011. It indicates that approximately 4.5% of girls 13-19 years had been pregnant in 2010, a slight decline from the preceding two years. Importantly it shows that the majority of these pregnancies were among teenagers who were 17-19 years old, and it supports Ardington's point that younger teen pregnancies appear to be declining (Statistics South Africa, 2008:18).

**Table 1: Percentage of females aged 13–19 who were pregnant during the year preceding the survey, 2009–2011** (source: *Stats South African General Household Survey 2012:18*)



The review considered data on whether teenage mothers fell pregnant a second time while still a teenager, the data available on this is very limited. Kaufman and de Wet (2001:149) used demographic data to explore this question and found that increasingly girls who become mothers as teenagers delay their second baby by at least four years. She also found a further emerging trend that becoming a mother while young, is associated with having a small number of children over one's lifetime. 'The completion of studies, financial security, and a stable relationship were the requirements that the young women mentioned most frequently should be met before they would choose to have a second child' (Kaufman and de Wet, 2001:156). Panday et al., (2009) noted that while the global trend is that teenage mothers are at increased risk of having more children over a short period, she concurred with Kaufman and de Wet (2001) that South Africa deviates from this norm.

Morrell, Bhana and Shefer (2012) noted that no national figures seem to be available on teenage fathers, and little is recorded on their feelings on fatherhood, whether they wish to become fathers, would accept responsibility and so forth.

## Racial, socio-economic, geographic and educational patterning of pregnancy

Jewkes, Morrell and Christofides (2009) highlighted that teenage pregnancy is affected by a number of social factors including: race, socio-economic status, geography and education. The 1998 and 2003 South African Demographic and Health Surveys showed that teenage pregnancy:

...displays marked social patterning. Being a teenage mother was more prevalent in rural areas (60% more likely), amongst women with lower educational attainment (a three-fold difference between completion of primary school and matric) and amongst African and Coloured women (a

seven-fold increase between African and Coloured women on the one hand and White and Indian on the other (Jewkes, Morrell and Christofides, 2009: 678).

Ngabaza (2011) found that while there is a general decline of teenage pregnancy across South Africa, rates are still higher in certain provinces such as: Mpumalanga, Northern Cape, Limpopo and the Eastern Cape, which is reflective of historic apartheid divides, and poorer black communities.

Rural areas also see a different trend, Ardington found that despite a general trend of declining teenage births, 'the proportion of teenagers who gave birth has remained higher in rural areas over time. While rural teen births increased slightly between 1984 and 2008, the increase was driven by births to older teen mothers and the proportion of younger teen births almost halved' (Ardington, 2012:2). Flanagan et al (2013) supported this noting that teenage pregnancy was higher in rural areas than urban areas, with 14% of rural teenage girls becoming mothers as compared to 11% in urban areas. 'The DBE suggest 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' (Flanagan et al, 2013:10).

In addition to socio-economic status and geography, teenage pregnancy was still more common among Black African and Coloured teenage girls – reflecting the complex inter-connectedness of these factors with race (Mkhwanazi, 2010; Marteleto and Lam, 2008; Panday et al., 2009). Panday et al., (2009) noted that: 'rates are significantly higher among Black (71 per 1000) and Coloured (60 per 1000) adolescents, [whereas] fertility among White (14 per 1000) and Indian (22 per 1000) adolescents approximate that of developed countries.' (Panday et al., 2009:11) No studies explore how these issues of geography, socio-economic status, education and race intersect, indeed it is likely that geography, socio-economic status and education may well explain the rates of pregnancy among different race groups.

## Abortions

Abortion figures remain a challenge to measure and compare over time, firstly as many young women who access abortions continue to access 'unsafe/illegal abortions' (which are difficult to capture in data). And secondly, the latest report on maternal mortality in South Africa: *Saving Mothers 2008-2010: Fifth Report on the Confidential Enquiries into Maternal Deaths in South Africa* (Department of Health, 2012) did not present the data in easy and comparable ways. For example, the data did not explicitly report on abortion figures. , Instead for the period 2008-2010 the new category is 'miscarriages' and while mining that data provides some insights into abortion figures, it has become difficult to analyse and compare with previous years.<sup>14</sup>

Nonetheless researchers do have data and manage to overcome many of the hurdles above to provide us with data that assists in our understanding of abortion uptake. Cooper et al. (2004) found that legal abortions in South Africa had increased from 29,375 in 1997 to 53,510 in 2001. In addition: 'maternal mortality from unsafe abortions has also decreased.' Cooper et al. (2004: 75) However, the National Contraception Policy Guidelines, (2012:19) found that the numbers decreased from 77 207 in 2009 to 68 736 in 2010. Jewkes et al., (2005) noted that despite this significant uptake since legalisation:

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<sup>14</sup> Thanks to Naomi Lince, Ibis for analysing the report and data.



...the legislative reform did not end the stigmatisation of abortion in South Africa. Four years later women still usually tried to conceal that they had induced from examining clinicians when they presented with an incomplete abortion (Jewkes et al., 2005: 1237).

Cooper et al. (2004) also noted that additional challenges arose from a shortage of health care providers willing to perform abortions, and despite the legal provision to refer patients to a willing provider some health care providers simply did not. The National Contraception Policy Guidelines, (2012:19) highlighted the ongoing challenges as: 'inadequate numbers of trained staff, long waiting times and conscientious objection by health care workers.' In terms of 'unsafe abortions' and 'abortions outside of designated facilities' Jewkes et al. (2005) undertook in-depth interviews with 46 women to explore why they did not access the 'safe abortions'.<sup>15</sup> They concluded that:

The fact that a third of women with incomplete abortions had abortions induced outside designated facilities suggests that there was still substantial abortion activity in South Africa's communities outside designated facilities. This study suggests multiple reasons for this. Some lack information on abortion rights, while for others the services are not accessible or acceptable. The greatest barrier to use of designated services in the study sample was lack of knowledge of the Choice in Termination of Pregnancy Act... Among those who knew of the law, especially those self-inducing, fear of hospital staff rudeness was a major barrier to service access (Jewkes et al., 2005: 1240).

Data on teenage abortions is difficult to access and interpret. Indeed, many qualitative studies have found very low rates of abortions among their respondents – however this needs to be sensitively interpreted given the high level of stigma associated with abortions these figures may be severely under-reported. Grant and Hallman (2008) found in their study of pregnant teenagers that less than 3% of reported pregnancies did not carry to term. MacPhail et al.'s 2007 study found similar rates, with only 2.6% of their sample having terminated the pregnancy, despite high levels of 'unplanned' pregnancies. Reported reasons for low uptake included: lack of knowledge about the option; social stigma; moralising about terminations and health care worker's attitudes towards those requesting termination. However, in contrast we note Grant and Hallman (2008) who reported that Makiwane found significantly higher numbers, finding that 13% of abortions at public health facilities were for girls under 18 years, and that this proportion is considerably higher than this age group's contribution to fertility generally.

Many teenage girls reported having considered abortions, largely as a result of social pressure not to be sexual and fall pregnant; fear of disclosing their pregnancy; likely impact on their own lives and decisions about whether they would have to leave school (Kaufman and de Wet, 2001; Ngabaza, 2011; Chohan, 2010).

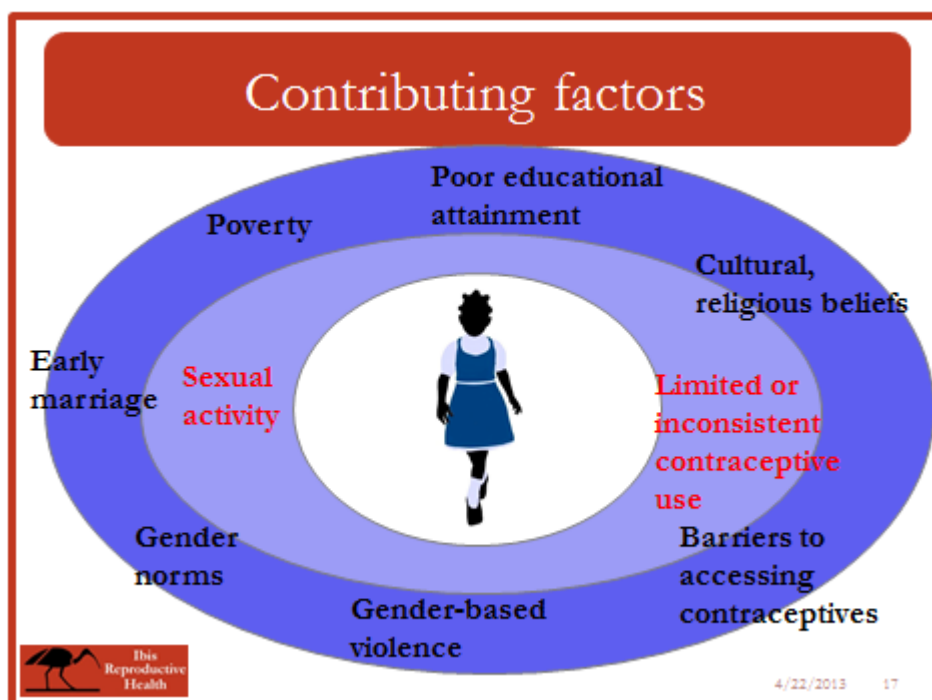
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<sup>15</sup> The aim of this study was to explore why women were still aborting outside designated facilities, and in many cases still having illegal abortions, in an area where there were plentiful services. Terminations performed outside designated facilities included: self-induced abortions with and without the assistance of others (n¼25); abortions induced by a lay abortionist (n¼10) or illegally by a nurse (n¼3) or pharmacist (n¼2); surgical terminations not performed in designated facilities (and therefore illegal, n¼1); and terminations started legally (medically) but where the provider acted as if it were illegal and failed to provide acceptable support once bleeding commenced (n¼5). What they have in common was that none of them were 'safe' terminations and all resulted in women attending emergency services with incomplete abortions.

## What is driving teenage pregnancy?

As noted above teenage pregnancy in South Africa is driven by many factors including: gender inequalities; gendered expectations of how teenage boys and girls should act; sexual taboos (for girls) and sexual permissiveness (for boys); poverty; poor access to contraceptives and termination of pregnancies; inaccurate and inconsistent contraceptive use; judgmental attitudes of many health care workers (HCWs); high levels of gender-based violence; and poor sex education (Jewkes and Morrell, 2009; Panday et al., 2009; Chigona and Chetty, 2007; Bearinger, 2007). The figure below from Flanagan et al (2013:11) provides a useful illustration of these inter-connected factors, highlighting how sexual activity and contraceptive-use place girls at immediate risk of unplanned pregnancy, yet these are influenced by structural and contextual factors.

### *Factors Contributing to teenage pregnancy*



*Source: Flanagan et al, 2013, Teen pregnancy in South Africa: A literature review examining contributing factors and unique interventions*

These multiple drivers mean that an effective response cannot simply be judgmental, technical, focused on individual behaviour change, or simply increasing contraceptive supplies. The response needs to be holistic, it needs to address structural factors that disempower young girls from being in control of when, how and with whom they have sex; it must also ensure improved accessibility, acceptability and appropriateness of contraceptives and clinics, and nurture individual behaviours that will lead to young women being able to, and choosing to protect themselves from both unplanned pregnancies and STIs and HIV.

### ***Gender inequality, intertwined with socio-economic factors***

[Girl's] subordinate position in the gender and social hierarchy contains their ability to make real choices around pregnancy (Jewkes, Morrell and Christofides, 2009:675).

Inequities in gender power shape young women's first and subsequent sexual experiences and makes many of these encounters risky (Pettifor et al., 2009:82).

Jewkes, Morrell and Christofides, (2009:678) reflected on the teen years as a key time for exploring and establishing one's gender identity, they noted that for boys 'in a context of poverty and limited alternatives, securing and maintaining sexual relationships are critical to self-evaluations of masculine success as well as peer group positioning' (Jewkes, Morrell and Christofides, 2009:678). For girls this includes expectations around 'sexual naivety' and acquiescence to male 'authority'. Mkhwanazi (2010:356) commented on the mixed messages sent out to girls. On the one hand gendered norms discourage girls from being 'sexual' and encourage girls to be 'sexually innocent', on the other, they are told they must protect themselves from pregnancy and are blamed should they fall pregnant, and also expected to be 'sexually ignorant' and subject to the view that carrying condoms 'jeopardise a girl's respectability.'

The literature repeatedly points to teenage girls not always being in control of whether, and how they have sex: 'In South Africa, studies cite unequal decision-making about sex between partners, where girls lacked autonomy, thus hindering the practice of safe sex' (Harrison, 2001; Varga, 2003; Flanagan et al, 2013: 15). Holt et al. (2012:288) noted that health care workers (HCWs) found that 'gender dynamics in relationships also played a factor in determining young women's risk' (Holt et al., 2012: 288). They went on to note that peer pressure to have sex and the 'culture of submission to male partners' often led to unprotected sex.

Despite these gender norms and power imbalances O'Sullivan et al., 2006 (in Jewkes and Morrell, 2009:678) noted that we must recognise that: 'Despite the commonness of gender-based violence, both teenage boys and girls are generally active and willing participants in their sexual relationships.'

Nonetheless, the high levels of gender-based violence in South Africa are critical to consider, as Jewkes et al., (2001)(in Jewkes, Morrell and Christofides, 2009:679) note 'women under 19 who were pregnant were 14 times more likely to report forced first sex than their peers.' Pettifor et al. (2009:86) found that: 'Forced sex was also associated with early debut: young women who reported that their first partner had ever forced them to have sex were more than twice as likely to have had sex before the age of 15 as opposed to those who had not been forced.' In addition Speizer et al. 2009 (Flanagan et al, 2013:15) reported that: 'Adolescents whose first sexual intercourse was coerced are significantly more likely to get pregnant, report the pregnancy as undesired, and experience an STI.'

In our interviews we explored ideas around perceptions of girls who carry condoms. We were specifically unpacking the common assumptions that 'girls should not be sexual' and yet they are held responsible if they fall pregnant, and we asked 'Do you feel you should be able to carry condoms? What might stop you from being able to carry condoms? How are girls who carry condoms perceived?' All respondents reported that they should be able to carry condoms; however, three noted that they would probably be seen as 'people who are loose. That is not a problem for boys.' Thandi (teenage mother, who was 16 years at the birth, and never returned to school) The responses clearly reflected the gendered views that girls should not be sexual and should carry condoms for protection during sex, however, these girls were all on injection hormonal contraceptives, highlighting that they had in fact taken steps to protect themselves during sex, but the injection is 'invisible' and does not need to be negotiated. This is worrying as they appeared to have taken no steps to protect themselves from HIV.

When considering teenage pregnancy and gendered drivers looking at intergenerational sex is critical as it places teenage girls at particular risk due to inequalities of power, which is exacerbated by poverty. Flanagan et al, 2013 noted that: ‘Many studies indicate that age gaps... are driven by poverty and gender-based inequalities where women are seeking financial support from men to meet basic needs.’ (citing Leclerc-Madlala, 2010; Nour, 2006). As Panday et al. (2009:12) noted: ‘When young people have sex with partners older than themselves they are at increased risk of engaging in sexual activity, not using contraception, contracting an STI and becoming pregnant’ (Panday et al., 2009:55). She went on to show that for teenage boys, 98% were having sexual partners within five years of their age, but for girls 18% reported a sexual partner 5 years and older (Panday et al., 2009:55). The risk for both pregnancy and HIV lie in the heightened probability of unprotected sex, and the 2005 SABSMM survey<sup>16</sup> showed: ‘when young women’s partners were within a five year age range, HIV prevalence was 17.2%. However, HIV prevalence almost doubled (29.5%) when partners were five years older than themselves’ (Panday et al., 2009:55).

‘Poverty is both a contributor and a consequence of early pregnancy’ (Flanagan et al, 2013:17) – in some cases it leads to intergenerational sex, transactional sex or simply sexual relationships which are not ideal but provide some benefits. Poverty decreases a girl’s ability to negotiate condom use, and can keep her in abusive relationships, and creates a further layer of unequal power (Mkhwanazi, 2010; Flanagan et al, 2013; Jewkes, Morrell and Christofides, 2009). In supporting the concern about the risks associated with inter-generational sex Pettifor et al. (2009:86) found that:

...Age differences between partners were associated with early sex among young women. For each additional year that a young woman’s partner was older than she was, the likelihood that she had had an early sexual debut increased significantly.

Gender inequality, poverty, gender-based violence and power inequalities all play a critical role in limiting young girls’ choices about when, and how to have sex, leading to a situation of many unplanned pregnancies.

### ***Do teenagers know about contraceptives?***

The most basic needs of adolescents...are for accurate and complete information about their body functions, sex, safer sex, reproduction, and sexual negotiation and refusal skills. Without information, adolescents are forced to make poorly informed decisions (Bearinger, 2007:1225).

The literature presents a mixed view as to whether teenage girls know about contraceptives. There is a body of literature which argues that teenage girls have relatively low levels of knowledge about contraceptives and another body which argues that knowledge is high. However, all studies agree that information about Emergency Contraceptives (EC) and Post-exposure Prophylaxis (PEP) was extremely limited.

Although poor knowledge is often cited as a reason for ineffective or non-use of contraceptives... studies have shown that most young people are well-informed about modern methods of contraception (Panday et al., 2009:56).

Panday et al. (2009) noted that the 1998 South African Demographic and Health Surveys (SADHS) showed universally high levels of knowledge, 99.2% of unmarried sexually active

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<sup>16</sup> The HSRC South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Surveys.

women knew about modern contraceptives, and sexually inexperienced young women reported only slightly lower levels of knowledge at 85.5% (South African Demographic and Health Surveys, 1998:56). In addition the data from the Reproductive Health and HIV Research Unit (RHRU) National Youth Survey in 2003 found that among the 3890 female youth respondents approximately 95% could accurately identify how to protect themselves from HIV (Sayles et al., 2006:1).

In terms of our interviews, all respondents noted that they had received some sex education in Life Orientation class, and all could list basic information about contraceptives to protect themselves from HIV, STIs and pregnancy. However, a number of them questioned the quality of the lesson, in the words of Thembi:

Yes, we were informed about condoms, but never really had access to them and also couldn't use them even if we had them because nobody took the time to show us the right way. We were not able to use the knowledge we gained in class as it was not enough to give us a picture of the right way. (teenage mother, 16 years at birth, who returned to school after one year).

In addition to comprehensive knowledge about contraceptives, concern has been raised that many teenagers do not understand how conception occurs, when they are fertile, and the impact of incorrectly or inconsistently using the pill (The National Contraception Policy Guidelines, 2012). This can lead to misunderstandings about how one falls pregnant, when one is most likely to conceive, and notions that 'if I just have sex once I won't fall pregnant'. Such essential information should be the basis of sex education.

However, Hoffman-Wanderer et al. (2013) reviewed a number of teenage pregnancy studies and found that: 'pregnant teenagers have relatively low levels of knowledge about modes of contraceptives' (Hoffman-Wanderer et al., 2013:15). A literature review on the topic by MIET (2012) found similarly that many adolescents do not have adequate knowledge on contraceptives. A further study of 250 adolescent mothers by Ehlers (2003) also found that: '34% did not know about contraceptives whilst 55.6% knew about contraceptive injections (n=113), pills (n=103), condoms (n=72), intrauterine device (n=16) and sterilisation (n=2)' (Ehlers, 2003:235).

Some studies of Health Care Workers (HCWs) also reflected low levels of knowledge among teenagers. Holt et al. (2012) in their work with HCWs highlighted that some of the HCWs they spoke to felt the level of knowledge was insufficient: 'young women don't have sufficient information about consequences of sex and the importance of prevention.' They went on to highlight poor communication, often between teenage girls and their mothers: 'for example when mothers take their daughters for family planning but do not discuss sex or why the daughter might need family planning' (Holt et al., 2012:288). Hoffman-Wanderer et al. (2013) also interviewed Health Care Workers and again they stressed their belief that teenage girls do not have enough information to protect themselves adequately.

Ehlers (2003) also enquired about other means of protection such as the emergency contraceptive: '189 out of the 250 respondents (75.6%), did not know about the availability of emergency contraceptives to be taken within 48-72 hours after unprotected sex' (Ehlers, 2003:236). And the National Contraception Policy Guidelines, (2012: 17) noted that: 'The 2003 SADHS indicates that knowledge of emergency contraception remains low (19.6% women and 3.6 % of men knew about emergency contraception).'



This review supports Panday's point that: 'While adolescents have high levels of knowledge about contraceptive methods, ***gaps exist in the accuracy of their knowledge or skill regarding correct use of contraception***... Incorrect usage can lead to tears in condoms and missed doses of birth control pills can lead to ovulation' (Panday et al., 2009:56). The last point highlights again how many teenagers are ignorant about their fertility cycles. As mentioned above all of our respondents felt that the content of Life Orientation was inadequate.

One of our respondents noted that she had received sex education at school and had learnt about:

Condom use [and] prevention of pregnancy. They taught us that unprotected sex has consequences and the spread of HIV and STIs. Sometimes we used condoms, but at times I failed to because it [the sex] would be unplanned, Buhle, (teenage mother, who was 16 years at the birth and returned to school one week after giving birth, talking about sex with her long-term partner.)

In addition, our respondents noted concerns about the ability of many of the teachers to deliver the sex education sessions effectively. They noted that many teachers were uncomfortable with the topic and brought their own moral views into the discussion, one went on to question her teacher's own morals and therefore the appropriateness of this teacher delivering these sessions. '[it should be taught by] someone that I can look up to not these teachers because they are not exemplary and they are always in taverns where we meet them' (Buhle, teenage mother, who was 16 years at the birth and returned to school one week after giving birth).

In conclusion, when reflecting on levels of knowledge it seems apparent that teenagers in South Africa have good basic knowledge but there appear to be ***significant gaps and inaccuracies in this knowledge***. For example many only know about the injection, pill and condoms, but very few recognise the importance of dual protection, and some of our respondents still reported not really knowing how to use condoms, despite knowing about them. As such despite high levels of basic knowledge a lot more work still needs to be done to ensure ***comprehensive knowledge*** about contraceptives.

### ***Lack of access to SRH services – focus on contraceptives***

The literature shows a number of barriers for teenagers, whether pregnant or not, to accessing contraceptives. Ibis Reproductive Health undertook a qualitative study in N'wamitwa, Limpopo Province with teenagers, parents, guardians and community stakeholders, and explored issues around access to health care services:

Young women pointed out that existing clinics close early (clashing with school times) and are not confidential, and many reported visiting traditional healers for SRH services because they do not ask as many questions and because termination of pregnancy (ToP) is not available at nearby clinics. In one group of parents/guardians and community stakeholders, and in several young women's groups, unfriendly service delivery for young women was also mentioned (No author: Ibis Reproductive Health: Young Women's Reproductive Health Brief Series. 2012).

One of our respondents, Nonhlanhla (who was 17 years at the birth) said that prior to becoming pregnant she could not access contraceptives: 'because I can't talk to my parents, and my boyfriend and I don't have money.' This highlights the complex inter-connectedness between shyness; sexual taboos; poverty; and ignorance around where to access free contraceptives.

Flanagan et al, (2013) also noted that even when girls do go to clinics, and are fortunate enough to find friendly HCWs they often still face limited contraceptive options (the injection being most common) and poor counselling.

## **Social issues**

Flanagan et al (2013) noted that ‘fear of adult biases’, ‘peer norms’, ‘concern about parent and boyfriend disapproval’ and ‘concern for confidentiality’ were all factors that limited teenage girls accessing and using contraceptives. This highlights that the issues are not as simple as knowing where to get contraceptives and clinic hours.

Hoffman-Wanderer et al. (2012), noted the stigmatisation of teenage sex as a significant barrier to accessing contraceptives, ‘Asking for contraceptives is seen as a ‘public admission of sexual activity which is frowned upon by nurses’ (Hoffman-Wanderer et al., 2012:15). For many this would result in lectures about ‘being too young for sex etc’, and often they receive no contraceptives despite coming in for those (Hoffman-Wanderer et al., 2012; Ehlers, 2003; Holt, 2012).

Because of this stigma toward adolescent sexuality, adolescents often report they do not access SRH services due to fear of being chastised, stigmatised or punished for sexual involvements (Bearinger, 2007, cited in MIET, 2012: 9).

Reticence in discussing topics that are generally known to be ‘taboo’, and not ‘something a girl should talk about’, and shyness over being seen by community and family members to be ‘asking about these things’ create further barriers. One of our respondents noted that she ‘was scared to meet people I know at the clinic, my mom would not like that I know the nurses’ (Thandi , teenage mother, who was 16 years at the birth, and never returned to school).

Linked to this is the fear that confidentiality cannot be guaranteed: ‘Whether teenagers are knowledgeable or ignorant about contraceptives, this [lack of confidentiality by HCWs] is a definite barrier for some patients who want to keep their sexual activities private’ (Hoffman-Wanderer et al., 2012: 33). All of our respondents expressed concern about their information being shared by the health care nurses, and everyone ‘knowing that they are having sex’.

## **Clinic staff and hours**

Often clinics are designed for adult clients, and service providers are not trained in adolescent sexuality and youth-friendly concepts. As a result, young people are neither well received nor comfortable in mainstream family planning clinics (MIET Literature Review, 2012: 9).

Clinics are reported to present a number of barriers to teenage girls accessing contraceptives including: clinic opening hours; waiting times at clinics; concerns around confidentiality; staff judging or lecturing teenagers; limited contraceptive options; limited staff knowledge and poor staff training (Hoffman-Wanderer, 2012; Ehlers, 2003; Panday et al., 2009; Wood & Jewkes, 2006; Flanagan et al, 2013; Ashton et al., 2009; MIET, 2012; The National Contraception Policy Guidelines, 2012).

The National Contraception Policy Guidelines, (2012: 16) reported that only around one third of clinics provided contraceptive options to people seeking contraceptives. ‘The 2009 DoH annual report states that 1053 (30.3%) of facilities provide an acceptable contraceptive mix to clients, defined as dual protection – condom and a contraceptive method.’



Panday et al. (2009) supported these points with her findings that barriers included:

*Accessibility*: lack of convenience in terms of long travelling distances, inconvenient opening times, costs of services and poor knowledge of services being offered. *Acceptability*: lack of trust in, and confidentiality, the health workers... judgemental attitudes of health workers and poor quality of health services (Panday et al. , 2009:89).

Health care worker attitudes; moral judgements; poor knowledge and insufficient training were repeatedly highlighted as barriers. Wood and Jewkes (2006) found, in a study in Limpopo where they explored barriers, that ‘nurses acknowledged problems associated with teenage pregnancy, and still preferred to teach abstinence to adolescents who presented for contraceptives’ (Flanagan et al, 2013:14). Wood and Jewkes (2006) provide a useful summary of many of the frustrations expressed by teenagers, namely:

...that the relationship between teenagers and nurses is particularly problematic. Teenagers saw nurses as ‘rude, short-tempered and arrogant’ and complained that nurses were asking ‘funny questions’ about whether they had boyfriends or why they wore mini-skirts. Furthermore, teenagers criticised that nurses would not allow them to choose the method of contraceptive (Hoffman-Wanderer, 2012:15).

Most of our respondents also reported unfriendly, judgemental and unhelpful HCWs. Nonhlanhla (teen mother, who was 17 years at the birth, and never returned to school) reported that the HCW’s ‘...shout and say that we are forward because we sleep with boys which made it hard to go there.’ Thandi reported a similar experience when asked if clinic staff are a barrier in any way to accessing contraceptives:

Yes, especially when I was in school. That is the reason I could not go to have an injection before the baby – they scream at you that you are a slut and they say it loudly that all the people in the clinic know why you came to the clinic. (teenage mother, who was 16 years at the birth, left school and never returned).

Staff knowledge on modern contraceptives, especially EC and PEP and the necessity for dual protection, was also found to be very limited in a number of studies. A recent study found that: ‘all HCWs in three public clinics in Soweto needed additional training on modern forms of contraceptives in order to provide comprehensive family planning counselling’ (Holt et al., 2012; Flanagan et al, 2013:14).

However, Hoffman-Wanderer’s (2013) study in Cape Town found that despite the reservations of many health care workers, the majority *would* give teenagers contraceptives (Hoffman-Wanderer’s, 2013:54-55). They also found that a number of HCW’s particularly tried to assist teenage girls, and one nurse ‘spoke of a ‘mind shift’ in her attitude towards teenagers as a result of working with them during her nursing career’ (Hoffman-Wanderer’s, 2013: 30). Ehlers’ (2003:236), work also found that of the 250 adolescent mothers she interviewed of those that answered the section, 86% of them ‘experienced the nurses as helpful’. This reminds one that this is a complex situation with many different experiences and contexts.

Indeed, one of our interviewees reported having developed a good relationship with a nurse at the local clinic: ‘I have come to being close to one of the nurses who usually gives them (the injection) to me she has become sort of like an older friend who I can always talk to about anything’ (Thembi, teenage mother, 16 years at birth, who returned to school after one year).

## Pregnant teenagers and teenage mothers have specific SRHR needs

The sexual and reproductive health and rights and service needs of pregnant teenagers and teenage mothers differ from those of other teenagers. Pregnant teenagers often fail to access appropriate support during pregnancy for a number of reasons: failing to reveal the pregnancy for many months; lack of acceptable and accessible services; and the fear, or actual experience, of stigma and judgement by HCWs for being pregnant. Many teenage mothers reported the difficulties of balancing accessing sexual and reproductive health (SRH) services and schooling following the birth – many spoke about unsupportive HCWs, lack of information about where to go, and clinic hours that clashed with school hours.

Indeed, as Chohan and Langa (2011:88) noted society does not really know how to ‘classify’ teenage mothers; are they still children who should be ‘sexually naive’, or adults who should be supported to ensure their legitimate sexuality is supported with services and commodities?. ‘One of the contradictions concerns their age – the teenage mother is no longer classified as a child (she is now a mother) but she is not considered an adult either (she is still young).’

Panday et al. (2009) noted that despite progressive policies many teenagers avoid accessing family planning and antenatal services until very late in pregnancy. Richter, Norris and Ginsberg noted that reasons for this: ‘related to accessibility and acceptability of services, as well as fear and shame regarding teenage pregnancy’ (Panday et al., 2009:88). An unpublished literature review by Lince (2011:9) supported this: ‘A survey conducted in Gauteng on 111 adolescent mothers in 2000 indicated that adolescent mothers did not make optimum use of the available reproductive health care services.’

In summary, in South Africa there are a number of barriers to teenage girls accessing a range of contraceptive choices.

### ***Do teenagers use contraceptives?***

When reflecting on contraceptive use three critical issues arise: firstly, not only whether they are using contraceptives, but whether they are using them, ***consistently and correctly***, secondly whether they are using ***barrier methods*** and thirdly whether they are using ***dual protection*** (barrier and hormonal methods simultaneously).

South Africa has a high contraceptive usage compared to other countries in the region, with 61% of sexually active women reporting currently using a contraceptive (Cooper, 2004: 74). While over the last few decades we have seen an increase in the use of condoms, condom use is still too low and there are still a large number who report never using contraceptives, or using them inconsistently, and very few report dual contraceptive use. It is also important to note that male condoms still predominate overwhelmingly with very little uptake of female condoms<sup>17</sup>. Indeed, there are still significant barriers to teenage girls reporting consistent and correct contraceptive use. The recent review by Flanagan et al (2013), noted a number of reasons for non-use: ‘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’ (Pettifor, 2009; Cooper et al.,

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<sup>17</sup> According to the Global Campaign for Microbicides website: ‘Almost all condoms distributed globally are male condoms. Female condoms make up only 0.2% of the total condom supply worldwide’ <http://www.global-campaign.org/female-condom.htm>

2004; Rachel Jewkes et al., 2001; Katz & Naré, 2002; Macleod & Tracey, 2010; MacPhail, Pettifor, Pascoe, & Rees, 2007; Panday et al., 2009:14).

The National Contraception Policy Guidelines, (2012:18) noted four key challenges facing adolescents in preventing unplanned pregnancies:

- peer pressure to be sexually active, or to conceive and demonstrate their fertility;
- inaccurate ideas about conception, reproduction and contraception;
- negative and judgemental health care provider attitudes towards teenagers who are sexually active; clinics which are not open after school, or are not youth friendly (e.g. embarrassment to be seen at the clinic by their community);
- unanticipated sex, sexual coercion.

Pettifor et al., (2009) found that condom use<sup>18</sup> at first sex among 15-19 years olds, was similar among men (44%) and women (53%). However, they also noted that young women who had had their sexual debut at a young age, or whose partner had ever forced them to have sex were less likely to use condoms at their sexual debut. '*The South African Youth Risk Behaviour Survey 2008*: 29% of male and 33% of female (learners from Grades 8 to 11)' (The National Contraception Policy Guidelines, 2012: 17). The RHRU survey 2003 showed that 52% of sexually active women (15-24 years) were currently using contraceptives. The 1998 South African District Health Survey showed that only 7.6% of sexually active 20-24 year olds had used a condom at last sex, and this increased to 47% in the 2002 SABSMM survey and **55.7%** by the 2005 SABSSM survey (Panday et al., 2009: 55). MacPhail et al. (2007) reported on a study employing a sample of 6217 young women, and 52% of the sexually experienced women reported 'currently using contraceptives'. In a study of 250 young mothers by Ehlers (2003:236) 46.8% reported having used contraceptives. Of this sample following the birth of their baby, 92.4% used contraceptives.

Talking to a partner about condom use was a strong predictor of actual use, especially within a first sexual relationship... Interestingly 75% of 15-19 year old women in our study reported that they had talked to their first sexual partner about condom use (Pettifor et al., 2009: 88).

Despite increasing condom use, a critical factor for pregnancy and HIV prevention is **consistent condom use**, and the 2003 RHRU survey found only 33% 'using a condom with their most recent partner' (Panday et al., 2009:55). Pettifor et al., (2009) found that consistent condom use with their first partner was infrequent, only 34-35% of 15-19 year olds reported consistent condom use with their first partner.

However, use is not consistent for women and men, and differs by age. Panday et al. (2009) noted that condom use is still almost 20% lower among women than men, and went further to highlight that: 'Condom use in fact peaks at a young age for women (16 years) but declines thereafter. Rates of condom use among men remain consistently high until about 21 years where after it declines' (Panday et al., 2009:55). Highlighting that some of these girls move from using condoms as young teenagers to using other forms of non-barrier contraceptives, especially as they move into longer-term relationships where hormonal, non-barrier contraceptives tend to be preferred. MacPhail et al. (2007) supported this: 'younger women make contraceptive trade-offs in which condom use declines as relationship length increases...the issue of trust becomes a significant factor in contraceptive decision making in longer-term relationships, usually to the

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<sup>18</sup> These figures all mention condoms generally and do not specify whether male or female condoms, however, we can assume that the overwhelming majority will be male condoms.

detriment of condoms' MacPhail et al. (2007:6). Interruption of contraceptive use has also been found to be a significant concern, in many cases women wish to see their menstrual cycle return to assure themselves of their fertility.

Exploring this further, Flanagan et al (2013) looked at 'unmet need' for contraceptives and also noted a 'higher unmet need for contraception among women living in rural areas and among women with only primary or no education' and further, that Department of Health data showed that: 'adolescents aged 15-19 have a higher prevalence of unmet need for contraception (17.7%) when compared to older women (11.7-16.8%)' (Flanagan et al, 2013:13). The National Contraception Policy Guidelines, (2012) also noted that education level affected contraceptive use,

'current contraceptive prevalence among sexually active women with post-high school qualifications is twice as high (75%) than among women with no education (38%)' (The National Contraception Policy Guidelines, 2012: 15).

While not much was reported on emergency contraceptive and access to PEP services, Cooper et al. (2004) noted that while emergency contraceptives are available at many public clinics, usage is very low, and they concluded this was due to a lack of knowledge among teenagers. Ehlers (2003:238) found that some pharmacists would not advocate the use of the emergency contraceptive, even if the teenage girl had a prescription. The suggestion of this review is that both are universally difficult to access.

Turning now to the question of dual protection and what contraceptives teenage girls use, MacPhail et al. (2007:6) reported that in the nationally representative survey of 6217 young women in early 2000: 66.6% only used a hormonal method, 26.5% used condoms alone, and **6.8% used dual protection**. Pettifor et al., (2009) found that among their sample of 15-19 year olds who reported using a contraceptive at first sex; 84% of males had used a condom and 18% the pill or injectable, whereas only 56% of females had used condoms and 48% the pill or injectable. Cooper et al.'s (2004) study supported this finding in a study across the general population, the injection was used most commonly (49%), followed by the oral pill (20%) and female sterilisation (20%). The latter option is very unlikely to be used by teenagers however. Cooper et al. (2004) also found only 6.3-7.5% using dual methods. However, Holt et al. (2012) found a different trend in a 2008 nationally representative survey that 42% of young women used condoms, 12% injectables and 5% the pill or other modern methods. The National Contraception Policy Guidelines, (2012:16) noted that 83% of women obtain contraceptives from the public health sector, and that: 'In all provinces more injectable progestogen contraceptives are used than oral contraceptives.'

Cooper et al. (2004: 74) highlighted that this overwhelmingly high preference for hormonal contraceptives 'may reflect use preference (however), the role of health care providers in influencing contraceptive choice is well-documented. Method choice is frequently limited in the public sector by the opinions and practices of primary care nurses.'

Cooper et al. (2004: 74) continued to note that 'many young women initiate contraception only as part of post-natal care after an unintended pregnancy', and as seen above the preferred option promoted by most nurses is hormonal contraceptives, especially the injection. MacPhail et al. (2007:3), found similar results: 'women who reported ever being pregnant were much more likely to report using hormonal methods and less likely to use male condoms compared to women who had never been pregnant.' They note that this could be because it is often only following

pregnancy that young women are offered counselling on contraceptives, and hormonal methods usually receive preference during this counselling.

This was certainly true for our respondents, in all cases following pregnancy all four young mothers were offered the injection by HCWs, and none reported being advised to use condoms as well, and all are now using the hormonal injection. Some also mentioned their boyfriends accessing condoms, indicating that some may be using dual methods, but none directly reported so, ***in all cases they only began using the injection following the pregnancy***. Prior to pregnancy condom use varied significantly with none reporting consistent use and most reporting occasional use. Reasons given by our respondents for not using condoms, at all or irregularly, varied: not having them to hand at the time of sex, the cost of condoms, ‘my boyfriend told me that I would not get pregnant if we had unprotected sex just once’ (Nonhlanhla, teenage mother, who was 17 years at the birth, and never returned to school), through to: ‘I was scared that it was an abortion and I would be labelled as a baby killer’ (Thembi, teenage mother, 16 years at birth, who returned to school after one year).

## Teenage pregnancy and schooling

The review turns now to reflect on the impact of teenage pregnancy on a girl’s education. In particular we explore the data on whether teenage girls remain in school while pregnant and return to school following a pregnancy; whether pregnancy is a cause or a consequence of school dropout; how teenage mothers perform academically when they return to school, factors that facilitate pregnant teenagers remaining in school and then returning to finish their education following childbirth, and factors that create barriers to this. During this discussion it is important to recall the three areas in which these teenagers face particular challenges, namely: continuing schooling during pregnancy; continuing schooling as a mother, and whether the school system supports them as mothers who may wish to parent at school (teenage motherhood).

As the data has shown, approximately one third of pregnant teenagers continue at school during pregnancy, and return as teenage mothers. The literature shows that there are a number of critical factors that influence whether pregnant teenagers and teenage mothers remain and then return to school, the sections below discuss these in detail. In summary:

Pregnancy, childbirth and motherhood transform the context in which adolescents live and make decisions, particularly with regard to household and individual time allocation, including care-giving responsibilities. Resources available within a household – both economic and social – play a role in determining whether or not a young woman resumes her education following childbirth. Likewise previous school performance... may reflect both her family’s economic ability to maintain her schooling enrolment and the young women’s aptitude and interest in school (Grant and Hallman, 2008:377).

### ***Educational impact of teenage pregnancy***

Across Africa teenage pregnancy seems to lead to teenage mothers terminating schooling, however ‘In South Africa the evidence suggests delay in [completing schooling] rather than dropout’ (Morrell, Bhana and Shefer, 2012:10). Marteleto and Lam (2008:352) support this argument ‘...in South Africa, unlike in most other African countries, girls commonly continue their education after giving birth.’ However, we still see a situation where only approximately one third of teenage mothers return to school.



Eloundou-Enyegue (2004) undertook a review of 38 African countries and they identified four critical factors which affect the impact of pregnancy on a girl's education, and they argue this is determined by the 'stages of societal development' of a community. This hypothesis is helpful in understanding why South African girls' experiences are so different from many others across Africa. Of the four 'stages of societal development' that they mention South Africa has already passed two, and she felt this would explain the comparatively high rates of returning to school. The third and fourth which she mentions are reflected in South African communities, and are both about gendered norms and inequalities, namely, 'where communities and families still favour boys education over girls', and 'where economic hardship still persists'. This hypothesis assists one in understanding why we still have around two thirds of teenage mothers not returning to school.

In addition, while it is critical for girls to return to school, the evidence shows that ***they must return as soon as possible following childbirth***, even a relatively short interruption in education has an impact on girls' futures. Morrell, Bhana and Shefer (2012) and Panday et al. (2009) noted that a delay in returning to school can reduce the likelihood of ever pursuing further education and reduce school performance. Equally the likelihood of failing a grade increases with pregnancy.

Being a teenage mother becomes a further struggle upon returning to school as most schools continue to place the burden of parenting on the learner-parents and in particular the mothers. This gendered response to teenage pregnancy, i.e. the mother is responsible and not the father, is both driven by gender inequalities and perpetuates them (Morrell, Bhana and Shefer 2012; Shefer, Bhana and Clowes 2008; Jewkes, Morrell and Christofides, 2009).

### ***Is leaving school a cause or consequence of teenage pregnancy?***

Much of the literature supported the critical point that often the key drivers of teenage pregnancy are also drivers for school dropout, meaning that often teenage girls had *already dropped out of school prior to becoming pregnant*. In other words, in many cases while pregnant teenagers and teenage mothers may have dropped out from school – the pregnancy may not have been the reason for the school dropout (Ardington, 2012; Panday et al., 2009; Marteleto and Lam, 2008; Morrell, Bhana and Shefer, 2012; Morrell and Devey, 2012; Eloundou-Enyegue, 2004; Chohan, 2010).

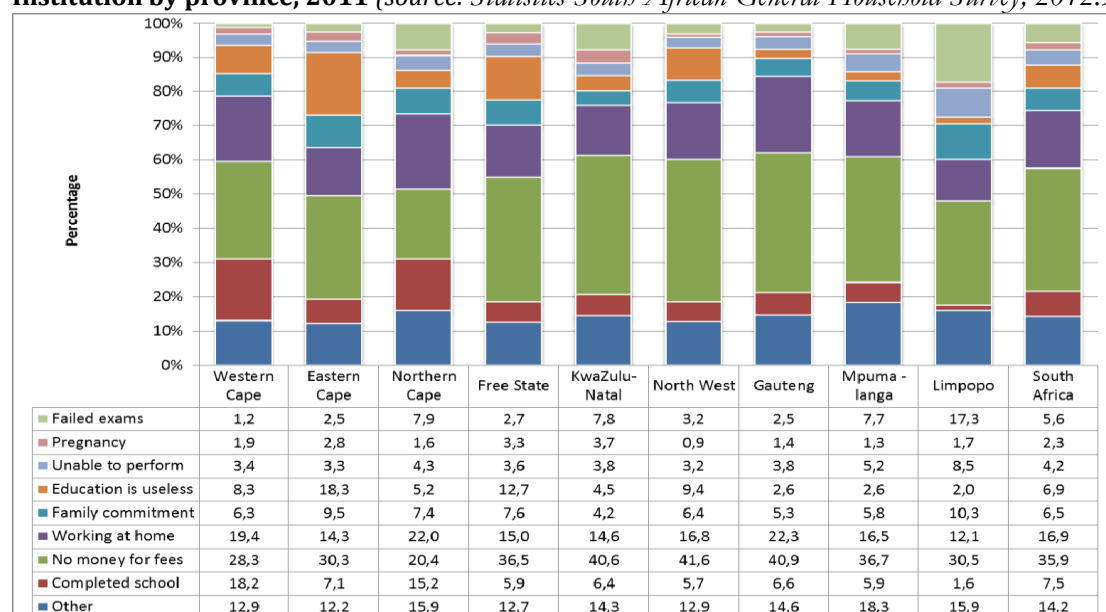
However, much of the data often fails to look at the sequencing of events or which came first, pregnancy or dropout: 'whether leaving school is a consequence of becoming pregnant or vice versa is not clear' (Marteleto and Lam, 2008:352) In South Africa due to a combination of a high dropout rate in secondary school and high teenage pregnancy rates, many assume the pregnancy to be the cause of the school dropout. However, the South African literature clearly shows that this is not always the case: Ardington (2012) cited the National Income Dynamic Study (2008) which looked at drivers for female school dropout, and found only 33.43% dropped out due to pregnancy. 'For example, 13% of 16 year old females are not in school, yet only 5% of this age group report ever having been pregnant' (Morrell, Bhana and Shefer, 2012:10). In addition, a study in the Cape Flats, Western Cape found that the three main reasons for leaving school, in order of importance were: 'not liking school, poor academic progress and economic constraints.' In this study of 548 teenagers 15.9% (88 girls) had dropped out of school but only two students reported dropping out due to pregnancy, highlighting the many reasons for school dropout (Morrell, Bhana and Shefer, 2012:11).

Table 2 reflects figures from the South African General Household Survey, looking at the main reasons given by people 7-24 years for not attending any school, by province (2011). Pregnancy accounts for only 2.3%, with 35.9% referring to lack of funds. In fact pregnancy as a reason for not being at school was the lowest, again we see the primary reason being economic, and in this study pregnancy and motherhood play an even smaller role than Grant and Hallman's (2008) study above.

While the primary reason for teenage girls leaving school is usually economic, and not due to pregnancy or motherhood, nonetheless Grant and Hallman (2008) found that around 25% of teenage girls did in fact leave as a result of pregnancy or motherhood – while it is not the primary reason, it is still a reason for many.

While it is very important to consider the sequencing of events, and to recognise that a teenager who is pregnant or a mother, and not in school, may or may not have left school as a result of the pregnancy. Nonetheless, whatever the reason for leaving school many teenage girls are unlikely to return to school following a pregnancy – whether or not that was the reason for her leaving.

**Table 2: Main reasons given by persons aged 7 to 24 years for not attending an educational Institution by province, 2011** (source: *Statistics South African General Household Survey, 2012:9*)



However, Grant and Hallman (2008:371) also caution when analysing such data because they note that there are often a number of reasons for leaving school, all of which may be interconnected:

...if a young woman gives a reason other than pregnancy for discontinuing her education, the possibility that she is also pregnant at the time she leaves school is rarely taken into account. Particularly for young women who mention such dominant concerns as financial issues, family obligations, or a lack of interest in school, a pregnancy may serve as an unacknowledged catalysing force for the timing of school drop-out...Likewise, young women who mention pregnancy as their reason for leaving school may be influenced equally by their families financial situation or by potential care-giving arrangements that will be available after the child is born.



## ***Do teenage mothers return to school?***

We have already noted that approximately a third of pregnant teenagers remain in school during pregnancy or return to school following childbirth (Jewkes, Morrell and Christofides, 2009; Morrel, Bhana, and Shefer, 2012; Grant and Hallman, 2008). Bhana et al. (2010:872) note that of teenagers *in school at the time of falling pregnant* ‘29% of 14-19 year olds who drop out of school due to pregnancy return to school by the age of 20 and, of this figure, only 34% complete their final year of schooling.’ Grant and Hallman (2008:369) showed similar figures ‘among girls aged 19 years and younger who had given birth, more than a third had returned to school.’ Karra and Lee (2012:3) also noted that in their analysis of the Cape Area Panel Study (CAPS), that in the Western Cape: ‘Teen mothers [as compared to non-mothers] lag two-thirds of a year behind, on average; are 25 percentage points more likely to drop out of high school; and are 20 percentage points less likely to graduate from school before the age of 22.’ This is a low rate of return, and an even lower rate of finishing school.

Returning to school following a pregnancy also reflects race and class. Black African teenage mothers are more likely than Coloured girls to return to school. Maretelo (2008) found that of the Black African women who reported a pregnancy by the age of 17 years 60% were enrolled in school, whereas only 35% of coloured mothers were.

Grant and Hallman (2008) found that the risk of dropout from school for both non-pregnancy and pregnancy related reasons increased with each additional grade completed after grade 8. However, for grade 12 learners, Grant and Hallman (2008) found that ***girls tended to complete their schooling if in Grade 12 at the point of conceiving or giving birth***; suggesting that they recognise the importance and ‘relative’ ease of completing their secondary education at this stage.

Karra and Lee (2012:3) also noted that younger mothers were less likely to return ‘Young teen mothers (women who had their first child at 17 or younger) are about 50 percentage points more likely to drop out of school than non teen mothers (who are still in school).’, highlighting that, ***the younger the teen mother is the higher the risk of not returning to school***. This supports the point that teenage motherhood has far heavier impacts for younger teenagers than those 17 years and older.

As mentioned earlier, the data shows that ***the longer a girl stays away from education the less likely it is that she will ever return to school***. ‘...for every year that passes after pregnancy-related dropout, young women are significantly less likely to return to school. The odds of returning to school among 14-24 year-olds declines significantly by 60% two years post-dropout, by 70% three years post-dropout, and by 80% four years post-dropout’ (Grant and Hallman, 2006 in Panday et al. (2009:40). The amount of time spent away also impacts on likely academic performance when returning.

## ***Academic performance of pregnant teenagers and teenage mothers***

The review has shown that pregnancy and motherhood does not *necessarily* end a girl’s schooling, however for many who remain in school or return following childbirth, it does affect grades, and sometimes, academic progression. Shefer and Bhana (2012:139) noted that when teenage mothers did return to school their performance was often affected, and many moved from doing well academically to becoming average or ‘underachievers’ once they were balancing motherhood and schooling. In the words of one of their participants:

My marks at school are suffering now. I have fallen back in all my subjects. I used to get A's in three of my subjects, and in all of them I have just fallen back to B's and C's. I'm tired at school with having the baby to deal with at home. I'm writing all these study timetables, but I'm not sticking to them. When I'm home my mom expects me to deal with the child. (Shefer, Bhana et al., 2012:139)

Morrell, Bhana and Shefer (2012) support this when referencing work by Hunter and May (2002:11), who found that '41% (of ever pregnant girls) repeated at least one grade.' This compares to data gathered by the National Income Dynamic Study (NIDS) that provides the first nationally representative data on the phenomenon. It indicates that 57% of adults and 25% of child respondents have repeated at least one class (UNDP, 2009). Ardington (2012) supports this, highlighting that the Southern African Labour and Development Research Unit (SALDRU) found that 'even when controlling for pre-birth characteristics (of the mother), teen mothers had poorer educational outcomes than girls who did not give birth during their teen' (Ardington, 2012:2). They went on to note that data in KwaZulu-Natal over 2001-2009 showed that teenage childbearing significantly impacted on educational outcomes: 'Teenage mothers were: two thirds of a grade behind their peers; 20 percentage points less likely to matriculate; and 25 percentage points more likely to drop out of school' (Ardington, 2012: 3). In addition the study highlighted that younger teens in rural areas were the most at risk of falling behind educationally.

However, some teenage mothers reported different experiences of doing well academically, often linked to whether they had childcare support at home, (this is discussed below in detail). Shefer and Bhana (2012:140) supported this when sharing the experiences of one of their participants:

Thabisile reported how having a child did not initially affect her school grades at all, but since she also had a rapid return to school, it appears that she must have also had considerable support at home... [Thabisile is then quoted as saying] After I had the baby I stayed home for two days with the baby and then came back to school. At the end of last year I got full colours. I was in the top ten. Everyone was surprised that I managed to do so well after having the baby and all that (Shefer, Bhana et al., 2012:140).

## **Facilitators to remaining in school and returning following childbirth**

We turn now to explore factors that make it easier or harder for a pregnant teenager and teenage mother to return to school and to achieve academically.

### ***Policy environment***

As mentioned above the policy environment in South Africa since the mid-nineties has been very supportive to teenage girls and teenage parents remaining in and returning to school. However, as already noted the policies are not 'judgement free' for example the earlier section noted how the *Measures for the Prevention and Management of Learner Pregnancy* (MPMLP) moralises against pregnancy. Nonetheless, as Grant and Hallman (2008) note the SASA policy, while not universally implemented, has seen some successes, for example it has: assisted in equalising educational opportunities for girls and boys; and has led to an increase in the number of pregnant and teenage mothers who remain in, and return to, school. In addition to policies that clearly support the girl's right to continue with her education the Child Support Grant is also a critical enabler, as accessing this support for one's baby can be the key financial input that

enables a girl to return to school. However as we have seen uptake among teenage mothers remains very low.

Furthermore, Bhana and Clowes (2008:87) have shown that these policies are also shifting mindsets among teachers and principals: 'Changing policies, the foundation of a human rights discourse emanating from the Constitution, are changing the perceptions of teachers and principals.' Their work noted a number of educators who reflected on how the progressive policies have challenged and shifted their own views, and as the teachers' and principal's views shift, some of the implementation challenges are addressed.

### ***Family support with childcare***

[For participants who returned to school] participants' mothers played a pivotal role with regards to childcare. This familial support is ***required*** for a teenage mother to return to school (Chohan, 2010:72).

***Childcare, and balancing this with school demands, emerged as probably the most challenging aspect of being a teenage mother.*** And while many members of extended families can and do assist teenage mothers with childcare, the literature agrees that the most enabling support a teenage mother can receive is from her mother (the baby's maternal grandmother). Girls who had support from their mothers were the most likely to return to, and remain at school (Chohan, 2010; Jewkes, Morrell and Christofides, 2009; Panday et al., 2009; Morrell, Bhana and Shefer, 2012).

Panday et al. (2009:49) supported this noting work by Grant and Hallman (2006) who found that 'the availability of an adult caregiver in the home was a strong determinant of whether girls in South Africa would return to school post pregnancy. When girls were solely responsible for childcare they were less likely to return to school' (Panday et al., 2009:49).

As one of our respondents, who returned to school one week after giving birth noted, support from her family was critical in enabling her to return to school:

They [my parents] encouraged me to go back to school although I did not want to and felt it would be too much for my parents to support me and my baby. They bought us food and clothing, they did everything for us (Buhle, teenage mother, who was 16 years at the birth, and returned to school one week after childbirth).

Another of our respondents took a year off and then returned to school, again her return was enabled by the support of her mother; her mother paid for crèche and supported her emotionally:

My mother is a single parent and was able to be understanding of the situation and she was able to support the baby as she was happy that she had seen her first grandchild and she spoils the baby when she can. My mom clearly outlined that I needed to spend one year out of school...to learn the basics of being a mother...as soon as I went back to school my mom was able to pay for day care where my little angel plays the whole day and I fetch her on my way home from school (Thembi, teenage mother, 16 years at birth, returned to school).

It is important to note that grandmother's active involvement in childcare is patterned by race, with black African girls often experiencing high levels of support from their mothers. Jewkes, Morrell and Christofides (2009:680) noted that: 'African teenage girls are rarely expected to raise

their children alone' (Jewkes, Morrell and Christofides, 2009:680). As Chohan (2010:73) noted in many black African communities in South Africa it is considered 'the norm' for the maternal grandmother to be very involved in raising her grandchild, of the eight participants in Chohan's study, six of the maternal grandmothers' assumed childcare responsibilities and the other two sent their children to crèche.

Chohan's respondents also noted that support from their mother was not only about providing daily childcare support, some of the mothers also provided emotional support, participants spoke about family support almost as a "shield" that protected them from the harsh, rejecting world' (Chohan, 2010:74) .

Shefer, Bhana et al. (2012) noted that it is sometimes also the paternal grandmother who provides the support that enables the teenage mother to return to school; although paternal grandmothers did not feature in the literature as prominently as maternal grandmothers.

Beyond the support of the baby's maternal grandmother, support and involvement by the baby's father, or his extended family, also played a role in enabling the teenage mother to return to school (Marteletto and Lam, 2008; Bhana and Clowes, 2008; Chohan, 2010; Shefer et al., 2012; Kaufmann and de Wet, 2001). In Chohan's (2010) study of eight teenage mothers, five of the mothers reported that the baby's father was involved (Chohan, 2010:88). One of her participants 'highlighted the importance of paternal support for the teenage mother as well as the baby' (Chohan, 2010:88). This involvement contradicts the common discourse of teenage fathers having low levels of involvement. She did not explicitly discuss how this assisted girls returning to school, however one said: 'The father is supportive, so everything is fine, he (baby) goes to his father when I do my homework and they talk' (Chohan, 2010:88).

Our interviews showed that while support from the father should be encouraged and welcomed, where support is offered the nature of this support varies and does not necessarily enable the mother to return to school. Among our teenage mothers two fathers supported their babies financially, and one of them was also involved in caring for his baby, the other two fathers were not involved at all. Reflecting on the work by Moore (2013) we note that the current generation of mothers have changing expectations from fathers, and many are calling for more involvement in 'caring for' their babies, not simply 'caring about' their babies.

Among those we interviewed we saw that 'caring about' one's baby may not be enough to enable a teenage mother to return to school. Indeed, two fathers provided financially for their babies (which can be interpreted as 'caring about' one's baby), and yet only one of those mothers, Buhle, was able to return to school, because the father also 'cared for' the baby. '[The baby's] father supports me, takes the baby to and from crèche so studying is like I don't have the child' Buhle, (teenage mother, who was 16 years at the birth, and returned to school.) In this case, the father left school to provide financially for the baby *and* to assist in caring for the baby, and the mother returned to school. In the other case the father provides financially when he can, and yet the teenage mother never returned to school, highlighting that a critical role of fathers in supporting teenage mothers returning to school is to provide childcare for the baby as well as financial support.

Marteletto and Lam (2008) found that *paternal acknowledgement* of the child was a further factor that contributed to a mother being able to return to school. This may be because acknowledgment of paternity is also linked to higher levels of support from a father.

Although involvement by the baby's father is mentioned throughout the literature it is not as dominant a theme as the importance of the grandmothers support - it was unclear to the researcher whether this was because: a) less research has been undertaken on the topic, or b) father's involvement had less impact than the grandmother's or c) whether it was reflecting how little paternal involvement there is.

### ***Teenage mothers strong motivation to complete schooling to benefit herself and her baby***

The literature showed that for many girls who remained at school while pregnant and returned after childbirth an important driver was their own motivation to complete their education, usually driven by a recognition that this would increase their likelihood of finding work, having higher earning potential and successfully supporting her child later in life (Chigona and Chetty, 2008; Chohan and Langa, 2011; Chohan, 2010; Grant and Hallman, 2008, Kaufman and de Wet, 2001). In the words of Ivy (a respondent): 'Education is the key to everything nowadays. Without education you can't get anywhere. I want to be educated as much as I can so I can have a brighter future for me and my son' (Chohan and Langa, 2011: 91).

As Chohan (2010) noted within her study, many girls were working very hard to ensure they could continue their schooling, as one participant noted: 'I have to sell to make money to go to school. Like I sell steel wool and scrape pot... I go house to house selling them on weekends...' (Chohan, 2010:70). One of our respondents, Buhle (teenage mother, who was 16 years at the birth, and has returned to school) also noted that her friends encouraged her to return because: 'if I don't come back to school then my life and that of my baby will be poverty.' Showing again the heightened sense of responsibility that many teenage mothers displayed - contrary to the mainstream portrayal of teenage mothers as 'incompetent and unlikely to finish school'.

In Chohan's (2010) study, young mothers identified education as an opportunity to excel and 'prove themselves', as they used their right to an education as a platform to 'rise above' others and prove their self worth to themselves and the rest of society. Amongst Chohan's participants, their high levels of motivation and aspirations reflected in their academic results as they excelled above their peers at school. One participant said: 'my test marks this term is good, the marks are perfect...last year I was a bit playful, but last term I worked really hard!' (Chohan, 2010:84).

Sadly for some this motivation to achieve academically and remain in school meant they hid their pregnancies as they feared being 'encouraged to leave' for 'their own good', and paradoxically it means they did not get support during their pregnancy (Shefer, Bhana et al., 2012).

Marteleto and Lam (2008:360) also noted that due to South Africa's generally high rate of grade repetition there is less stigma and shame around repeating a grade, which in many ways made it easier for a motivated teenage mother to return and repeat a grade if necessary.

Kaufman and de Wet (2001) found that the links between marriage and lobola and education played an important role in girls' decisions to return or not. They noted that in a number of communities in South Africa lobola is higher for girls with education, and for some families this serves as an incentive to both the teenage mother and her family to support her returning to school following childbirth.



## ***Previous academic performance and grade at time of falling pregnant***

Building on the previous point about motivation, previous academic performance is also an indicator of whether a teenager mother is more likely to return to school. Grant and Hallman (2008) noted that 'highly motivated students with good grades prior to pregnancy are those most likely to return' (Grant and Hallman, 2008:372) which they believe in some way explains how among girls in the same socio-economic situation, some teenage mothers return while others drop out.

They then continue to say 'any student who manages to return to school following a pregnancy is likely to have the impetus to advance her education' (Grant and Hallman, 2008:372). They found that:

...those young women who had ever withdrawn temporarily from school are almost two times more likely...to drop out of school...Respondents who had repeated a grade prior to becoming pregnant are almost two times more likely...to drop out of school when becoming pregnant (Grant and Hallman, 2008:372).

While we did not explore this issue in particular in our interviews, Buhle, the teenage mother who was 16 years at the birth and returned to school one week after giving birth and who is coping very well is also an 'A' Grade student. Indeed her friends encouraged her to return and noted her academic success as an incentive for returning. She has also found it easy to cope with childcare responsibilities in the evenings and studying, quite possibly because she has an aptitude for studying, combined with support from her mother and the baby's father.

Marteletto and Lam, (2008) also considered educational achievements as an indicator for likely school dropout across the board, not only in relation to pregnancy, however her findings can be applied to whether teenage mothers would return to school. They look at literacy and numeracy of teenagers, and argue that these two measures are more accurate indicators than grade repetition as it reflects ability, skills and proficiency. They found that girls and boys with higher numeracy and literacy were significantly less likely to drop out of school, for any reason, including pregnancy.

## ***Teachers as enablers for continuing schooling***

Teachers can be, and often are, important enablers for pregnant teenagers to stay at school and return following childbirth. Many teenagers reported that teachers were supportive, and that this was very important in enabling them to continue with their education. However, while teacher support is obviously desirable, and should be encouraged, it does not seem to be *critical* to ensure teenage mothers return. This was seen in Chohan's (2010) study of her eight participants (all of whom have returned to school) only two had supportive teachers. In other words six out of eight of Chohan's participants returned to school despite *not* having supportive teachers, and much of the literature showed similar patterns of limited teacher support.

Support offered by teachers included helping the teenager to feel 'comfortable with being pregnant' this role of supporting and helping teenagers to deal with stigma was reportedly very important to the girls. Some teachers were very understanding about pregnant teenagers and mothers needing to take time off, especially for childcare, and would assist the girl in catching up with work. One of Chohan's (2010:78) participants reported that her teacher gave her baby clothes in winter. Bhana and Clowes (2008) noted that it was often the female teachers who, identifying as mothers themselves, provided care and support to the young mothers often



empathising with ‘(the) pain, difficulty, challenges and responsibility associated with pregnancy and parenting’ (Clowes, 2008:88).

Of the four teenage mothers we interviewed, two reported having supportive teachers. Buhle, who was 16 years at the birth, and returned to school within a week of childbirth, reported very supportive teachers:

My Maths teacher (she is a lady) supported me very much. In fact most of the teachers who knew that I was pregnant were supportive. My Maths teacher told me that it’s allowed for me to have a baby and come back to continue school.

On the other hand Thandi, who was 16 years at the birth, and did not return to school following childbirth, reported that one of her teachers had encouraged her to return to school, ‘...but I refused. I don’t wish to go back to school. I need to take care of my child’ This again shows that while supportive teachers are important, the most important factor is whether there are people to assist with looking after the baby, or money to pay for childcare.

The literature has shown that teachers can be important supporters and enablers, but in order to do this meaningfully they need structural support and training themselves. Bhana et al. (2010) noted that:

In order to ensure teachers’ support for pregnant teenagers and teenage mothers, the state must acknowledge the important role that teachers play – and provide them with more professional development around policy and develop guidelines (Bhana et al., 2010:881).

Some teachers highlighted the difficulties in knowing how to provide support: ‘We want to help, but it is difficult’ (Bhana et al., 2010: 54).

These caring and nurturing attitudes are important not only as they assist the girls to continue with their education, but also as it helps a pregnant teenager or teenage mother to deal with any stigma and shame that she may be experiencing and it provides her with support during a very important time in her life. Pregnancy and early motherhood are often demanding and scary times, when women, especially young women, need additional support and care.

## ***Peer attitudes***

A recent study by Devey and Morrell (2012) showed that many pregnant teenagers are being encouraged by their peers to be involved mothers and also continue schooling. However, while this is encouraging as it shows a sense of responsibility and support by teenage peers, it can also add to the pressure experienced by teenage mothers who are being encouraged in two contradictory roles: to prioritise childcare and motherhood, potentially at the expense of their academic progress, *and* continue with schooling.

Devey and Morrell (2012) asked pupils whether ‘girls should look after their children?’ nearly 83% agreed or strongly agreed, showing that teenagers believe that their peers who are mothers should care for their children. A further question asked was whether ‘pregnant girls should be encouraged to complete their schooling’ and more than 80% agreed or strongly agreed that they should. While these findings are encouraging and show support, the difficulty of succeeding in both should be acknowledged.

## Barriers to remaining in school and returning following childbirth

The final section of this review will reflect on barriers that pregnant teenagers experience both in staying in school during pregnancy and returning following childbirth. Many of these barriers are the opposite of the factors that facilitate girl's returning to school, and to avoid repetition we do not go into as much detail, therefore we recommend this section be read in conjunction with the previous one.

Panday et al. (2009) captured many of the barriers in the following comment:

Only about a third of teenage mothers return to school. This may be related to uneven implementation of the school policy, poor academic performance prior to pregnancy, few child-caring alternatives in the home, poor support from families, peers and the school environment and the social stigma of being a teenage mother. South African data shows that the likelihood of re-entering the education system decreases when childcare support is not available in the home and for every year that teen mothers remain outside of the education system (Panday et al., 2009:130).

It is critical that these barriers are understood and addressed to ensure that pregnant teenagers remain in school and that teenage mothers return to school *as soon as possible*, as returning to school becomes harder with each year away. It is also important to note that teenagers have reported they experience the most stigma and pressure to leave school once their pregnancy becomes visible.

### ***Gender Inequalities, race, class and geography***

Teens most impacted by teen pregnancy are young women who are already living in impoverished conditions prior to becoming pregnant (Chigona and Chetty, 2008:273).

As discussed under the previous section, race, class, gender and urban/rural factors significantly affected teenage girls' experiences around pregnancy and motherhood, and whether they remain in, and return to, school (Bhana et al., 2010; Eloundou-Enyegue, 2004; Bhana and Ngabaza 2012; Chigona and Chetty, 2008; Chohan, 2010; Marteieto and Lam, 2008; Grant and Hallman, 2008 and Panday et al., 2009).

Of the two teenage mothers we spoke to who had not returned to school, both cited finances as a significant barrier to returning. In Thandi's case she did not return to school as she needed to earn money to support her baby, her mother is a domestic worker and cannot afford to pay for childcare or care for the baby herself.

My mother said she can't stop going to work because of my baby. If she stopped then who would fend for the family as I have a younger brother and sister at home who she also needs to support.

In addition, in poorer families there is likely to be less space in the house, this was highlighted as a very practical issue because it can become hard to find somewhere away from the babies cries to work. Teenage mothers in poorer families often find it harder to return to school, Marteieto and Lam 2008 found that 'household shocks and low household income increase the probability of school dropout *for girls*.' (This was found for all school dropouts – not specifically linked to

teenage pregnancy) (Marteleto and Lam, 2008:367). Grant and Hallman (2008) also noted that an extra person (baby) brings additional expenses that poor households may struggle with.

However, Grant and Hallman (2008:379) found in their analysis of data from KwaZulu-Natal that in fact 'household wealth as measured by asset ownership' was *not* significant in determining whether a teenage mother would return to school. They found other factors discussed elsewhere to be more important such as having a grandmother to assist with childcare.

Similarly, Marteleto and Lam (2008) noted that low social capital is also a factor for teenage girls not returning to school. Social capital refers to the extent and strength of community and social networks a person has and how strong these networks are, in other words someone with 'low social capital' will not have very strong community support and community ties and is not likely to have connections to influential people within the community. In relation to being a teenage mother, having 'low social capital' is likely to mean a girl does not have much community support to assist with childcare.

### ***Progressive policies are not enough – implementation continues to falter***

This review has already noted the uneven implementation of schooling policies, and a number of researchers have found that supportive policies do not necessarily lead to changes in the class room (Bhana and Clowes, 2008; Grant and Hallman, 2008). In summary, despite progressive policies in South Africa, they are not effectively guaranteeing all pregnant teenagers and teenage mothers' right to complete their education.

The extent and reasons behind these failures have already been noted above, therefore this simply reiterates that many girls are not able to return to school due to policy implementation failure and because even among schools and teachers with the best intentions there is a lack of school level implementation guidelines, or training, to support the teachers. Bhana and Clowes (2008) also noted that the absence of special social provisions for pregnant and teenage mothers fed the lack of policy. 'While the law is clear that such learners [pregnant girls] cannot be turned away from school, it is less clear about how schools should deal with pregnant learners and learner-parents' (Bhana and Clowes, 2008:78).

### ***Caring for the baby***

When girls were solely responsible for childcare they were less likely to return to school (Panday et al., 2009: 49).

Those who were primary caregivers are 77% more likely to drop out of school than those who were not (Grant and Hallman, 2008:378).

The literature agrees that teenage mothers without childcare support find it very difficult to return to school. This was supported by one of our respondents, Nonhlanhla, 17 years at the birth, who and left school while pregnant and never returned: 'The issue [preventing her from returning to school] was not the school but home as there was nobody to look after my child.'

As with all mothers of young babies, teenage mothers have many demands including: childcare, caring for sick babies; sleep deprivation; finding time to work/study and the psychosocial demands on new mothers. Chigona and Chetty (2008) found in their study that:

Teen parents face an overwhelming number of difficulties. Parental and peer pressures are far more common than support and understanding. Mature, adult decisions are required of emotionally pressured adolescents. Managing to care for an infant and devoting adequate time to schoolwork is a great challenge for the teen parents (Chigona and Chetty, 2008:264).

Lack of support with childcare from families was named as a significant barrier by *both* teenage mothers themselves and the teachers and principals in schools. Bhana and Ngabaza (2012) found that among the principals and teachers that they interviewed ‘The issues of childcare, child-related illness and financial difficulties were raised in many cases as a significant barrier to learning within the class’ (Bhana and Ngabaza, 2012:55). Chigona and Chetty’s (2007) work supported these findings, many teenage mothers in their study reported conflicting and multiple demands on their time, in the words of one of the teenage mothers: ‘Due to having a baby at home...I don’t have time to do most of the schoolwork’ (Chigona and Chetty, 2007:7).

We found that amongst our respondents the key reasons for not receiving support from home were: socio-economic – as noted above Thandi’s mother was a domestic worker with two other children to support and could not afford to either pay for childcare or stay home and care for the baby herself, Thandi, who was 16 years at the birth, left school to care for her baby. For Nonhlanhla again there was nobody at home to look after the baby and they do not have much money: ‘...my family is not well off and the little we had was further stretched to be able to support the baby for such reasons I was unable to go back to school even though I wanted to.’

This reality, of childcare preventing many teenage mothers returning to school, is gendered and reflects the gender inequalities in our society (Morrell, Bhana and Shefer, 2012 and Jewkes, Morrell and Christofides, 2009). The literature showed that only the girls were expected to stay home and care for the baby and although we are seeing a greater move towards involvement of fathers then previously, the social pressure and expectations of caregiving remain on the girl. This presents an interesting conflict with the policies about teenage mothers ‘right to complete their education’ and return to school. ‘In the context of an education system that is in transition, the expectations that young mothers should conform to the gendered norms of parenting has come into conflict with the new norm that they should finish school’ (Morrell, Bhana and Shefer, 2012: 21).

Chohan and Langa (2011) also highlighted the contradiction that teenage mothers experience, on the one hand if they stay home to care for their babies (whether on a permanent basis, or occasionally when the baby is sick) they are being ‘responsible mothers’ which they are pressured to be, and yet common discourse then ‘judges’ them as being irresponsible for not returning to school. Teenage mothers are in a very difficult position, as much of the discourse will judge them whatever their decision.

### ***Babies are not supported in the schools***

Having and caring for a child occurs away from and outside of school, and there seems little thought given to integrating these two roles of being a parent and a learner (Shefer and Bhana, 2012:146).

Even in supportive schools where teenage mothers are expected, and supported, to be primary caregivers and the dual demands of being a mother and a learner are recognised, ***the research found no schools that allowed the mother to parent at school*** (Bhana and Clowes, 2008; Shefer, Bhana et al., 2012; Clowes and D’Amant, 2012 and Bhana et al., 2010). Shefer, Bhana et al. ‘found no evidence that schools allowed or encouraged young parents to bring their children

to school and, in response, young parents expressed no desire to have their children accompany them' (2012:146).

This in itself is a problem as it affects how one can parent, and a second concern is that much of the literature was silent on this critical issue. Most research and policy work is focusing on ensuring the mother is supported to complete her education, but does not consider that the school could also be a space where she can take her baby if necessary or desired.

Mrs Gopal (a teacher respondent) highlights breast-feeding, childcare facilities and nappy changing as important aspects in the everyday life of a parent, but facilities for these remain peripheral to and absent in most schools. It appears then that while teachers may have the will to care, specific school interventions are required, which must address *where* pregnant young women and teenage mothers are situated within the South African landscape. (Bhana et al., 2010: 879).

Other teachers and principals expressed views that parenting must *not* be a part of schooling:

We cannot allow you to breastfeed here...we had instances where...some of the family members bring the child to school and now the mother must breastfeed in front of other children. You know, we try to discourage that kind of practice...So we try to ask parents to make practical arrangements, you know, to bottle feed the child...in the afternoon, early morning and afternoon.(Principal) (Bhana and Clowes, 2008:84).

Devey and Morrell's study (2012) showed that despite the majority of learners being supportive of their peers caring for their babies (as noted above), they were opposed to the idea of schools being spaces where mothering itself is supported and found that: 'although in many schools mothers are accepted, there is strong resistance (by learners) to the suggestion that babies should have a presence in schools... There was minimal support (less than 10%) for breastfeeding and only 5% support for mothers bringing their babies to school' (Devey and Morrell, 2012:87).

### ***Changing social status of teenage mothers***

Teenage mothers face particularly difficult barriers around their 'changing social status' in some ways they are still considered 'school children' and treated as such, but in other ways they are 'mothers' and expected to be mature adults responding to those responsibilities.

Preston-Whyte and Zondi (1992) cited in Jewkes, Morrell and Christofides (2009) noted that 'Childbirth, whether in or outside marriage, is traditionally regarded as the ultimate rite of passage to womanhood and thus elevates a girl's social status' (Jewkes, Morrell and Christofides 2009:681). And yet at school she is still treated as a 'school-child'. As Chohan and Langa (2011) note: 'This is confusing for a teenage mother, who is treated like a child but still expected to act like an adult' (Chohan and Langa, 2011:88).

Kaufman and de Wet (2001) noted: 'For girls in Agincourt (Limpopo) and sometimes in (urban) Soweto, pregnancy and childbirth often mean moving to the homes of their boyfriends, where they are subject to the financial decisions of in-laws' (Kauffman and de Wet, 2001:155). While this tends to be more common in rural communities, the reality is that with childbirth many teenage girls are seen now as primarily a mother, and in these cases with obligations to partners and in-laws – and this often precludes them from returning to school. Among our respondents none moved in with their in-laws, all remained living with their mothers; however, these were all urban areas, which would bias the findings.

A key reflection in Chohan's (2010) study was that all eight of her teenage mothers felt that motherhood had made them more mature and responsible, in addition they did not regret having their babies, nor leaving the 'fun life' they no longer had time for. This is interesting as it supports the assertion that teenage mothers have experienced 'a change in social status' – and some reported enjoying this change. Although we must note that all of Chohan's (2010) participants had returned to school, presumably mothers who have not been able to return to school may feel differently.

Among our respondents all showed a sense of responsibility towards their babies and a maturity about being teenage mothers, none expressed any regret or bitterness about the additional responsibilities they face.

### ***Insufficient support from school and teachers***

Teacher and school attitudes varied widely, and there were many teachers and schools who are not supportive of either pregnant teenagers or teenage mothers, and teenage mothers reported that they experienced the greatest stigma while pregnant, once it was visible.

The literature was full of examples of teachers and schools that did not support pregnant teenagers and teenage mothers – as noted earlier in some cases it was due to an inability to do so, and in other cases it was due to judgemental attitudes (Bhana and Ngabaza, 2012; Bhana and Clowes, 2008; Clowes and D'Amant, 2012; Chigona and Chetty, 2008). Chigona and Chetty (2008) noted three clear areas where pregnant teenagers and teenage mothers do not get adequate support to perform at school: 1) lack of academic support from teachers (for example, to go over work missed); 2) lack of counselling to assist in combating stigma associated with teenage pregnancy and how to cope with parenthood and schooling simultaneously and 3) misunderstandings and pressure from teachers and fellow learners.

Teen mothers felt some teachers did not empathise with them and they were expected to perform and behave just like any other learner in their class. The teachers and fellow learners put a good deal of pressure on them without really understanding what the girls were going through (Chigona and Chetty, 2008:270).

Chigona and Chetty (2008) also noted that many teenage mothers felt that teachers simply 'gave up on them' and stopped helping them academically, indeed none of their study participants received any counselling at school. Similarly, none of our respondents reported receiving any counselling or support while pregnant or once returning to school, for those that returned to school even where they felt welcomed none reported receiving any additional support or specific counselling.

Clowes and D'Amant (2012) emphasised that pregnant learners and teenage mothers experienced different challenges, with most reporting at least some experiences of discrimination and 'pressure to leave school' during the pregnancy. Some principals who did not support pregnant teenagers remaining at school framed 'time off' for pregnant learners as 'desirable, necessary and legitimate' (Clowes and D'Amant, 2012:41).

Principals and teachers seemed far more welcoming of learner-parents [as opposed to pregnant girls]. The Principal of Richmond High in the Western Cape emphasised that he 'focused on getting them back into the school system'. While in his school a pregnant learner must leave, she must also 'return as soon as she is healthy'. She must resume her schooling (Bhana and Clowes, 2008:83).



Many teenagers reported that teenage mothers often found it easier to be back in school following childbirth than in the last trimester of pregnancy, as motherhood attracted less stigma than being visibly pregnant. Some teachers spoke about 'the pregnant girl infecting others' and the 'problem' was often framed around illness and health concerns, such as 'we can't support a pregnant girl, what if she goes into labour, faints etc'. 'A pregnant girl is sick, a sick person, who should be attended by those people who are professional in handling such cases. Sometimes they are dizzy, sometimes they vomit' (Morrell, Bhana and Shefer, 2012:20). Bhana et al. (2010) noted that 'Pregnant teenagers incited anger and hostility, (and) were framed as sexually immoral and were censored' (Bhana et al., 2010:874). This extreme problematising of the pregnancy leads to many pregnant teenagers leaving school well in advance of childbirth.

In our interviews one pregnant teenager left school while pregnant as a result of the pressure she experienced. She left because 'during the pregnancy it was a lack of support from the teachers and the comments that were passed around by my peers that led to me dropping out of school. No the teachers did not support me in anyway.' When asked if anyone at school had made her aware of her right to remain and return to school she replied 'I was not aware of such...and was chased away from school.' (Nonhlanhla, teenage mother, who was 17 years at the birth, and never returned to school)

The literature showed that very few schools appeared to have formal or effective mechanisms in place to offer sufficient opportunities for girls to catch up on missed work. However Clowes and D'Amant (2012) did note that 'the lack of support is not especially aimed at pregnant or parent learners, but is a consequence of the ways in which schools are institutions with a very particular mandate, and the ways in which this mandate is structured, staffed and financed' (Clowes and D'Amant, 2012:41). In other words teachers do not support girls who need to catch up for a number of reasons: time constraints, lack of skills or disinterest – in some cases pregnancy and teenage mothers are not being particularly targeted, but are just part of a general lack of support and challenges within the education system. Although others note that some teachers do particularly resist assisting pregnant teenagers and teenage mothers.

In summary, Shefer et al. (2012) noted that the majority of learners in their study received no special concessions recognising their dual responsibilities (learner and mother); there was very little acceptance or attempt to accommodate their parenting responsibilities and 'Generally, those learner parents who had to take time off school to take their children to the clinic or for other health visits experienced punitive and unsympathetic responses from teachers' (Shefer, Bhana et al., 2012:146). And yet around one third managed to remain in school, highlighting that while support from teachers is beneficial, it is not critical to teenage mothers return to school.

### ***Stigma and lack of support from the community***

The literature shows that pregnant teenagers and teenage mothers also experienced stigma from friends, peers and the community, and a number reported that this was a barrier to them remaining in school while pregnant and returning following childbirth (Shefer, Bhana et al., 2012; Chigona and Chetty, 2008; Grant and Hallman, 2008; Panday et al., 2009; Choha, 2010). However, while this was unpleasant, and such behaviour should not be tolerated, it does not appear to have been a critical factor in determining whether teenage mothers returned to school following childbirth.

Shefer and Bhana (2012) reported that the teenagers they interviewed had all experienced instances of being shunned by peers. Of their sample, two pregnant girls left school at an early stage of pregnancy because of stigma and discrimination by teachers and fellow learners. Both returned following childbirth. Chigona and Chetty (2008) noted that many pregnant teenagers and teenage mothers experienced gossiping, teasing and unkind comments: ‘...sometimes other students do tease me because I have a baby whilst at school...’ (Grade 12 teen mother) (Chigona and Chetty, 2008:271).

Among our four respondents one experienced extreme stigma from peers at school, as already reported Nonhlanhla left school while pregnant and one of her reasons was ‘the comments that were passed around by my peers.’ However, she also reported that after childbirth she had many friends with babies, and there was less shame or stigma attached to teenage motherhood among these friends. Our other respondent, Thandi, who was 16 years at the birth, and did not return to school noted that she ‘could not return to school because I felt embarrassed and out of place. I let down a lot of people, [when I fell pregnant] my mother, my family.’ Thandi appears to have a few reasons for not returning including shame, a sense of failure and expectations of being judged.

The literature also noted a common trend where teenage mothers changed schools, following childbirth, as a way to avoid returning to ‘the environment of shame’. In contrast, the same study also found girls who ‘reported the belief that such stigma was less marked then it had been in the past and that the experience of being able to return or not was closely linked to socio-economic contexts’ (Shefer, Bhana et al., 2012: 135).

Stigma and discrimination from community members was also frequently reported, Chigona and Chetty (2008) noted that a number of girls reported that the community discouraged them from completing school and shunned them as the ‘other girls’. The concern around ‘contamination’ was another driver of discrimination that led to isolating and labelling pregnant teenagers and teenage mothers. Chohan (2010) noted that:

Two interesting themes emerged when participants’ discussed reactions from friends, educators and community members. The sub-themes that emerged were: parental disapproval of their child associating with a pregnant girl. Educators and learners’ perception that pregnant girls make other learner’s feel sleepy in class (Chohan, 2010:54).

Panday et al. (2009) noted that this lack of support and shunning can have far reaching impacts: ‘Stigma during or after pregnancy can lead to depression, social exclusion, low self esteem and poor academic performance affecting the prospects of employment in the future’ (Panday et al., 2009:50).

### ***Previous academic performance***

As noted in the section on facilitators, Grant and Hallman (2008) and Marteleto and Lam (2008) stressed that previous academic performance is a relatively reliable indicator as to whether a teenage mother will return to school. In other words, teenage girls who had repeated grades and had low levels of literacy and numeracy were less likely to return following childbirth.

Furthermore, while not directly related to issues of school performance, school attendance is also a significant factor: ‘Young women who had previously withdrawn from school for non-pregnancy-related reasons are less than half as likely to return to school as are young women who had never withdrawn’ (Grant and Hallman, 2008:379).

## Conclusions and Recommendations

This review has shown that there are multiple drivers of South Africa's high levels of teenage pregnancy. The evidence shows that in order to reduce unplanned teenage pregnancies a multi-pronged approach is needed at both structural and individual level: gendered norms and gender inequalities between girls and boys need to be addressed to enable girls to have autonomy and decision-making over their own bodies. Furthermore, poverty, race-based inequalities and living in rural areas are additional factors that drive unplanned teenage pregnancies and need to be tackled.

In addition, on an individual level, although teenagers reported having relatively high levels of basic knowledge of how to prevent unplanned pregnancies, STIs and HIV, it was evident that this knowledge is often superficial and many girls' reported not really knowing how to apply the knowledge and frequently 'just not using contraceptives'. In other words correct and consistent contraceptive use was low. Furthermore, there were very low levels of knowledge around dual protection, emergency contraceptives, PEP and limited understanding of fertility and conception. Finally, access to contraceptives was difficult for teenagers, especially younger ones. Barriers to access included: clinic locations, costs, clinic hours, contraceptive choice and in particular the poor knowledge and judgemental attitudes of HCWs. MacPhail et al. (2007) captured the tragedy of access and use of contraceptives by many teenagers in South Africa:

South Africa has the best provision of reproductive health care and HIV prevention programmes in sub-Saharan Africa, yet the data presented here indicate that we continue to fail young women in terms of ensuring their access to and use of contraceptives, to termination of pregnancy services; and to HIV protection (MacPhail et al., 2007:7).

Importantly this review has stressed that there is a significant difference between a young teenager of 14 or 15 years and an 18 or 19 year old, and has highlighted that the impact of teenage pregnancy and motherhood varies across the teenage years. Pregnancy and motherhood as a young teenager is significantly more challenging, and medically problematic than for an older teenager – and this difference should be borne in mind when developing strategies to reduce teenage pregnancies and support teenage mothers.

While working on strategies to reduce unplanned teenage pregnancies it is imperative that teenagers who do fall pregnant are supported in realising their right to continue with their education, during pregnancy and following childbirth. The literature highlighted that despite progressive policies in this regard nearly two thirds of teenage mothers never return to school. Factors that discourage many from returning include: being the primary caregiver for the baby; poverty; weak school performance prior to falling pregnant; lack of support and moralising attitudes from teachers and ignorance about their rights to schooling.

The most critical factor that emerged in supporting teenage mothers to return to school is whether she has the support of her mother, both support to care for the baby and emotional support. Additional factors that supported teenage mothers returning to school was whether the family had the resources to support her baby; her school performance prior to falling pregnant, (strong performers tended to return and continue doing well); early return following childbirth; whether she had supportive teachers and peers and the support of the father of the child.

Below are a few suggestions of possible areas for action. It is not intended as an exhaustive list but rather the start of a discussion among key stakeholders as to what could be done.

## ***Recommendations for key policy reforms***

### **Implementation failures**

The South African policies relating to teenage sexuality, teenage pregnancy, teenage motherhood and girls' right to continuing education are relatively progressive, and the major obstacles are around implementation, which is also linked to attitudes of healthcare providers, principals, teachers, families and communities. Therefore critical work is needed to ensure policies are effectively or accurately implemented.

Indeed, healthcare workers, educators, principals, School Governing Bodies, parents, community gatekeepers and some implementing NGO's need support around implementation. Much of the literature highlighted two key barriers to effective implementation: firstly, confusion or lack of knowledge about the policies and how to support young girls to realise these rights, and secondly, moral beliefs from 'implementers' that prevent them from objectively implementing the policies. As such there is an urgent need for training and re-orientation for all critical service providers, parents and community leaders, to create spaces where these policies can be understood, accepted and implemented, free from moral judgements. Fortunately the recent Department of Health Integrated School Health Policy has noted this as a critical area of work. And as Chigona and Chetty (2008:262) noted: 'If society expects the girls to succeed with schooling, provisions must be made for meeting the special needs of [pregnant or parent] learners.'

Consideration should also be given to ensuring stronger 'consequences' for schools who violate policies – the literature showed many cases where girls rights to education were violated and very little action was taken by the state.

### **Policy reform**

Additionally, there are a few policy areas where reform is required. A number of the policies to reduce pregnancy are still stressing abstinence-based approaches, which have been shown to be ineffective. Moreover, as far as this review could ascertain ***none of the policies support teenage mothers in their role as carers for their babies*** – they all support the mothers' right to study, but fail to recognise the importance of the school as a space that needs to support her dual role as a learner and a parent. For example, teachers must be clearly mandated to recognise the dual role and additional strain on her studies, and must provide academic support when she has to take time off for clinic visits or tend to a sick child. Additionally schools could be encouraged to allow her baby to come to school during breaks to be breastfed, or have a crèche linked to the school where the baby could be cared for.

Furthermore, the *Measures for the Prevention and Management of Learner Pregnancy* (MPMLP) should be reviewed in light of whether it is serving the best interests of the teenage girls and ensuring her right to education, it needs to be amended to ensure a balance between the child's rights and that of the mothers. In particular, two of the MPMLP recommendations are problematic, namely that a girl cannot return in the year she gave birth, and that ideally she should take two years away from school. Both are in conflict with evidence that early return following childbirth benefits the girl academically and many qualitative studies which highlight cases of young girls returning soon

after birth and succeeding academically. Panday et al. (2009:17) noted that: ‘The suggestion of ‘up to a two year waiting period’ before returning to school in the Department of Education learner pregnancy guidelines (MPMLP), may be counterproductive to both maternal and child outcomes.’

Finally, most policies are still based on gendered notions of the girl being the primary caregiver for the child and do not engage with *the teenage father and his rights and responsibilities* at all, which perpetuates gender inequalities and the mother carrying the sole or primary burden of childcare.

## ***Recommendations to increase knowledge, access and use of contraceptives***

Jewkes, Morrell and Christofides (2009) note that accepting gender inequalities and gendered norms as a critical driver of unplanned pregnancies necessitates that responses to reduce teenage pregnancies must focus on *empowering women* and *reducing gender inequalities* (Jewkes, Morrell and Christofides, 2009). In addition responses need to address *comprehensive sexuality education*, and not merely ‘preventing teenage pregnancy’ through a simple reproductive health or family planning lens.

## **Empowering young girls and reducing gender inequalities**

As noted above, while protection during sex is critical to reduce unplanned pregnancies, simply expanding family planning programmes and distributing more contraceptives will not achieve this. Any strategy for family planning initiatives and increased contraceptive use needs to be run alongside programmes that empower young girls and enable them to make decisions about whether, when, and how to have sex.

These initiatives can be integrated into school-based comprehensive sexuality education (CSE) sessions, as well as rolling out the many excellent community-based programmes that already exist to empower young girls and boys, some of which also involve critical work with parents. The Stepping Stones intervention is a very comprehensive model which has been assessed through a randomised control trial in the Eastern Cape and found to be a training intervention that powerfully challenges gender norms and inequalities (Jewkes et al., 2008). It can be used with same age groups or cross-generationally and can be a powerful tool for working with parents, community leaders and youth. Both schools and communities present fertile opportunities for rolling out such initiatives, and implementation in communities has the added benefit of also targeting out of school youth, parents and critical service providers.

## **Comprehensive sexuality education**

South Africa has embraced sexuality education in schools, currently delivered through Life Orientation (LO) lessons, this review recommends that in order to increase effectiveness the programme needs to expand to become *comprehensive* sexuality education (CSE), and needs to tackle gender relations and norms, more effectively. For example, CSE sessions should include multiple issues that relate to equality and girls’ power and these issues should be mainstreamed into many of the sessions and not simply dealt with as ‘stand-alone’ issues. Issues to be addressed include: negotiation and communication skills; healthy, happy relationships (both sexual and platonic); sexual rights; gendered roles and norms; sexual pleasure; alternative sexualities such as lesbian, gay, bisexual and transgender people; how the ‘world can look different’; ‘daring to dream’ as a girl child etc.



In addition, there needs to be more basic information and facts provided in these sessions. As was shown above among our respondents, and much of the literature, a number reported that the sessions did not provide enough information (around basic reproductive health nor contraceptive options); moved to fast; did not effectively teach the teenagers how to actually use condoms correctly and did not create enough space for questions and discussion. One girl responded by saying: ‘Sex education should form a major part of the syllabus and create an open field for us as students to question and learn until we have a full understanding’ (Thembi, teenage mother, 16 years at birth, who returned to school after one year).

In addition, findings from the Youth Risk Behaviour Survey (YRBS) suggest that educational programmes would improve if they specifically addressed situations of 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). (Flanagan et al, 2013:26)

Furthermore, sexuality education can no longer be open to ‘interpretation’ by the teacher, for example teachers cannot choose a much harder ‘abstinence only message’ than is prescribed in the curriculum, nor can the individual teachers’ views inform what and how s/he teaches LO. The curriculum must be compulsory and delivered in a non-judgemental manner.

Comprehensive sexuality education must be about ***empowering girls and boys to ensure that they choose their first sexual encounter and that it is pleasurable and safe.*** In order to achieve this current LO sex programmes will need some revising, and many teachers will need re-training and values clarification sessions. The recently launched Integrated School Health Policy may create some new spaces and opportunities to do this. In addition we are pleased to note that the Department of Education is currently piloting some new sex education modules, which need to be reviewed and taken to scale if effective. The Stepping Stones model again is a powerful intervention that be implemented through the LO classes and addresses gender norms and inequalities.

The evidence shows that enabling young girls to take control of their relationships is far more powerful than simply handing out condoms or hormonal injections. A focus on supporting young people to improve all their relationships (with friends, parents, siblings, partners etc), will mean that their relationship with a boyfriend or girlfriend should be better - it should be more equal, based on trust, love and respect, and flowing from that will emerge healthier and safer sexual relationships. Comprehensive sexuality education is an opportunity to support teenagers in developing and enhancing their relationship skills. In the words of one of our respondents:

They must give us means and guidance for us to be able to approach our parents so that they are open to us about sex, which would allow us to ask them for contraceptives. Sex education needs to be made longer to give more information and there must be stories we can learn from.  
Nonhlanhla (teenage mother, who was 17 years at the birth, and never returned to school)

## **Improving access to contraceptives**

The literature and our interviews all reiterated that the ***acceptability, accessibility and appropriateness***, to teenagers, of the staff and facilities distributing contraceptives, and all SRH services, are critically important. Throughout the review critical factors have emerged to assist with increasing acceptability, accessibility and appropriateness in South Africa, and are summarised here:

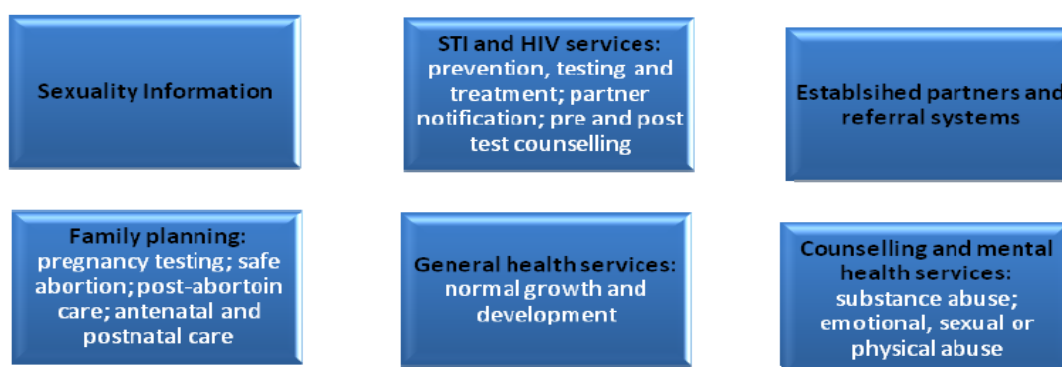


- HCWs need training in order to be up to date on all modern contraceptives
- HCWs need values clarification sessions to address those that moralise, judge and lecture teenagers
- Teenagers need comprehensive knowledge on all forms of modern contraceptives, especially the importance of consistent and accurate use; as well as basic reproductive health information about conception, fertility cycles, their right to abortions etc. Dual protection needs to be constantly emphasised
- It must be recognised that many teenagers are having same-sex sexual encounters, and further that a number of teenagers are transsexual or intersex. HCW training and contraceptive supplies need to address these teenagers particular needs and experiences
- Emergency contraceptives and PEP need particular attention: HCWs need more training, they need to be available in all clinics and teenagers need to know about them.
- Easy access to contraceptives – the easier they are to access the greater the uptake:
  - Schools provide critical opportunities to distribute (male and female) condoms
  - Clinics need to ensure they are open outside of school hours
  - Clinics need to ensure shorter waiting times
  - Clinics need to operate in such a way that youth believe that they will be treated confidentially and respectfully
- Staff shortages and lack of equipment and supplies at clinics must be addressed
- SRHR services must be integrated across all ‘clinic days’ so that teenagers can easily access contraceptives when visiting clinics for other reasons
- Restrictive costs must be removed
- Male partners should be involved in discussions and accessing contraceptives
- All stakeholders need training in critical SRH rights and girl’s rights to continue schooling
- Any initiatives should also work with the communities to ensure community and community ‘gate-keepers’ support, so that teenagers are not struggling with stigma, shame and secrecy while accessing contraceptives.

## Examples of models to increase access

Much of the Literature speaks of the *Youth-Friendly Health Services* (YFHS) concept, and while it is still being implemented differently across South Africa, the MIET (2012) Literature Review developed the diagram below to show the host of possible services that could be made available at such services. It is also important to note that these ***YFHS do not need to be staffed by youth themselves, but the staff must be youth-friendly.***

## Potential services offered at Youth-Friendly Health clinics



Sources: IPPF 2007, Baloyi 2006, Bearinger et al 2007, Oxfam 2007, Rogstad et al 2002, WHO 2002

In addition, the National Department of Health has a number of good policies and guidelines that through good implementation could create opportunities for change. The National Contraception Policy Guidelines (2012) are discussed in detail under the policy section, and offer many opportunities for ensuring improved access, acceptability, availability, and take-up of contraceptives by adolescents. The Department has also developed recommendations for what they term *Adolescent and Youth Friendly Services* (AYFS) in 2009<sup>19</sup>. This includes: increased SRHR knowledge and contraceptive use; gender equality in sex; men's involvement in SRH programmes and encouraging sexual delay. There seems to be a lot of energy from government departments around AYFS services and this might be a useful entry point for discussions with government.

To conclude this section we briefly reflect on the MIET Literature Review (2012:18), which noted that a successful intervention to reduce unplanned teenage pregnancies would be three-pronged:

1. Clinical services that assure accessible and high-quality reproductive health care
2. Sex education programmes that provide developmentally appropriate, evidence-based curricula
3. Youth-friendly strategies to enhance life skills, connections to supportive adults and educational and economic opportunities.

### ***Recommendations to support pregnant teenagers and teenage mothers completing school***

A multi-pronged approach is required to keep girls in school:

Instituting strategies to retain girls in school by addressing both financial and school performance reasons, as well as ensuring early return post-pregnancy, may be the most effective social

<sup>19</sup> Reported in a meeting hosted by Ibis on 26 February 2013 to discuss a 'National Partnership on Teenage Pregnancy'

protection that the education system can offer to prevent and mitigate the impact of early pregnancy. When learners do dropout of school, concerted effort is required to re-enrol them in school or in alternative systems of education. (Panday et al., 2009:13).

## **Assist teenage mothers with childcare support**

The evidence shows that the most critical intervention to assist a teenage mother to return to school following childbirth is providing her with childcare support during the day to enable her to attend school and study.

Young mothers need support to raise their children. It is essential to prioritise young mothers' access to parenting programmes, early intervention services for children at risk and integrated early childhood development programmes such as good and affordable crèches. These programmes are dependent on sufficient funding for the implementation of the Children's Act. (Ardington, 2012:4)

This report suggests a number of ways childcare support for teenage mothers could be increased:

### ***Maternal grandmothers***

Maternal grandmothers play a critical role in enabling teenage mothers to return to school, where they are in a position to care for the baby themselves, or pay for childcare, this is usually the critical factor that enables teenage mothers to return to school. Given their critical role grandmothers should be supported so that they can support their daughter's continuation at school.

### ***Parenting support***

Teenage mothers need parenting support and advice, especially if they are uninformed and battling to parent, and are likely to battle with school, or not return at all. In order to assist with the dual demands of being a learner and a parent., these young women need advice on how to parent and coping strategies. This is particularly relevant to teenage mothers, as pregnant teenagers (especially young teenagers) often hide their pregnancies, and seldom access pre-natal care or any form of 'parenting classes'. Counselling at school while pregnant can also assist with preparing teenage mothers.

### ***Being a mother at school***

There is a strong, albeit possibly controversial, argument that a schools role can be expanded to support a mother **both** as a learner and as a mother, and as such if she chooses to exclusively breastfeed for the first six months, the school should provide a space for her to do so. Similarly, if she chooses to express breast milk there should be facilities both to express and to safely store the milk. Especially in light of both the World Health Organisation and South African Department of Health's strong recommendations for exclusive breastfeeding for six months. It does not seem inconceivable that schools could have childcare facilities attached to them to support all mothers of young babies - whether the mothers are learners or teachers. A similar model (which occurs in some communities) could be to encourage community crèches to open next to schools, so that mothers could breastfeed during breaks etc. This would significantly assist teenage mothers who do not have childcare support at home, and

reduce the burden of purchasing formula<sup>20</sup> which is critical in poorer households. This recommendation recognises the many competing demands on limited resources within the Department of Education, however we argue that social transformation is desperately needed to assist teenage mothers, especially young ones, to return to school – and this is an exciting possibility to consider.

### ***Increased access to Child Support Grant***

The report has shown that there is a very low uptake of the Child Support Grant among teenage mothers, and also that finances often prevent teenage mothers being able to pay for childcare – preventing their return to school. In addition, Ardington et al. (2012:4) noted that ‘Social grants are linked to improved nutritional outcomes for children.’ Steps should be taken to assist teenage mothers to access the grant which it has been argued could ‘tip the scale’ towards enabling teenage mothers to pay for childcare and return to school. Schools could be urged to inform and encourage pregnant teenagers how to access it. Clinics could also be places that encourage teenage mothers to access the grant.

### **Early return following childbirth**

The evidence has shown that the longer a teenage mother stays away from school the less likely she is to ever return, and to succeed if she does return. Therefore we recommend awareness campaigns be developed to highlight the importance of returning to school quickly following childbirth. They need to target a broad audience to ensure the teenager has family and community support for her return, the audience includes: pregnant teenagers, their parents, schools, health care workers and community leaders.

### **Academic support at school**

Returning to school is the first step of continuing one’s education, the teachers and principals’ then need to recognise the particular experiences and needs of teenage mothers. Teachers need to be encouraged to provide additional support to teenage mothers; if they are absent due to childcare demands they should be provided with support to complete missed work, and consideration needs to be given to the additional responsibilities that they have after school hours. Again awareness campaigns could be useful to both reduce the stigma associated with teenage mothers and highlight the amazing balancing that many teenage mothers perform. In addition, teachers need to be given training on how to provide adequate support.

We conclude with recommendations made by Chigona and Chetty (2007:13) which provide a useful summary of many of the points above. They identified the following four recommendations for supporting teenage mothers in completing their education:

- Provide proper counselling to the teen mothers before they return to the school system;
- Make lessons and time available for teen mothers at times that are convenient to them;
- Provide teacher training on how to support teen mother students in their schools; and
- Schools may consider providing crèche facilities for teen mother students.

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<sup>20</sup> Note: The Department of Health no longer provides free formulae in an attempt to encourage exclusive breastfeeding.

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