ARTICLES

Contraceptive Prevalence in Rural South Africa

By Orieji Chimere-Dan

A study of 2,290 women aged 15–49 in the predominantly rural Transkei subregion of South Africa reveals an exceptionally high prevalence of contraceptive use and unexpected patterns of use for a poor Sub-Saharan African society. Overall, 60% of women have ever used a contraceptive method, and 42% are currently using one. Moreover, highly effective contraceptives, particularly injectables and the pill, represent 58% and 29% of use, respectively. Among women who have never used a method but intend to at some time, 90% plan to use injectables or the pill. About half of women have heard of the condom, but use of this method is negligible. Another striking feature of contraceptive use is that the proportions of never-married women who have ever used a method (64%) and who are current users (53%) exceed those among currently married women. Four-fifths of contraceptive users in Transkei obtain their method from government facilities. The largest proportion of women who use contraceptives say they wish to stop childbearing (43%); birthspacing and postponement of the first birth account for 33% and 21% of use, respectively.

(International Family Planning Perspectives, **22:**4–9, 1996)

Throughout the 1970s and 1980s, the possibility of major changes in reproductive norms and widespread adoption of fertility-regulating behavior in poor Sub-Saharan African settings appeared quite remote. It seemed that the African culture was resistant to changes in reproductive behavior and that there was little prospect for fertility decline.

At least two factors contributed to this perspective. First, demographic transition theory, which has guided most research in population, has embodied too narrow a conception of how to achieve socioeconomic progress in non-Western societies; consequently, alternative forms of and routes to development (and the resulting changes in reproductive norms) in African societies have not been seriously researched. Second, until recently, the available data were not comprehensive and accurate enough to permit detailed analyses of subnational and local-area demographic processes in many African societies.

Emerging evidence from national-level surveys in Botswana, Kenya and Zimbabwe and local data from other countries of Sub-Saharan Africa indicate some fertility decline. These declines, occurring amid different socioeconomic conditions, suggest important regional and subnational variations in the context in which reproductive behavior can change.

In South Africa, major changes in fertility and in reproductive and contraceptive behavior have been reported, but the lack and inaccessibility of appropriate data have prevented detailed analysis.[1] The available evidence indicates that fertility has been declining for three decades. Furthermore, this trend is evident both in industrialized urban areas and in impoverished rural areas. A study of three poor communities in different provinces showed a consistent downward trend in fertility.[2]

Related to this trend is the widespread practice of contraception. By the end of the 1980s, even in rural subregions where use was lowest, contraceptive prevalence reached 35%; in other rural areas, it was 43%.*[3] The aim of this article is to identify the dominant features of contraceptive behavior in the predominantly rural South African subregion of Transkei.

Orieji Chimere-Dan is senior lecturer in demography, Department of Sociology, and director, Population Research Programme, University of the Witwatersrand, Johannesburg, South Africa.

Study Setting

Transkei was one of four black subregions of South Africa that were made politically independent as part of the government's apartheid policy of racial segregation and territorial fragmentation.† These areas, which were known as homelands, were allowed fewer employment and other economic opportunities than "white" South Africa; consequently, on the whole, they were poorer than the white areas. Since 1994, Transkei has been part of the Eastern Cape, one of the country's poorest provinces. With 3.6 million inhabitants,[4] Transkei contains 55% of the population of the Eastern Cape and approximately 10% of the South African population.

The subregion's population grows at a rate of 2.6% per year; the crude birthrate and crude death rate are 43 births per 1,000 population and 17 deaths per 1,000, respectively.[5] The infant mortality rate is 70 infant deaths per 1,000 live births, and the total fertility rate is 4.7 lifetime births per woman.[6]

*These figures, from the 1987–1989 South African Demographic and Health Survey, should be interpreted with caution. They are based on the experiences of women who either are currently married or have had a birth, and are not representative of prevalence among all women, ever-married women or currently married women.

†The other three are Venda, Bophuthatswana and Ciskei. (Six additional areas in the formerly "white" South Africa were given some autonomy and designated "self-governing territories" during the apartheid regime.) Transkei is in most respects typical of the former homelands regarding the socioeconomic legacies of apartheid and other historical experiences; it was chosen for this analysis primarily because it has the most recent detailed data on contraceptive behavior. Generalization of the Transkei evidence to the other former homelands is only implicit, although fragments of data pieced together for other rural areas and former homelands present a similar picture to that offered here. (See: O. Chimere-Dan, "Demographic Patterns," in Health Systems Trust and Henry J. Kaiser Family Foundation, *South African Health Review,* Durban, South Africa, 1995; and Henry J. Kaiser Family Foundation, *A National Household Survey of Health Inequalities in South Africa,* Johannesburg, South Africa, and Menlo Park, Calif., USA, 1995.)

Table 1. Percentage distribution of women aged 15–49 by selected characteristics, according to age-group, Transkei, 1994

Characteristic	Total (N=2,290)	15–19 (N=388)	20–24 (N=401)	25–29 (N=420)	30–34 (N=375)	35–39 (N=261)	40–44 (N=271)	45–49 (N=174)
Residence								
Urban†	9.4	8.5	10.2	10.0	10.9	9.6	7.7	7.5
Other	90.6	91.5	89.8	90.0	89.1	90.4	92.3	92.5
Marital status								
Ever-married	57.8	5.7	35.7	64.8	76.3	81.6	86.7	87.4
Never-married	42.2	94.3	64.3	35.2	23.7	18.4	13.3	12.6
Yrs. of education								
0	11.3	1.0	2.2	6.2	13.3	16.1	26.9	31.0
1–3	15.5	5.9	14.0	17.4	19.2	22.2	16.2	16.7
4–6	31.6	26.8	29.4	31.2	28.3	35.6	39.1	37.9
7–9	24.7	52.3	27.9	21.0	22.4	15.3	9.2	7.5
≥10	16.9	13.9	26.4	24.3	16.8	10.7	8.5	6.9
Currently working								
Yes	14.9	2.1	9.2	19.5	25.1	20.3	15.9	14.4
No	85.1	97.9	90.8	80.5	74.9	79.7	84.1	85.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

†Certain areas of Transkei are designated "urban" on the basis of their administrative functions; they share most characteristics of the rest of the subregion.

Only 5% of the people of Transkei live in areas that are considered urban, but this designation is based mainly on these areas' administrative functions; the "urban" areas have most of the same basic characteristics as other parts of the subregion.

A notable feature of the population of Transkei is the excess number of females over males in most adult ages—particularly in the economically active ages—due to the massive migration of men to other parts of South Africa for employment in the mining and industrial sectors. Men make up just 32% of the population aged 15–64 and 29% of the population aged 20–59. Women head 46% of households in Transkei.[7]

The subregion is one of the poorest parts of South Africa. An estimated 74% of total household income is contributed by migrant members, and 64% of the population have no income;[8] the per capita personal income averages R119 (US $33) per month.[9] The rate of unemployment is approximately 50%,[10] and the average number of nonworking persons supported by working persons in the population is 7.7 (compared with 1.7 for areas of the country other than the former homelands).[11]

Most households lack basic amenities: In 78%, water is drawn from a river, stream or dam,[12] and 37% do not have toilets; a woodlot is the source of cooking fuel used by 73% of households. Basic health services are lacking in Transkei, and diseases of poverty (such as measles, typhoid and tuberculosis) are common.[13]

Data and Methods

This article is based on data from 2,290 women interviewed between March and June 1994 for a survey on fertility and family-size preferences in Transkei.[14] The survey was conducted by the Department of Welfare and Pensions of the former government of Transkei, in collaboration with the Central Statistical Office and the Department of Health. Technical assistance was provided by the Population Research Programme of the University of the Witwatersrand, in Johannesburg. All personnel involved in the study design and implementation were employees of the former homeland government.

A multistage, stratified probability sampling design was used to generate a sample size sufficient to produce the desired estimates for Transkei overall and for broad socioeconomic categories. For the study, Transkei was divided into eight regions. Within each region, a self-weighting sample was drawn, using Transkei's 28 districts and 968 administrative areas as primary and ultimate sampling units, respectively.

Two pretested questionnaires were used for data collection. In the first stage of the interviews, basic demographic and socioeconomic data were collected on 2,290 households and on each household member. In the second stage, one woman aged 15–49 per household (out of all women in this age-group) was selected at random for interview. Respondents provided information on fertility; family-size preferences; and a wide range of other variables, including breastfeeding, postpartum sexual abstinence, unwanted pregnancies, contraception, abortion, infant mortality and public awareness of government activities in population (specifically the Population Development Programme) in Transkei.

Questions about contraception were adapted from the Demographic and Health Survey questionnaires and included information on whether the respondent had ever attempted to prevent a pregnancy, her age and parity at her first attempt to prevent a pregnancy, and whether she had ever heard of and used different methods of contraception. The survey also covered current use of various contraceptives, the source of the most recently used method and reasons for current use.

Table 1 shows the distribution of the women in the sample by a variety of background characteristics. The age distribution of the respondents is fairly similar to that of all women of reproductive age reported in the 1991 census. A similar comparison for other characteristics cannot be made because the relevant census data have not yet been published.*

Results

Levels of knowledge and use of any contraceptive method are shown in Table 2 (page 6). Contraceptive prevalence is quite high: Overall, 60% of women in Transkei have ever used a method, and 42% are currently using one. The level of current use is particularly surprising in view of Transkei's socioeconomic profile. Some 89% of women have heard about any method of contraception, a somewhat lower proportion than would be expected for the level of contraceptive use.

Contraceptive knowledge and use vary to different degrees according to women's background characteristics. For example, while contraceptive knowledge is highest among women younger than 30, use peaks among those between the ages of 20 and 34. A higher proportion of urban women than of women living in other areas are current contraceptive users. Additionally, never-married women are more likely than currently married women to be using a method (53% vs. 34%). The proportions of women who have ever used and who are currently using a method increase markedly with the level of education; current use ranges from 16% among uneducated women to 67% among those with the most schooling. Finally, women

*The educational status of the sample appears quite high, given other socioeconomic characteristics. However, a similar distribution was obtained for Eastern Cape women aged 15–49 in the 1993 World Bank Living Standard Survey. For example, in the Living Standard Survey, only 9% of women aged 15–49 had no formal education, and 38% had at least seven years of schooling; the proportions among women in the Transkei sample were 11% and 42%, respectively. The relationship between educational status and demographic patterns and processes in this population invites detailed investigation. (See: South Africa Labour and Development Research Unit, University of Cape Town, *South Africans Rich and Poor,* Cape Town, South Africa, 1994.)

Table 2. Percentage of women who have ever heard about, have ever used and are currently using a contraceptive, by selected characteristics

Characteristic	N	Ever heard about	Ever used	Currently using
Total	**2,290**	**88.7**	**59.7**	**42.0**
Age-group				
15–19	388	91.2	47.4	41.8
20–24	401	94.5	69.6	55.4
25–29	420	91.9	68.3	46.7
30–34	375	88.5	69.6	51.5
35–39	261	89.3	63.6	36.4
40–44	271	78.6	45.8	24.0
45–49	174	77.6	37.9	16.1
χ^2		*692.0**	*126.6**	*134.0**
Residence				
Urban	216	95.8	78.7	61.1
Other	2,074	88.0	57.7	40.0
χ^2		*12.0**	*35.8**	*35.9**
Marital status				
Currently married	1,102	86.8	57.5	34.4
Widowed	152	77.0	42.1	23.0
Divorced	69	97.1	68.1	46.4
Never-married	967	92.1	64.3	53.3
χ^2		*41.0**	*32.3**	*99.5**
Yrs. of education				
0	258	65.1	23.6	15.5
1–3	355	81.7	50.1	33.5
4–6	724	90.6	60.5	38.5
7–9	565	94.5	64.1	46.4
≥10	388	99.0	84.5	67.3
χ^2		*223.6**	*257.0**	*194.5**
Currently working				
Yes	342	91.5	67.0	52.9
No	1,948	88.2	52.9	40.0
χ^2		*0.03*	*20.4**	*19.8**

*Differences are statistically significant at p<.001.

who are employed outside the home know about and use contraceptives somewhat more than nonworking women.

Table 2 revealed that the level of current use is higher among never-married women than among their currently or formerly married counterparts in Transkei. The current-use data below confirm this pattern for all age-groups except the oldest:

Age-group	Ever-married	Never-married
15–19	13.6	43.4
20–24	35.0	66.7
25–29	36.8	64.9
30–34	47.2	65.2
35–39	35.2	41.7
40–44	25.1	16.7
45–49	15.8	18.2

As in several other parts of South Africa for which data are available,[15] marriage appears to be losing its hold as the prerequisite for socially accepted sexual relations in Transkei. An important aspect of this phenomenon is the high rate of sexual activity among never-married teenagers.[16] More than 70% of Transkei teenagers who have never been married are sexually active, and 68% of those who are sexually active currently practice contraception (not shown).

Table 3 shows women's levels of knowledge and use of various contraceptive methods. Injectables are the most widely known and used methods, representing 58% of current use. The pill is the second most widely used method of contraception, accounting for 29% of current use. The condom is relatively well-known (recognized by 45% of all women), but is not widely used. Rhythm is the least known and least used method.

These data reveal another characteristic of contraceptive behavior in the Transkei society: the widespread use of highly effective methods of contraception. This feature, which is common among black South African contraceptive users,[17] is due mainly to the limited range of methods provided by the government program. In the past, government services to blacks promoted methods that required minimal education, little client involvement and few follow-up services.[18]

Table 4 shows age patterns among users of various methods. As it illustrates, use of the pill (and to a lesser extent, injectables) varies noticeably by age. Oral contraceptive use is concentrated among very young women; pill prevalence falls from 43% among 15–19-year-olds to less than 20% among 30–44-year-olds. In contrast, reliance on injectables rises gradually with age, peaking at about 65% among women in their 30s. While these two methods account for most use among women in each age-group examined, reliance on female sterilization also becomes sizable among those in their 40s.

The government is the main source of contraceptive services in Transkei. Most users obtain their method from a government health center or clinic (63%) or a government hospital (22%). Only 3% rely on mobile clinics as their source, and 1–2% go to private hospitals or clinics. Alternative modes of delivery, such as community-based distribution, social marketing and networks of personal acquaintances, are not common in this society.

As Table 5 indicates, the most common reason women give for using contraceptives is to terminate childbearing (43%). In all, 33% of users wish to space births, and an additional 21% want to delay their first birth. As one would expect, most teenagers who use contraceptives (59%) do so to delay their first birth. The same reason is given by the largest proportion of women aged 20–24 (34%). Women in their late 20s use contraceptives more for birthspacing than for other reasons. Most users aged 30 or older wish to stop childbearing. Currently married users are about equally likely to want to space and stop births; their never-married counterparts, by contrast, predominantly want to either delay their first birth or terminate childbearing.

Finally, Table 6 (page 8) shows that sexual inactivity and desire for a pregnancy are the most common reasons women give for never having practiced contraception (given by 21% and 17%, respectively). Other reasons include husband's objection (13%), religious or cultural objections (13%) and fear of side effects (11%).

Desire for pregnancy and being pregnant are the main reasons women give for having discontinued contraceptive use (22% and 15%). Husband's objection (14%), sexual inactivity (12%) and fear of side effects (11%) are also factors in current nonuse of contraceptives by women who have previously used a method.

Among women who have never used contraceptives, 41% intend to use a method in the future. Of these, 88% know the

Table 3. Percentage of women who have ever heard about, have ever used and are currently using a contraceptive, and percentage distribution of current users, all by method

Method	Ever heard about	Ever used	Currently using	% dist. of current users
Pill	82.4	26.9	12.5	28.9
IUD	39.6	2.6	1.3	3.0
Injectable	83.4	32.4	24.8	58.1
Spermicide	14.1	0.4	0.0	0.1
Condom	45.1	1.0	0.3	0.6
Female sterilization	22.4	1.0	2.0	4.8
Male sterilization	11.3	0.0	0.0	0.1
Withdrawal	12.4	0.6	0.3	0.6
Traditional	20.8	8.2	1.6	3.7
Rhythm	2.8	0.2	0.2	0.1

Table 4. Percentage distribution of women currently using a contraceptive, by method, according to age-group

Method	15–19	20–24	25–29	30–34	35–39	40–44	45–49
Pill	43.2	37.8	26.5	18.7	18.9	15.4	28.6
IUD	1.9	1.8	4.1	5.2	3.2	0.0	0.0
Injectable	49.4	55.4	62.8	64.8	65.3	50.8	42.9
Spermicide	0.0	0.0	0.0	0.0	0.0	1.5	0.0
Condom	1.2	0.9	1.0	0.0	0.0	0.0	0.0
Female sterilization	0.0	0.0	2.6	7.8	6.3	23.1	17.9
Male sterilization	0.0	0.0	0.0	0.0	1.1	0.0	0.0
Withdrawal	0.0	0.0	0.5	2.1	0.0	0.0	3.6
Traditional	4.3	4.1	2.6	1.6	4.2	9.2	7.1
Rhythm	0.0	0.0	0.0	0.0	1.1	0.0	0.0
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0

method they plan to use, and the same proportion know where to get their intended method. Injectable contraceptives and the pill are the two methods that most potential first-time users intend to use (59% and 31%, respectively). Some 4% of women who intend to use a method say their preference is to undergo sterilization; none plan to use the condom. The remainder intend to use spermicide or traditional methods.

Discussion

The central question raised by the results of this study is the reason for the high level of contraceptive use in this society. In what social environment has widespread use of highly effective contraceptive methods by poor rural women become an acceptable norm? The three main features of contraceptive behavior identified in this article—the high prevalence of contraceptive use in Transkei, the use of highly effective methods and widespread use among never-married women—cannot be adequately explained using isolated development indicators such as income and urbanization. Measured by any such indices, Transkei is a typical poor African society, in which one would not expect the levels and quality of contraceptive use that are reported here.

Historical, political, social and economic changes provide a wider context within which to understand the high prevalence of contraceptive use among the South African poor. In the rural South African society that evolved through the long periods of colonialism and apartheid, the realities of material conditions arising from public policy changed the sexual norms such that the widespread use of birth control in marital, nonmarital and extramarital sexual relationships became increasingly tolerated.

By far the most powerful factor in this process is the economic and political policies that transformed rural areas into reserves of cheap wage labor for the services of South African mines, industries and commercial agriculture. The sex-selective nature of the South African migrant labor system is a key factor in its impacts on socioeconomic structure, family life and reproductive behavior in rural areas. Several studies have shown destabilizing effects of the migrant labor system on the rural economy, community and family.[19] The system upset the marriage market and created a scarcity of marriageable men in the former homelands. Furthermore, migrant workers' wives were not permitted to stay at their husbands' place of employment, and men's usually long periods of absence put considerable strain on the sexual faithfulness of married couples.

A general result of this situation is the relaxation of norms governing nonmarital and extramarital sexual relations. One specific effect is that never-married women in their late 20s or older who engage in sexual relations and childbearing are no longer stigmatized.

Another effect is the high proportion of marital and nonmarital households in the former homelands that are headed by women. The migrant labor system in South Africa conferred superficial economic and conjugal autonomy on many women. Women's involvement and roles in economic production grew dramatically as they performed household, economic and community activities in the absence of most economically active men. Although men still make important household and community decisions, women gained more freedom to make household and personal (including reproductive) decisions.

In this context, rural women in South Africa see and use contraceptives as part of a socioeconomic adjustment strategy; motivational activities by the government cannot fully account for the prevailing contraceptive behavior in Transkei. In fact, only 29% of women in the study knew about the government's Population Development Programme, which since 1984 has invested a vast amount of resources in information, education and communication programs aimed at controlling the population growth rate. Although the program's message may well have reached the respondents in indirect ways, its effect on reproductive and contraceptive behavior has been limited. Among those who had heard about the program, only 38% indicated that their views and family-size preferences had changed as a result.

The types of reproductive decisions that rural South African women make in the absence of their husbands and other men should be understood in the context of expanded female responsibilities and relative autonomy. Within and outside marriage, women use contraceptives to avoid becoming pregnant and thus jeopardizing their chances to fulfill their multiple socioeconomic responsibilities. Deserted wives, women who fail to find husbands and teenagers with little prospect for socioeconomic advancement often resort to offering sexual favors in return for financial or other economic assistance from men.

In situations where women do not per-

Table 5. Percentage distribution of women currently using a contraceptive, by reason for using a method, according to age-group and marital status

Characteristic	Space births	Stop childbearing	Delay 1st birth	Prevent STDs	Other †	Total
Total	**33.2**	**43.3**	**21.1**	**0.2**	**2.2**	**100.0**
Age-group						
15–19	13.6	21.0	59.3	0.6	5.6	100.0
20–24	31.1	32.0	34.2	0.5	2.3	100.0
25–29	49.5	38.8	10.2	0.0	1.5	100.0
30–34	39.9	54.9	4.1	0.0	1.0	100.0
35–39	33.7	65.3	1.1	0.0	0.0	100.0
40–44	26.2	69.2	3.1	0.0	1.5	100.0
45–49	17.9	78.6	0.0	0.0	3.6	100.0
Marital status						
Currently married	48.8	48.5	2.4	0.0	0.3	100.0
Widowed	14.3	80.0	0.0	0.0	5.7	100.0
Seperated/divorced	34.4	62.5	0.0	0.0	3.1	100.0
Never-married	22.9	35.7	37.7	0.4	3.3	100.0

†Includes financial reasons, husband's preference, feeling that contraceptive use is the "norm."

Table 6. Percentage distribution of women who have never used any contraceptive and of women who have previously used any contraceptive, by reason for current nonuse

Reason	Never used (N=549)	Previously used (N=394)
Not having sex	20.6	11.9
Husband is absent	4.7	6.9
Pregnant	1.8	14.5
Wants a pregnancy	17.3	22.1
Cost of contraceptives	0.0	0.3
Fear of side effects	11.3	11.2
Religious or cultural objection	12.7	3.1
Husband objects	13.3	13.5
Woman objects	5.5	4.1
Reached menopause	2.2	5.6
Other	10.6	7.1
Total	100.0	100.0

ceive cooperation from their male partners or where sexual activity is a result of unavoidable economic pressures, adult and teenage women may engage in sexual intercourse but use contraceptives. In such circumstances, women opt for methods with maximum efficacy and a high level of secrecy; this explains the popularity of injectables, which are widely distributed in the government program.

Lastly, the role of government family planning services must be highlighted here. Obviously, some positive correlation would be expected between the availability of contraceptives in government hospitals, clinics and health centers and the ease with which women realize their contraceptive desires. In Transkei, all 30 government hospitals and 255 clinics and health centers are outlets for contraceptive services. However, a shortage of doctors, poor services, inadequate transport for clients and staff, understaffing, lack of drugs, poor working conditions and low staff morale characterize health facilities that offer family planning services.[20] Although no rigorous evaluation of the national family planning program has taken place, recent reviews have reported that a major problem of the program is that it has not been client-friendly.[21]

The point here is that the government family planning program could not have created the high demand for contraception that exists in rural areas of South Africa. Instead, government services met and continue to meet the demand created by social conditions that resulted from decades of unfavorable public policy in these areas.

The high levels and unexpected patterns of contraceptive use in Transkei can be understood in the context of family, community and social disorganization introduced by the system of migrant labor. Whereas the migrant labor system may not have been the immediate cause, it created a social and economic environment in which changes in contraceptive norms and behavior were easily accepted by rural women as part of a sociocultural and economic adjustment strategy. The Transkei evidence confirms that reproductive norms and behavior in African societies, as in other societies, adapt to changes in the economic and social environments of which they are an integral part.

References

1. O. Chimere-Dan, "Racial Patterns of Fertility Decline in South Africa," in International Union for the Scientific Study of Population, *International Population Conference, Montreal 1993, Vol. 1,* Liège, Belgium, 1993, pp. 43–51; D. Lucas, "Fertility and Family Planning in Southern and Central Africa," *Studies in Family Planning,* **23:**145–158, 1992; J. C. Caldwell and P. Caldwell, "The South African Fertility Decline," *Population and Development Review,* **19:**225–262, 1993; J. M. Lotter, "Historical Trends in Fertility," in W. P. Mostert and J. M. Lotter, eds., *South Africa's Demographic Future,* Human Sciences Research Council, Pretoria, South Africa, 1990; and W. P. Mostert, "Recent Trends in Fertility in South Africa," ibid.

2. O. Chimere-Dan, "Demography of the Village Study Sites," in R. Levin and D. Weiner, eds., *Community Perspectives on Land and Agrarian Reform in South Africa,* University of the Witwatersrand, Johannesburg, South Africa, 1994.

3. W. P. Mostert, 1990, op. cit. (see reference 1).

4. Central Statistical Office, *The 1991 Population Census Report, Vol. 1,* Umtata, South Africa, 1994.

5. O. Chimere-Dan, *Fertility and Family Size Preference in the Eastern Cape Province South Africa: A Study of the Transkei Sub-Region,* University of the Witwatersrand, Johannesburg, South Africa, 1995.

6. Ibid.

7. Ibid.

8. S. A. Mpambani, *Poverty Profile of the Transkei Region,* Southern Africa Labor and Development Research Unit, University of Cape Town, Cape Town, South Africa, 1994.

9. D. Moller, *Population Development Survey Report,* Bureau of Development Resources and Training, University of Transkei, Umtata, South Africa, 1990.

10. P. A. Black, P. J. McCarton and P. M. Clayton, *A Demographic and Socioeconomic Profile of Region D,* Institute of Social and Economic Research, Development Studies Working Papers, No. 30, Rhodes University, Grahamstown, South Africa, 1986.

11. Development Bank of Southern Africa, *SATVBC Countries: Statistical Abstracts 1989*, Halfway House, South Africa, 1989.

12. O. Chimere-Dan, 1995, op. cit. (see reference 5).

13. S. A. Mpambani, 1994, op. cit. (see reference 8).

14. O. Chimere-Dan, 1995, op. cit. (see reference 5).

15. E. M. Preston-Whyte, "Women Who Are Not Married: 'Illegitimacy,' and the Nature of Households and Domestic Groups Among Single African Women in Durban," *South African Journal of Sociology,* **24:**63–71, 1993; S. Burman and E. Preston-Whyte, eds., *Questionable Issue: Illegitimacy in South Africa,* Oxford University Press, Cape Town, South Africa; E. Preston-Whyte, "Women-Headed Households and Development: The Relevance of Cross-Cultural Models for Research on Women in South Africa," *Africanus,* Vol. 18, No. 1, 1988, pp. 58–76; ——, "Families Without Marriage," in A. Aryle and E. Preston-Whyte, eds., *Social System and Tradition in Southern Africa,* Oxford University Press, Cape Town, South Africa, 1978; ——, "Culture, Context and Behaviour: Anthropological Perspectives on Fertility in Southern Africa," *Southern African Journal of Demography,* Vol. 2, No. 1, 1988, pp. 13–29; and ——, "Qualitative Perspectives on Fertility Trends Among African Teenagers," in W. P. Mostert and J. M. Lotter, 1990, op. cit. (see reference 1).

16. D. Ncayiyana, "Teenage Pregnancy in Transkei: Perspective of a Devil's Advocate," *Transkei Medical Quarterly,* Vol. 1, 1991, pp. 24–31; N. M. Xaba-Mokoena, "Teenage Pregnancy," paper presented at the symposium on Population Development in Transkei, February 27–28, 1990, Umtata, South Africa; and E. Preston-Whyte et al., "Teenage Pregnancy: Whose Problem? Realities and Prospects for Action in KwaZulu/Natal," *Southern African Journal of Demography,* Vol. 3, No. 1, 1990, pp. 11–20.

17. O. Chimere-Dan, "Determinants of Racial Fertility Differentials in Some Urban Areas of South Africa," *Journal of Biosocial Science,* **26:**55–63, 1994; and W. P. Mostert, 1990, op. cit. (see reference 1).

18. F. Sai, H. Rees and S. McGarry, "Reproductive Health and Family Planning Consultancy: National Review and Recommendations," prepared for the Commission of the European Communities Special Programme for South Africa, Johannesburg, South Africa, 1993; and H. Rees, "Population and Family Planning," paper presented at the Population Development Programme conference Population Realities and the Future of South Africa, Johannesburg, South Africa, Sept. 1993.

19. M. Edmunds, "Population Dynamics and Migrant Labor in South Africa," in K. Michaelson, ed., *And the Poor Get Children: Radical Perspectives on Population Dynamics,* Monthly Review Press, London, 1981; A. Donaldson, "Dependent Transkei: The Economics of a Labor Reserve and a Caretaker Regime," *Journal of Contemporary African Studies,* Vol. 11, No. 2, 1992, pp. 129–153.; S. Jones, *Assaulting Childhood: Children's Experiences of Migrancy and Hostel Life in South Africa,* Witwatersrand University Press, Johannesburg, South Africa, 1993; M. Wilson, "So Truth Be in the Field," Alfred and Winifred Hoevnte Memorial Lecture, South African Institute of Race Relations, Johannesburg, South Africa, 1975; D. James, "Family and Household in a Lebowa Village," *African Studies,* Vol. 44, No. 1, 1985, pp. 159–187; C. Murray, *Families Divided: The Impact of Migrant Labor in Lesotho,* Cambridge University Press, Cambridge, UK, 1981; T. D. Moodie, "Migrancy and Male Sexuality in the South African Gold Mines," *Journal of Southern African Studies,* **14:**228–256, 1988; T. Thomas, "Sowing the Seeds of Deprivation," *Sash,* **17:**8–11, 1974; R. Palmer and N. Parsons, eds., *The Roots of Rural Poverty in Central and Southern Africa,* University of California Press, Berkeley and Los Angeles, Calif., USA, 1977; J. May, "Migrant Labor in Transkei: Causes and Consequences at the Village Level," *Journal of Contemporary African Studies,* Vol. 6, No. 1, 1987, pp. 123–147; and M. Ramphele, "The Dynamics of Gender Politics in the Hostels of Cape Town: Another Legacy of the South African Migrant Labor System," *Journal of Southern African Studies,* Vol. 15, No. 3, 1989, pp. 393–414.

20. J. Segal, "Health Care at the Village Level: Transkei and Ciskei," *Journal of Contemporary African Studies,* Vol. 11, No. 2, 1992, pp. 223–240; and C. Simon, "Dealing with Distress: A Medical Anthropological Analysis of the Search for Health in a Rural Transkeian Village," master's thesis, Rhodes University, Grahamstown, South Africa, 1989.

21. F. Sai, H. Rees and S. McGarry, 1993, op. cit. (see reference 18); and H. Rees, 1993, op. cit. (see reference 18).

Resumen

Un estudio realizado a 2.290 mujeres de 15 a 49 años de una zona predominantemente rural de la región del Transkei de Sudáfrica, revela una prevalencia excepcionalmente elevada de uso de anticonceptivos y tendencias de uso

inesperadas para una sociedad pobre de la zona del Africa Subsahariano. En general, el 60% de las mujeres había utilizado alguna vez un método anticonceptivo y el 42% lo estaba haciendo en ese momento. Además, utilizaban anticonceptivos muy eficaces como los inyectables y la píldora, cuyo uso representa el 59% y el 30% del total, respectivamente. Entre las mujeres que nunca habían utilizado un método, pero que intentaban hacerlo en algún momento, el 90% indicó que utilizarían inyectables o la píldora. Aproximadamente la mitad de las mujeres había oído hablar del condón, pero el uso de este método es insignificante. Otro elemento que llama poderosamente la atención sobre el uso de anticonceptivos es que las proporciones de mujeres que nunca se casó y que ha utilizado alguna vez un método (64%) y que son usuarias actuales (53%), superan a las entre las mujeres actualmente casadas. Los cuatro quintos de las usuarias de anticonceptivos en el Transkei obtienen su método en dispensarios del gobierno. La mayor proporción de mujeres que usan anticonceptivos indicaron que lo hacen para suspender la procreación (43%); lo hacen para espaciar y postergar el primer nacimiento, el 33% y el 21%, respectivamente.

Résumé

Une étude entreprise auprès de 2,290 femmes âgées de 15 à 49 ans dans la sous-région Transkei principalement rurale d'Afrique du Sud révèle une prévalence exceptionnellement élevée d'utilisation contraceptive et des scénarios inattendus d'utilisation au sein d'une société pauvre d'Afrique subsaharienne. Dans l'ensemble, 60% des femmes ont jamais utilisé une méthode contraceptive, et 42% en pratiquent une au moment de l'étude. En outre, les contraceptifs très efficaces, particulièrement les injectables et la pilule, représentent, respectivement, 59% et 30% d'utilisation. Parmi les femmes qui n'ont jamais utilisé une méthode mais ont l'intention de le faire à un moment donné, 90% ont l'intention d'utiliser des injectables ou la pilule. Environ la moitié des femmes ont entendu parler du préservatif, mais l'utilisation de cette méthode est négligeable. Un autre trait saillant de l'utilisation contraceptive est que les proportions de femmes célibataires qui ont jamais utilisé une méthode (64%) et qui sont des utilisatrices courantes (53%) dépassent ces proportions parmi les femmes mariées au moment de l'étude. Les quatre cinquièmes des utilisatrices de contraceptifs à Transkei se procurent leur méthode auprès de centres gouvernementaux. La plus forte proportion de femmes qui utilisent des contraceptifs déclarent qu'elles veulent cesser d'avoir des enfants (43%); l'espacement des naissances et le retardement de la première naissance représentent, respectivement, 33% et 21% d'utilisation.