

Teenage Contraceptive Needs in Urban South Africa: A Case Study

By Zanele Mfono

Adolescent exposure to the risk of pregnancy has attracted considerable research attention in different societies, in efforts both to understand its extent and to address it as a problem. Studies in developed countries have shown a high incidence of such exposure.¹ Western European countries reacted with strong sexuality education programs and adolescent contraceptive services, coupled with mandatory confidentiality. Due in part to resistance to such measures, the United States lags behind other developed countries in the extent to which teenage fertility has declined.²

Research in Latin America has also shown a relatively high proportion of teenagers to be exposed to the risk of pregnancy.³ Access to sexuality education and to family planning services are poor among adolescents in this region, and the incidence of teenage childbearing is high. Results from Asia vary, with early marriage and childbirth persisting in rural India despite the government-prescribed marriage age of 18 for females.⁴ In China, abortions are increasing among teenagers, indicating rising sexual activity within this age-group.⁵

In Africa, studies have demonstrated that a large proportion of adolescents in Uganda and Nigeria are exposed to the risk of conception, receive poor sexuality and contraceptive education, and experience a high incidence of adolescent childbirth.⁶ And research in South Africa has indicated that in most respects, South Africa's situation resembles that prevailing in developing societies in Africa and Latin America.⁷

Teenage contraceptive use in South Africa is constrained by attitudes associating sexual involvement with marital commitment and stable relationships, neither of which usually characterize teenage relationships. However, social changes have led to an in-

crease in age at marriage in South Africa, which has been accompanied by a rise in premarital sexual activity and premarital births. Many of these births occur during the teenage years, to women who are neither economically nor emotionally ready to deal with parental responsibilities.

With an estimated annual population growth rate of 2.2%⁸ and many developmental challenges, South Africa is cautious about population growth, especially where it is associated with unwanted childbearing, as is often the case with teenage childbirth. A draft White Paper for a Population Policy for South Africa cited the high incidence of unwanted fertility and teenage pregnancy as one of the country's major population concerns.⁹

From a human rights perspective, the African National Congress, the major political party in South Africa, states that "reproductive rights must be guaranteed and reproductive health services must promote people's rights to privacy and dignity."¹⁰ The question of whether adolescents have reproductive rights is potentially contentious, however. Socially, adolescents are minors, but biologically, they are women in their reproductive ages, whose exclusion from reproductive health access can only be viewed as discriminatory.

Further, adolescents are a major component of the population. The 1991 census estimated that those aged 19 and younger represented 46% of South Africa's population.¹¹ Well-considered sexuality and contraceptive education and service policies will be necessary if these young people are to deal responsibly with their sexuality.

However, adolescents' access to contraception in South Africa has traditionally been restricted by legislation requiring parental consent. Although adolescent exposure to the risk of pregnancy creates pressures on service providers to react, their initiatives are likely to be constrained if they lack strong legislative support.

In recent years, the Planned Parenthood Association of South Africa introduced the concept of the youth service point. In addition to being focused on young clients, the services at such points are provided by trained youth peer-counselors, who conduct sexuality education in an atmosphere

of informal discussions. The youth service points are equipped with videotapes and pamphlets, as well as with music that has popular appeal among young people. The number of such sites has been expanding in urban areas, and their existence indicates an improving outlook on and increasing sensitivity to the needs of adolescents. Such service outlets still are very few, however; most sources of reproductive health care combine all age-groups.

Because of the young age-structure of the South African population, the reproductive attitudes and behavior of teenagers will likely have an important impact on overall reproductive health, demographic and social outcomes. Contemporary concern about adolescent fertility arises from its health implications both for mother and for child, its demographic implications in societies with rapid population growth and its social development implications for women.

Methodology

This article explores qualitatively the needs of urban South African teenagers for sexuality education and contraceptive services, and the problems such youths encounter, as perceived both by the teenagers themselves and by the service providers. The information is taken from a descriptive process evaluation of the needs and use patterns of teenage clients at family planning outlets in urban areas of Gauteng Province. Descriptive methods are used instead of quantitative data, based on field notes made in the course of visits to four service points.

These providers are designated as sites A, B, C and D, and their main features are shown in Table 1. Three serve youths only, while one serves both adults and adolescents.* All four service points are in Pretoria and Johannesburg, the two major cities in metropolitan Gauteng Province, South Africa.

The research described here was conducted in 1995, before the 1994 political changes had produced any substantive changes in service provision.[†] Thus, only

Zanele Mfono is senior lecturer in development studies, University of Fort Hare, South Africa.

*Most health service points in South Africa are incorporated into primary health care services and serve all age-groups. Thus, service points that target youths are a new phenomenon in family planning service provision in this country.

†During apartheid, services were provided in accordance with the racial categorization of South African society into Africans, coloreds, Asians and whites.

Table 1. Main features of service outlets at which study participants were recruited, South Africa, 1995

Outlet	Location	Service provider	Year opened	Services offered
A	Residential township for blacks	Provincial administration	1987	Available on weekdays; exclusive to youths; frequented by both sexes; sexuality education is conducted by team of sexuality educators; youth recreational activities are included in program services; and STDs are referred to primary health care.
B	Residential township for blacks	Academic institution/medical university	1987	Saturday mornings only; for youths only; sexuality education conducted by health educators; only females frequent the service; no other youth activities are included; STD treatment is available.
C	Johannesburg city center	Nongovernmental organization	1996	Available on weekdays and Saturdays; for youths only; sexuality education is conducted by trained youth volunteers; both sexes frequent the service; includes variety of entertainment activities; STD treatment is available.
D	Residential township for blacks	City council	u	Available on weekdays; for adults and public health clinic clients as well; only females attend; there are no other youth activities; STD treatment is available.

Note: u=unavailable.

one service point (Site C, which was operated by a nongovernmental organization) had clients from diverse racial backgrounds; the others served only black communities and reflected the services provided at that time to black urban adolescents.

Information was collected in four ways:

- *Direct observation.* Behavior within each setting was identified, interpreted and quantified through brief on-the-spot notes compiled during service hours. Information was compiled on the service provision process, on the health educational materials used, on the availability of equipment and on privacy.

- *Informal discussions.* At each service point, personnel were asked about the contraceptive methods that are provided, their attitudes toward teenage contraceptive use and the problems that they encountered in serving teenage clients.

- *Focus-group interviews.* Focus groups were conducted with teenage clients, using a discussion schedule covering the information sources on sexuality and contraception that are available to teenagers, the stage at which this information reaches them, the information on sexuality and contraceptive use that is available to teenagers at the service point, the desirability of providing separate family planning services for youths, the teenagers' views on teenage pregnancy and their evaluations of the service point.

The focus groups were convened by personnel at the service point, and participants were selected randomly, with age and willingness to participate in discussions being the only criteria. Altogether, seven focus-group discussions were conducted. The

size and sex composition of the groups varied, and are reflected in Table 2.

Discussion items were presented in questionnaire form. Before discussions began, each item was explained to the participants, who recorded their response on the questionnaire, in any chosen language. (This ensured that all participants' views were elicited.) Responses on the questionnaires were consulted along with contemporaneous notes when this article was compiled.

- *Reading of administrative records.* Record cards of teenage clients were inspected for the clients' age, their regularity of attendance, the contraceptive method they used, their marital status and their number of previous pregnancies.

Findings

Site Characteristics

The service hours of three of the four service points were generally suited for teenage clients, and accommodated their school attendance; site B, however, had much shorter hours (Table 1).

At all four service points, the first client visit consisted of taking the teenager's history and establishing his or her individual needs, as well as providing sexuality and contraceptive education and counseling. The client was referred to a doctor for a physical examination, and findings were recorded on the client's card. No payment is requested for these services. At service points A, B and C, subsequent visits included participation by each client in a group discussion on teenage sexuality and contraception.

Contraceptives were distributed by trained nurses at all sites. The nurses in-

quired about any problems with the method the client was currently using and recommended ways to minimize any side effects. Occasional problems that merited medical attention were referred for care.

All service points prominently displayed posters with information on family planning, sexually transmitted diseases (STDs) and AIDS. Pamphlets in different languages were utilized by personnel during the health education sessions.

Sites A and C were walk-in youth centers that offered various kinds of activities in addition to sexuality and contraceptive education and services. They also had outreach programs that recruited youths from the community.

B and D, on the other hand, were formal health facilities and had a businesslike atmosphere. At site B, which operated under the guidance of the gynecology department of a medical university, there was more selective use of contraceptive methods, firm opposition to any use of IUDs and concern about inconsistent supplies of hormonal contraceptives, which are considered optimal for adolescents by the gynecology department in charge of the service point. The result was that some teenagers attending site B had to settle for less-preferred contraceptive methods. The other three service points permitted teenagers greater flexibility of method choice, even offering IUDs to young clients who had already given birth.

All facilities were adequately equipped, but site D seemed stretched beyond its capacity. This was reflected in part in the lack of privacy for interviews. Despite all of these differences, however, large numbers of teenagers came to all four of the service points.

Personnel at all sites indicated that contraception was the only realistic intervention for addressing teenagers' exposure to the risk of conception. The workers at service points A, B and C also found adolescent clients to be interesting and challenging, because of the clients' curiosity about the opposite sex, their playful ridiculing of some traditional beliefs and their eagerness to replace these with sound facts.

Table 2. Characteristics of focus groups

Service point and group	Member information	
	Number	Sex composition
A-1	8	Mixed
A-2	8	Mixed
B-1	8	Females only
C-1	4	Males only
C-2	7	Mixed
D-1	8	Females only
D-2	8	Females only

Personnel at site D, on the other hand, saw adolescent clients as difficult and sometimes rude. They felt that adolescents would benefit from sharing services with older clients in the long run, because the situation exposed the latter group to the reality that adolescents may be exposed to the risk of conception and forced them to confront their denial of this reality. They also believed that adolescent contraceptive use must be provided through primary health care clinics, as the state could not afford the luxury of separate services for adolescents. These workers pointed out that at times when teenage clients become more numerous (usually in the afternoons), adult clients avoid the clinic site; thus, concerns about the mixing of age-groups sort themselves out.

Information from Records

At sites A, B and C, the ages of female clients ranged from 12 to 30, but they were predominantly 17–19-year-olds and clients in their early 20s. No records are kept for male clients, however.* Site D had clients in their 30s and 40s, but even there, younger age-groups were in the majority, and adolescents represented close to 25% of service users.

The teenagers using the services were unmarried, and all of them were students. Nearly 50% of teenage service users had at least one child, especially those aged 17–19. Among the younger teenagers, however, a substantial proportion were practicing contraception before having a first child.

Hormonal methods predominated among the methods that were used, with injectables the most commonly used method. A small minority were using the pill, and only two had an IUD in place.

Information from Focus Groups

Peers were the predominant source of advice to teenagers on visiting family planning service points. Parents, nurses and teachers followed, but ranked much lower, and, rather surprisingly, sexual partners were the least common source.

Because of their conservatism, parents were seen as having difficulty in communicating with young people on sexual matters. The teenagers also reported that parents never saw their children as grown up and ready to discuss or contemplate

sexual involvement. However, some discussants felt that parents just abandoned their responsibility. Only a small minority of teenagers had been referred for help by their mothers and none by fathers, even among the males.

Just a small proportion of teenagers said they had visited family planning centers before initiating sexual activity. Most had been involved sexually for less than a year before visiting a provider, while a few came after a year or longer. These delays were caused by inadequate information about service providers, fear of adult disapproval and vague concerns about the side effects of contraceptives.

The boys indicated that it is the responsibility of girls to seek “protection;” they also routinely assumed that their partners were protected from conception. The young men visited the service points mainly to obtain information and protection against STDs. Condoms were unpopular, but were accepted as a “necessary evil.”

The young men were more regular attendees at service points than the young women, once they had begun to attend a clinic. The male focus-group participants criticized girls for discontinuing clinic attendance because of complaints about weight gain and vague problems arising from contraceptive use. The young women also admitted that some of their peers stop using family planning for what could be considered frivolous reasons, considering the risk of conception.

The young people said they obtained information from the service points on a wide variety of topics, including sexual development and maturation, personal hygiene, dating, relationships, sexual responsibility and making choices, peer pressure, the advantages of sexual abstinence, conception and contraception, sexual abuse, incest, rape, abortion, STDs and AIDS. The members of the focus groups considered this information valuable. They also strongly supported the view that sexuality education should begin earlier in life.

Most participants felt that separate services for adolescents would be ideal—mainly because of embarrassment about being known by adults to be sexually active. On the written responses, one discussant answered: “Because adults regard it as their own thing and discourage youth or be very rude to them.” Another said: “Because adults tend to think that young people are rushing things.” One respondent wrote: “Because parents talk too much! They will be intimidating me by asking me what I want here when I am so young.”

Discussions revealed that some ado-

lescents visit service points located in neighborhoods far from their homes to avoid meeting adults who know them or their families. Some mentioned that having a boyfriend with a car is an asset, because he can drive you to the best service points and pretend that you are his wife.

In all groups, the question of whether a teenage birth is a “disaster,” a “bad thing,” “not so bad” or not a problem elicited a most lively and informative discussion. Most participants saw a teenage pregnancy as a disaster, because of the responsibilities it imposes on the family. However, a few of the teenagers felt that a teenage pregnancy was not such a serious incident, and one male said simply “Why not?”

No mention was made of any social stigma arising from such an event; the discussants were preoccupied only with the practical realities facing the affected teenager and her family. When the question of the social stigma of a premarital birth was raised, the teenagers dismissed this as not important. In one group, the response elicited by this question was a dismissive “They must mind their own business!” The whole group then laughed and shifted the discussion to their own concerns on the subject.

The focus-group participants evaluated the services available at the service points positively. Some criticized behavior of personnel at site D toward teenagers who use that service, such as telling them that they are too young to use contraceptives and asking for a letter from their parents.

Teenagers who visited sites A, B, and C believed that separate services for youths were the best way to address their needs. Teenagers sharing site D with older clients felt that only the first few visits were problematic, and that subsequent visits presented fewer problems. These participants also pointed out, however, that a separate service point for teenagers would help many adolescents who shy away from family planning because they do not want adults to know that they are sexually active.

Discussion

The Draft White Paper for a Population Policy for South Africa, which was presented to South Africa’s parliament for approval in 1996, proposes as one of its major strategies “promoting responsible and healthy reproductive and sexual behavior among adolescents and youth to reduce the incidence of high-risk teenage pregnancies, abortion and STDs, including HIV or AIDS, through the provision of life skills, sexuality and gender-sensitive education, user-friendly health ser-

*Young males in South Africa insist on not having their use of reproductive health services recorded. This instance on confidentiality seems to be a carryover from the cultural outlook that reproductive behavior is primarily a woman’s responsibility, but which is tempered by a need for personal safety. In view of the AIDS epidemic and the high incidence of the STDs in South Africa, service providers accede to this arrangement rather than lose these clients.

vices and opportunities for engaging in social and community life."¹²

The problem of teenage fertility can also be viewed in the context of recommendations made at the International Population Conference in Cairo in 1994—that youths should be involved in planning, implementing and evaluating development activities that have a direct impact on their daily lives. Emphasis was given at that conference to information, education and communication activities and to services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV, AIDS and other STDs. Access to and confidentiality and privacy of these services were also emphasized, as well as parental guidance and support.¹³

The research described in this article preceded and anticipated the orientation of the new South African population policy, and sought to determine how well family planning services in urban areas of South Africa meet the needs of youths. Through it, a number of concerns and shortcomings have been identified.

- In general, all of the service points studied were suitably organized for serving school-going adolescents, and information sessions conducted by the health educators were an important aspect of service provision. The formal school system could handle such activities much more efficiently, however, and could reach the entire school-going population with such information.

- While the sexuality education provided at the service points was comprehensive, it was focused narrowly on the health aspects of family planning, ignoring broader human rights and demographic perspectives. These are issues teenagers should learn about to better understand the importance of their decisions.

- Personnel at the service points had a progressive outlook towards teenage contraceptive use and seemed sensitive to the needs of teenagers. Their different points of view on whether there is a need for separate services for teenagers raise the question of optimal resource utilization, however. The establishment of separate hours for services for teenagers at existing service points, for example, has as yet not been fully explored.

- The fact that the males who participated in the focus groups saw contraception as their partner's responsibility indicates that an attitude of joint responsibility for contraceptive practice is not yet in sight

among South African youths.

- Many teenagers exhibit high risk behavior, only visiting family planning service centers after several sexual encounters. Even in urban areas, South African adolescents have yet to develop the responsibility and initiative to seek out the sources of information that will help them take advantage of the reproductive health services available to them.

- The apparent tendency of girls to drop out from clinical services warrants research and attention. Because physical appearance is often an important aspect of an adolescent's self-image, claims that contraceptives cause weight gain and loss of muscle tone demand attention.

Social change has brought South African society to a point where the need for sexuality and contraceptive education of teenagers can be denied only at great cost to teenagers and to wider society. Urban teenagers appear ready to receive sexuality and contraceptive education and services, but service providers seem hesitant in their approach, perhaps because policymakers are not providing firm guidelines. A laissez-faire approach prevails on issues such as adolescent contraceptive use.

These are challenges to the implementation of the newly formulated population policy of South Africa. They raise the question of the extent to which the concerns of the 1994 International Conference on Population and Development—specifically on the protection of sexual and reproductive health and the reproductive rights of youths—will be achieved by this policy.

The failure to help young people deal with their sexuality leads to a high incidence of pregnancies, abortions, STDs, and HIV and AIDS, as well as high maternal and infant mortality. There is a strong need for South African teenagers to have access to sexuality and contraceptive education and services, as well as confidentiality in the provision of services.

A positive development from the scenario mapped out in this article concerns the new government's positive outlook on human rights, including women's rights and reproductive rights. Moreover, the youth of South Africa are seizing the moment to claim their rights in many spheres of life. In the provision of reproductive health services, young people are becoming more vocal consumers than their seniors. The needs and attitudes of South Africa's young—who represent a large

proportion of the South African population—are bound to influence service provision in the coming years.

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