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Sexual and reproductive well-being of teenage mothers in a South African township school

Nomvuyo Nkani and Deevia Bhana
School of Education, University of KwaZulu-Natal, South Africa
vuyonkani@telkomsa.net

Research addressing the sexual health and reproductive rights of pregnant teenagers and teenage mothers is growing, although attention to the sexual well-being of young mothers who are already in school remains limited. This omission places teenage mothers at risk, who may be susceptible to repeated pregnancies that may compromise their well-being and educational outcomes. By drawing on a qualitative study, we focus on young mothers' sexual relationships and their knowledge and choice of contraceptive methods, as well as their accessibility to them. In this paper, we ask how sexual and reproductive well-being is constructed in relation to knowledge, choice and accessibility to contraceptive methods. While the study found that schooling was constructed as vital to economic empowerment, teenage mothers' aspirations were compromised by limited contraceptive knowledge and choices, and enduring patterns of gender inequalities within relationship dynamics. Effective interventions require attention to a comprehensive understanding of sexual health, which includes a focus on gender and relationship dynamics, as well as knowledge of and access to contraceptive methods. Accessibility to all methods of contraceptive use remains vital in all health centres. Community health workers need to engage better with young mothers so as to support their reproductive well-being.

Keywords: accessibility; contraceptives; intervention; reproductive well-being; schooling; sexual health; South Africa; teenage mothers

Introduction

Globally, teenager mothers who become parents are viewed as a vulnerable group, with limited future educational opportunities often leading to poverty and economic dependency (Black, Bentley, Papas, Oberlander, Teti, McNary, Le & O'Connell, 2006). Teenage mothers located in the crucible of deep poverty face extreme challenges related to social and economic inequalities and the difficulties related to negotiating care-giving and the demands of school (Bhana, Morrell, Shefer & Ngabaza, 2010). However, studies have shown that young mothers, despite poverty, can successfully complete schooling with the support of their families, should there be no subsequent childbirth (Morrell, Bhana & Shefer, 2012). A more acute focus on contraception is thus paramount for teenage mothers' sexual well-being, and particularly for preventing second pregnancies before the completion of school.

In South Africa, studies have generally focused on teenage pregnancy, with an emphasis on reproductive rights and sexual health of pregnant women and young mothers in school, who have just given birth. Teenage mothers who have had children for a while remain less visible (Chigona & Chetty, 2008; Ngabaza, 2011). Teenage mothers' reproductive rights are safeguarded by policy and legislation such as the South African Schools Act No. 84 (SASA) (Republic of South Africa, 1996), which promotes pregnant learners and teenage mothers continuing access to school. However, these learners face obstacles when trying to successfully negotiate the simultaneous complexities of pregnancy, motherhood and schooling (Bhana et al., 2010). The difficulties experienced by the young women compromise their educational aspirations (Jewkes, Morrell & Christofides, 2009).

This article offers insights into the circumstances faced by young mothers in the schooling system, their reasons for wishing to stay in school, and the measures that could be taken make this more possible. Through an analysis of a study of young women undertaken in a poor peri-urban area of KwaZulu-Natal, we explore teenagers' knowledge and perceptions of contraceptive methods and their access to them. We further discuss the factors that impact on sexual and reproductive well-being, including relationship dynamics, arguing that a greater understanding of the dynamics of poverty, gender power imbalances and teenage mothers' aspirations might lead to significant improvements in government policy, and in the life chances of these young women.

Literature Review

We begin by providing an overview of the literature, so as to provide a context, as well as to situate our discussion in a broader scholarship around teenage mothers and their sexual and reproductive health. Extant scholarship suggests that the majority of South African teenagers are in the paradoxical position of knowing about contraceptives, yet rarely using any, as is indicated by the prevalence of unplanned and premarital pregnancies (MacPhail, Pettifor, Pascoe & Rees, 2007). Most teenagers only begin using contraceptives after the first pregnancy (Christofides, Jewkes, Dunkle, Nduna, Shai & Sterk, 2014). A major reason cited for non-use of contraceptives is a lack of access to comprehensive reproductive health services (MacPhail et al., 2007; Mkhwanazi, 2010).

While some attention has been given to the sexual health and reproductive rights of pregnant teenagers and teenage mothers who have just re-entered school, there has been little focus on the sexual health of young mothers who have been back in school for a longer period of time. Yet this is an important cohort, whose needs must be addressed – including the need to prevent further pregnancies – if they are to stay in school. Harrison (2008) suggests that if teenage mothers remain in school there is less likelihood of immediate subsequent pregnancies. Completion of schooling, it is argued, is beneficial to the young mothers, as education is one of the more effective ways of improving life chances, as well as being a signifier of social well-being and personal empowerment for young people (Harrison, Cleland & Frohlich, 2008).

Why do many teenage mothers continue with their schooling? Firstly, as Grant and Hallman (2006) argue, education is widely seen as an effective route out of poverty. Such a view is supported by the fact that education has been designated a human right, and is supported by the 1996 legislation, the South African Schools Act. However, the socio-economic conditions of households in poverty can, and do, impose major constraints on a teenager's ability to provide and sustain childcare, and this places an excessive burden on the home and the family. As a result, parents are often hostile, rather than supportive towards teenagers who become pregnant. This creates difficult conditions for teenage mothers who have returned to school.

The sexual health and well-being of young women is further compromised by enduring gender inequalities within relationship dynamics. Teenage women are often unable to negotiate condom use due to their subordinate status within intimate partner relationships (Jewkes et al., 2009; Macleod & Tracey, 2010). This also makes them vulnerable to sexually transmitted infections (STIs), and the ever-increasing rates of HIV are of particular concern. Indeed, a study by the Human Sciences Research Council (HSRC) revealed that between 2008 and 2012, the incidence of new HIV infection in young women between 15 and 24 years old was four times higher (1.5%) than the incidence found in men of the same age group (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya et al., 2014).

These figures raise urgent questions about teenagers' knowledge and use of contraceptive methods. Male condom use is widely reported to be a challenge, because it is greatly dependent on male acquiescence. This limits the ability of young women to make independent decisions in the case of a non-cooperative partner (MacPhail et al., 2007). Other studies have found resistance to male condom use due to complaints about irritation and sensitivity to latex, or to the fact that there was improper or sporadic use of condoms (Littlejohn, 2013; Polis & Curtis, 2013). The evidence is that teenage women commonly encounter challenges in negotiating condom use and resort to injectable methods of contraception as access to other options remains limited (Smith & Harrison, 2013; Whipkey, East & Coffey, 2014).

However, the first pregnancy usually means that teenage women become better informed about contraception through attending health centres, ante-natal clinics and through post-partum care (Willan, 2013). The result is that they then have greater agency in contraceptive use and are better able to make informed choices about contraceptive methods. The challenges experienced with the first birth also leads to a greater awareness of the demands of school and babies, as well as the fact that as mothers they bear the brunt, not only of the pregnancy, but of childcare and support of the child (Chigona & Chetty, 2008). In the context of major economic distress, child-care and support are made even more challenging due to ongoing economic insecurity. However, these factors can also combine to produce greater agency in enhancing sexual health, as teenage mothers aspire to break out of poverty through completing their schooling (Singh & Hamid, 2015).

Although there are policies meant to focus on improving school health services (Department of Health, 2003; Department of Health and Department of Basic Education, 2012), they have not yet been implemented in all sub-districts, especially schools in rural and informal settlement areas. Many organisations do attempt to increase access to sexual and reproductive health services, where LoveLife,[i] a South African multi-media HIV/AIDS awareness and education youth programme, and the AIDS Legal Network (ALN), advocated, in 2012, for the use of female condoms. However, teenage mothers generally have little knowledge of these organisations, or access to them. As Shisana et al. (2014) assert, the national distribution of female condoms is much lower than that of male condoms, an imbalance that is more extreme in rural areas, where accessibility is constrained by lack of infrastructure, the high costs involved in providing female condoms, and ensuring access to rural populations which are often difficult to reach.

Emergency contraceptives, which, according to the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (Department of Health, Republic of South Africa, 2012), should be available in all public health centres, are also in limited supply; and knowledge about them is not widespread (Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Mnyani & Blanchard, 2012). This limitation further jeopardises the success of teenage mothers in their attempts to complete their schooling. The South

African Schools Act (Republic of South Africa, 1996) encourages young mothers to return to school, although there is limited attention given to promoting sexual literacy and gender equality, distributing sexual health information and ensuring access to emergency contraceptives. Further to this, as research illustrates, the challenges teenage women experience in negotiating condom use is directly related to the persistence of gender inequality, and this needs more attention (Jewkes et al., 2009; Pettifor, O'Brien, MacPhail, Miller & Rees, 2009). One of the main threads that runs through our paper is that gender inequality is a major reason for unintended pregnancies, and the associated perpetuation of gendered poverty. The challenges with negotiating condom use also puts teenage mothers in subordinated positions in the overall gender landscape, where they are unable to initiate the use of condoms, not only because of gender norms, but because they are often economically dependent on men. In the main, whilst women in townships head households, some of whom work as domestic labourers or get support from state grants, women remain subordinate within the political economy, where men remain in more economically viable positions and earn more than women do. Statistics South Africa (2014) reported that one in four people in the country are unemployed - almost 25% of the country do not work. They also report that 63.1% of youth are jobless, and that unemployed youth have become a major crisis in the country, as the state seeks to find ways of creating employment, which is especially difficult, as the economy is under huge pressure. Combined, the economic pressures, gendered norms and limited knowledge of and access to contraceptive methods create vulnerability to positive school outcomes for the teenage mother.

Method

Semi-structured interviews, in-depth individual interviews and focus group discussions were used in this study. We sought to understand teenage mothers' views and perceptions about their sexual health. The use of semi-structured interviews and focus group discussions provided a greater opportunity to understand how teenage mothers make sense of their sexual well-being in an open-ended way (Hussey & Hussey, 1997). The fieldwork was conducted in 2013, and the first author collected data from 25 teenage mothers at the research site, one of the secondary schools in Inanda Township, which is approximately 30 kilometres away from the city centre of Durban, in the province of KwaZulu-Natal, South Africa.

The community of Inanda, from which the research participants for the study were drawn, is ethnically diverse, although predominantly black. The majority of people are isiZulu-speaking. The area where the study was conducted is a low-cost housing township characterised by very high levels of poverty, a high unemployment rate and a high prevalence of teenage pregnancy (Nkani & Bhana, 2010). Interviews were conducted in isiZulu, as both the researcher and the participants were first language speakers. This allowed insights into the lives of the participants, particularly because the first author had been working in the area for twenty years.

The semi-structured interview schedule was guided by questions which sought the reason why teenage mothers remained in school. If remaining in school was important to them, we enquired as to how young mothers maintained their sexual and reproductive health. The questions sought to ascertain teenage relationship dynamics, and especially the ways in which teenage mothers engaged with contraceptive use, and included the following: how do you make sure that you don't get pregnant again while you are still in school; do you use any protection; what kind of contraceptives do you know about; how did you learn about these methods; and, who makes the choice of the protection you use and why? We also sought to understand how teenage mothers gained access to the contraceptives and if they experienced any constraints.

A sample of 25 respondents who were teenage mothers with a child older than a year was drawn from the school records, which were provided by the principal, and all the participants agreed to be involved in the study. With the help of a Life Orientation (LO) teacher, consent forms were distributed to young mothers and their parents or guardians. In order to gain as broad a picture as possible we used both individual interviews and focus group discussions as the data gathering instruments. According to Nieuwenhuis (2007), employing various methods of data gathering in a study is good way of ensuring the reliability of the data generated. After transcribing and translating the interviews and discussions into English, participants were consulted to verify the accuracy of what they had said. Because we were aware that there might be limitations regarding translation, participants were consulted regarding the accuracy of the data both before and after the translation.

Five focus group discussions (FGDs) with five members in each group were held within the school premises after school hours. The groups were selected according to their residential proximity, for ease of transporting them back home on completion of the discussions. Each FGD took approximately 90 minutes. Thirteen in-depth individual interviews were also held with participants who were available on weekends at

their respective homes, and each interview lasted about 45 minutes. All interviews were tape-recorded.

Ethical approval for the study was granted by both the University of KwaZulu-Natal and the Provincial Department of Education. Permission was sought from the principal of the school, participants and their parents/guardians for them to participate in the study and to tape-record the conversations. They were assured of confidentiality and that only pseudonyms would be used in the study.

The data was analysed thematically: together, the authors organised and categorised it according to patterns to generate various themes (Braun & Clarke, 2006). Subsequently, a thematic map was produced and the following themes emerged: completing school and having a career; parental disapproval; knowledge of contraceptives and relationship dynamics.

Findings

From the outset of the analysis, certain features were clear. First, while the sexual health and well-being of the teenage mothers were sometimes compromised by insufficient sexual knowledge and gender-unequal sexual relationships, for these young mothers, avoiding a second pregnancy at all costs was paramount. We found that all the young mothers were consistently using hormonal contraceptives or relying on the use of condoms by their male partners to prevent a second pregnancy. Secondly, the key reason to avoid a subsequent pregnancy was given as schooling and socio-economic status. The participants came from poor backgrounds and their view was that the only way to attain social mobility and financial independence was through completing their schooling and pursuing a career that would provide better job opportunities.

The high rate of unemployment in South Africa intensifies competition for employment, making it even more difficult for those who have not completed schooling. In order to lessen disruptions to their goal of completing school and securing economic advantage in spite of their grim economic conditions, the young mothers said they needed to be determined in the use of contraceptives to avoid repeated pregnancies.

The investment in and deep desire to complete schooling was motivated by the correlation between educational qualifications and economic possibilities – and this is especially the case for black women in the context of affirmative action in the political and economic environment in South Africa. Yet, while the completion of schooling is assumed to lead to economic benefits, this view must be situated within the broader political economy, where unemployment remains significant, and where the poor in particular continue to suffer and be marginalised. Despite the unemployment crisis and youth vulnerability in the job market, teenage mothers continue to aspire towards, and place a high value on the completion of schooling. In the context of deep poverty, unemployment and income insecurity, having a school qualification may still provide better options than no qualification at all.

Completing School and Having a Career

All the young mothers in the study valued education and hoped to complete their schooling and then proceed to a tertiary institution for an education that would place them in a better position to obtain employment. These young mothers saw education as promising financial security and upward mobility. They saw the prospect of subsequent births as deterring them from their goal of completing their schooling, thus trapping them in their current circumstances of poverty (Chigona & Chetty, 2008; Panday, Makiwane, Ranchod & Letsoalo, 2009).

> …so it is very important to me to finish school first so that I'll get a job and become independent … I have seen how people without a career struggle for jobs, we've got many going around here doing nothing because they don't have skills (Zinhle, 19 years old).
>
> After being pregnant, my mother gave me a chance to come back to school, I can't mess that up [sic] again … that is why I really don't see myself having another baby until I complete my studies (Sisa, 17 years old).

Parental Disapproval

Although there is high rate of teenage pregnancy in South Africa, especially amongst black people, the majority of parents still disapprove of it, for cultural and economic reasons. In most cases, the teenage mother's child becomes the burden of the young mother's family, and this puts further strain on the household budget (Bhana & Nkani, 2014). Indeed, respondents have highlighted how, in addition to schooling, what motivated them to avoid a second birth was fear of condemnation from their parents, particularly as condemnation could lead to their parents refusing to provide support. Without their parents' support the young mothers said they were afraid that they would not be able to remain in school – and that they might be thrown out of home. This reliance on parents is a result of the fact that most extramarital births are financially supported by the young mother's family, with little or no support from the child's father (Jewkes et al., 2009). These young mothers are thus in a powerless position, forced, by circumstance, to respect their parents, particularly by avoiding a second pregnancy. Moreover, by toeing the line drawn by her parents, the teenage mother is showing respect and remorse for bringing disgrace to the family by having an unplanned

pregnancy while still at school (Mkhwanazi, 2010). Much international research demonstrates that teenage motherhood is not always viewed as disastrous by teenagers, that it may be perceived as a way of acquiring social recognition and gaining the status of womanhood (Campero, Herrera, Benítez, Atienzo, González & Marín, 2014). But for these South African learners, motherhood does not increase their social status, nor does it enable the independence found by De Carvalho (2007) amongst teenage mothers in Brazil. Take, for example, the words of two of the respondents:

> I am still very young … it was a mistake when I got pregnant; but if I get pregnant for the second time, it would mean that I don't learn from my mistake … my parents would chase me away from home because that would mean that I am disrespectful of my father's household by repeatedly getting pregnant without any payment of *ilobolo* [bride price] (Lee, 16 years old).
>
> Wow! [sic] My parents would kill me if I get pregnant again … as it is they don't forget to remind me that they are struggling by supporting me and my baby (Ntombi, 17 years old).

According to these respondents, the fear of repeated pregnancy typically results in the teenager's mother engaging the teenager in an open discussion about contraceptive use and, to help ensure she is consistent in taking contraceptives, by reminding her of the date to go to the clinic, even providing the transport fare. In general, though, most parents do not feel comfortable talking to their children about sexuality because sex out of wedlock is taboo and cultural norms often make it difficult to discuss these issues. Moreover, talking about sex is often viewed as encouraging sex, where the concern is that children will be made curious to try it. Sexual relationships among teenagers are kept secret, because of fear of parental disapproval (Harrison, 2008).

Not only are young mothers concerned about subsequent pregnancy, their parents too show active concern and involvement in preventing repeated pregnancy. Thus, parents engage with young mothers about sexual and reproductive health matters after pregnancy, because the young mother is viewed as someone who has experienced an adult sexual life, with knowledge of sex. Mothers engage in 'sex talk' based on abstinence and protection in order to try to prevent a second pregnancy. In contrast, before the first pregnancy, the teenager had little access to contraceptives, and little knowledge about them, with almost no parental communication about sexual matters.

> She [her mother] keeps the card with herself so that she reminds me to go to the clinic when the time is due (Futhi).
>
> My mother always encourages me to check my card so that I'm not going to miss the date and provides me with money for the transport to go to the clinic (Ntombi).

A further motivation to postponing and preventing a second birth was the difficulty of being a young mother while still at school, particularly in the context of extreme poverty. With the first child, the teenage mothers realise that the gender-biased nature of child-rearing entails them being fully responsible. Because they are unmarried, their families shoulder a financial burden, with little or no support from the child's father (Jewkes et al., 2009). The burden of childcare also means that schooling is often disrupted, as teenage mothers are forced to be absent or are unable to complete their homework.

Knowledge and Use of Contraceptives

Respondents said that using contraceptives empowered them to make an independent decision about how long to delay a second pregnancy (see Mohan & Shellard, 2014), however they acknowledged the limited choice they had in enforcing their partners' condom use for dual protection. The research found that all the participants knew something about modern contraceptives and were all using one or two methods. Their knowledge, however, was limited as most knew of only three contraceptives, namely: a pill, condom and injection. In the latter method, the contraceptive is injected into a muscle and slowly enters the bloodstream. Only one participant had heard about the emergency contraceptive pill from a friend. It also transpired that there was no privacy when family planning was explained to the participants. The information was presented to a large group of women who were all attending an antenatal clinic. Their choice of contraceptive method was limited to what they were told and if they wanted more information or clarification, they felt uncomfortable asking questions. For example, according to Soso: "…others asked questions but I didn't ask any … although I wanted to know more … I couldn't in front of so many people" (Soso, 16 years old, focus group discussion, 29 May 2013).

To begin with, all the young mothers opted for the injection. It is known from previous research that the injection is the most widely used form of modern contraception among teenage mothers in South Africa (Department of Health, 2008; Panday et al., 2009). The participants' choice of injection was based on the fact that it was easily manageable. They said they were afraid to choose the pill in case they forgot to take it regularly. As Futhi said:

> I chose three months injection … it's easy to manage … you don't have to take it every day … as long as you make sure that after every three months you go to the clinic … that is all. It's unlike a pill that you have to take daily even if you are not going to have sex … it's easy to forget taking it (Futhi, focus group discussion Interview, 06 June 2013).

However, some young mothers stopped taking the injection because of its side effects as the extract below indicates and instead tried to have discussions with their boyfriends on the use of condoms. The non-availability of a wider range of contraceptive methods led them to rely on their boyfriends' use of condoms, which made them more at risk of subsequent births, STIs and HIV infection. When asked how they approached their boyfriends, Khumbu responded:

> I tried both the two months and three months injections and I was bleeding non-stop … I couldn't choose a pill, because I used it before, and I used to forget taking it daily, and I ended up pregnant. We talked [with her boyfriend] and decided that he is going to use protection; otherwise we'll end the relationship, because I don't want to get pregnant again.

The above extract shows that it is not always the case that young women have no agency in the use of male condoms. In this case, the realisation that she has a right to make choices in a sexual relationship provided the young mother with the ability to negotiate safe sex with her partner, and she was also motivated by the problems encountered due to side effects caused by the injection.

The participants mainly learnt about contraception in public health centres, either in the hospital or the clinic. Although they learn about contraceptives in school, it is mostly about the use of condoms in relation to HIV protection, with less emphasis on family planning. The emphasis is on the use of the male condom, rather than on the female condom. On the other hand, once the young mothers started using hormonal contraceptives, the majority of their partners stopped using condoms, with various excuses, and this lowered the possibility of practising dual protection. The findings on male condom use echo other study findings, which show inconsistency in condom use (MacPhail et al., 2007; Polis & Curtis, 2013). Our respondents cited a variety of reasons, too, which include complaints about physical irritation ("he refuses to use a condom because he says it hurts him" Sindy, individual interview, 15 June 2013); forgetting to buy condoms or not having money to buy them ("I use [the] injection and he sometimes uses condoms if he has money or doesn't forget to buy them" Thule, individual interview, 13 May 2013), and due to issues of distrust on the part of the male partner ("…his argument is: 'why I ask him to use one [condom] now because all along we've been not using any' … unless I know that I've got someone else" Bongi, 19 years old, individual interview).

While the participants were concerned about their boyfriends' non-use of condoms, and worried that they would contract STIs, they did not use female condoms. It was noted that the participants had a limited knowledge of, and no accessibility, to female condoms. When asked the reason why they don't use female condoms, these were typical responses:

> Zola: I've heard about female condoms at school, but I have never seen it and I don't know how to use it.
>
> Thembi: At the clinic the nurses demonstrated on how to insert it [female condom] but when they explained, it sounded as if it's painful to insert, so I'm afraid of using it.

The respondents reported a very low level of dual protection use, which left them vulnerable to contracting STIs and Human Immunodeficiency Virus (HIV).

Similarly, the fact that the vast majority of respondents had never heard of the emergency contraceptive pill resonates with the findings of previous studies, where knowledge about emergency contraception among South African teenagers is very low (Hoffman-Wanderer, Carmody, Chai & Röhrs, 2013). Only one of the 25 participants had information about the emergency contraceptive, and it was flimsy: "I once heard from my friend that there is *muthi* [medicine] that you buy from the chemist that you can take after having sex if it happens that the condom had burst" (Lee, focus group discussions, 18 July 2013).

Lack of accessibility is also problematic: the emergency contraceptive pill is available in pharmacies and cost becomes a barrier, especially as the teenagers who are most susceptible to unplanned pregnancies come from underprivileged communities (Jewkes et al., 2009; Ngabaza, 2011). Another problem raised by some participants was the challenges they experienced in accessing family planning clinics, due to the distances they had to travel to reach a clinic and because of problems finding money for transport. For example, Zinhle reported: "in our area we don't have a clinic … we are only serviced by a mobile clinic which sometimes takes weeks and weeks not coming around … then you have to have money to travel to a nearest clinic which is about 27 kilometres from here" (Zinhle, focus group discussion, 03 June 2013).

Poverty was thus a major obstacle to accessing contraceptives. All the participants said they could only access contraceptives in the health centres and mobile clinics, and those who lived far from the health centres needed transport fare to visit them, an amount which they could not always source.

Relationship Dynamics

Of the 25 teenage mothers, two were no longer in a relationship with the baby's father and also did not have a sexual partner. The 23 teenage mothers were still in a relationship with the baby's father: the partners of 17 young mothers were an average of five years older and were either working fulltime or part-time, and six of them had school-going partners. Most of the young mothers voiced

concern about unprotected sex. Their fears were based on the knowledge that their boyfriends engaged in relationships with multiple sexual partners, resulting in distrust (Macleod & Tracey, 2010; Pettifor et al., 2009). In spite of these fears and concerns, the young mothers were reluctant to enforce safe sex. Their inability to make decisions about condom use was based on power imbalances in the relationship. Whilst it has been argued that teenage mothers have far more agency in negotiating condom use, particularly after first birth, this was not always the case. Teenage women, who were involved in sexual relationships with older working men who gave them gifts and money in exchange for sex, found it difficult to negotiate condom use (Leclerc-Madlala, 2002). The nature of transactional sex allows girls limited scope for negotiating safe sex (Chadwick, 2010). This sense of disempowerment is intensified by the pressure to have and maintain a sexual relationship at all costs. Instead of insisting on condom use, they use only hormonal contraceptives to avoid pregnancy:

> I am worried, especially because he is staying very far from here and I don't know what he is doing there … I always make sure that I don't miss my date to go to the clinic (to get injection) (Zola, focus group discussion, 15 June 2013).
>
> Eish! I am concerned … I know that I might get an infection … you'll never know what your boyfriend does behind your back, but I don't know how to ask him to use condoms, because all these years we've been having sex without using them (Senzi, individual interview, 15 June 2013).

This lack of power in the relationship to make decisions about safe sex exposes young mothers to greater risks, both of a second pregnancy, as well as to HIV and other STIs. These risks jeopardise young mothers' sexual well-being as well as their ability to successfully complete their schooling.

Conclusion

Despite, or perhaps because of, the high rate of unemployment in South Africa, teenage mothers are adamant to acquire education. Completing school and getting a career is viewed as their best chance of employment, thereby escaping poverty. The desire of these teenage mothers to remain within the schooling system, together with their fear of parental disapproval, motivated them to take steps to avoid a second pregnancy. Their understanding was that access to family planning leads to more years of schooling, and thus elevates their quality of life. While these young mothers wish to use contraceptives, their knowledge of methods of contraception is limited, and their choices in this area are restricted to the availability of contraceptive methods in the health facilities – and, indeed, to their access to health facilities. Therefore, effective sexual health education in school is of paramount importance, and more emphasis on family planning for more well-informed choices about contraceptive methods is required.

It is to be hoped that issues tackled in the Draft Department of Basic Education National Policy on HIV, STIs and TB (Department of Basic Education, Republic of South Africa, 2015) will intensify the distribution and use of contraceptives. Sexual and reproductive health matters must be incorporated into life skills lessons that address contraception, relationship dynamics and gender inequalities. A further suggestion is that either a nurse or a mobile clinic is stationed at schools in order to provide knowledge, counselling and advice to young women and men, who may not feel comfortable talking to either their teachers or parents.

Programmes based on preventing and reducing teenage pregnancy need to focus more on engaging men to understand that teenage women's right to negotiate sex and condom use is key to gender equitable relationship dynamics. It is vital that young women be encouraged to be assertive rather, than to submit to the pressure of engaging in risky sexual behaviour in order to satisfy the needs of her partner. Working with men to understand intimate partner dynamics underscored by gender quality remains important. Addressing gender norms and challenging women's subordination within intimate partner relations is key to changing unequal relations of power. Furthermore easy accessibility of contraceptive services to all learners in South Africa is required, especially in rural and other socio-economically disadvantaged areas. At the structural level, attention to the political economy, the creation of jobs and addressing poverty remains urgent in order to prevent young women's relationships with older men based on economic need.

Recommendations

Access to high quality contraceptive services would immeasurably improve the life chances of these young women. Both the Department of Health and the Department of Basic Education must make sure that a range of contraception methods are available in every public health facility, easily accessible to young women. As most participants indicated, they have a tendency to forget to use contraceptives that are administered daily. Contraceptives that are managed monthly or yearly are more effective to alleviate this problem. Moreover, contraceptive use that is discreet is recommended, especially as parents' and/or boyfriends' judgements and power infringe on the reproductive rights of young women. Although the study shows that health workers provide counselling for teenage mothers on their choice of contraceptives, there is a need for improvement in how they interact with teenagers. Health centres need to become more youth-

friendly, enabling young people to talk and ask questions freely, without feeling intimidated being in large groups or placed in the presence of older women. In addition, more support is needed on the care provided to young people who seek contraceptive methods.

Given the fact that in South Africa the number of new HIV infections is still on the increase (Shisana et al., 2014), interventions encouraging youth to use dual protection must be intensified, especially the advocacy of the use of female condoms in case of the inability to negotiate the use of male condoms. This is necessary in order to avoid the twin threats of unplanned pregnancy and infection by HIV and other sexually transmitted diseases (World Health Organisation, 2004). Whilst the use of the female condom might introduce its own difficulties when it comes to working with male partners who might demand not to use it, the fact is that women do have a certain measure of control over a condom that they themselves might be able to use.

Notes

i. Information adapted from New LoveLife Trust 2012. *Annual Report 2012*. Sandton, South Africa: New LoveLife Trust. Available at http://www.lovelife.org.za/corporate/files/3113/8251/5667/Annual_Report_2012_loveLife_Website_LR_08-10_Revised.pdf. Accessed 27 October 2014.

References

Bhana D, Morrell R, Shefer T & Ngabaza S 2010. South African teachers' responses to teenage pregnancy and teenage mothers in schools. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 12(8):871-883. doi: 10.1080/13691058.2010.500398

Bhana D & Nkani N 2014. When African teenagers become fathers: culture, materiality and masculinity. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 16(4):337-350. doi: 10.1080/13691058.2014.887780

Black MM, Bentley ME, Papas MA, Oberlander S, Teti LO, McNary S, Le K & O'Connell M 2006. Delaying second births among adolescent mothers: A randomized, controlled trial of a home-based mentoring program. *Paediatrics*, 118(4):1087-1099.

Braun V & Clarke V 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2):77-101. doi: 10.1191/1478088706qp063oa

Campero L, Herrera C, Benítez A, Atienzo E, González G & Marín E 2014. Incompatibility between pregnancy and educational projects, from the perspective of socially vulnerable adolescent women and men in Mexico. *Gender and Education*, 26(2):151-167. doi: 10.1080/09540253.2014.898024

Chadwick R 2010. *Gender, sexuality and South African childhoods: A child rights approach*. Literature review prepared for Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN).

Chigona A & Chetty R 2008. Teen mothers and schooling: lacunae and challenges. *South African Journal of Education*, 28(2):261-281. Available at http://www.scielo.org.za/pdf/saje/v28n2/a08v28n2.pdf. Accessed 19 March 2016.

Christofides NJ, Jewkes RK, Dunkle KL, Nduna M, Shai NJ & Sterk C 2014. Early adolescent pregnancy increases risk of incident HIV infection in the Eastern Cape, South Africa: a longitudinal study. *Journal of the International AIDS Society*, 17:18585. doi: 10.7448/IAS.17.1.18585

De Carvalho JEC 2007. How can a child be a mother? Discourse on teenage pregnancy in a Brazilian *favela*. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 9(2):109-120. doi: 10.1080/13691050600994448

Department of Basic Education, Republic of South Africa 2015. *Draft National Policy on HIV, STIs and TB*. Pretoria: Department of Basic Education, Republic of South Africa.

Department of Health 2003. *School health policy and implementation guidelines*. Pretoria: Department of Health.

Department of Health 2008. *Progress report on declaration of commitment on HIV and AIDS: Republic of South Africa. Reporting period: January 2006-December 2007. Prepared for the United Nations General Assembly Special Session on HIV and AIDS*. Pretoria: Department of Health. Available at http://www.gov.za/sites/www.gov.za/files/prog-rpt_hiv-aids_0607.pdf. Accessed 22 March 2016.

Department of Health, Republic of South Africa 2012. *National contraception and fertility planning policy and service delivery guidelines: A companion to the national contraception clinical guidelines*. Pretoria: Department of Health, Republic of South Africa. Available at http://www.partners-popdev.org/wp-content/uploads/2015/08/National-contraception-family-planning-policy.pdf. Accessed 22 March 2015.

Department of Health and Department of Basic Education 2012. *Integrated school health policy*. Pretoria: Government Printer. Available at http://www.health-e.org.za/wp-content/uploads/2013/10/Integrated_School_Health_Policy.pdf. Accessed 29 March 2016.

Grant M & Hallman K 2006. *Pregnancy-related school dropout and prior school performance in South Africa*. Policy Research Division Working Paper 212. New York, NY: Population Council. Available at http://www.popcouncil.org/uploads/pdfs/wp/212.pdf. Accessed 15 April 2016.

Harrison A, Cleland J & Frohlich J 2008. Young people's sexual partnerships in KwaZulu-Natal, South Africa: Patterns, contextual influences, and HIV risk. *Studies in Family Planning*, 39(4):295-308. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3848499/. Accessed 19 March 2016.

Harrison D 2008. *Three ways to reduce teen pregnancy in South Africa*. Paper prepared for the HSRC Youth Policy Initiative Roundtable 5: Teenage Pregnancy. Pretoria: Reserve Bank.

Hoffman-Wanderer Y, Carmody L, Chai J & Röhrs S 2013. *Condoms? Yes! Sex? No! Conflicting responsibilities for health care professionals under South Africa's framework on reproductive rights*. Cape Town, South Africa: The Gender, Health & Justice Research Unit, University of Cape Town. Available at http://www.ghjru.uct.ac.za/sites/default/files/image_tool/images/242/documents/Condoms_Yes_Sex_No.pdf. Accessed 29 March 2016.

Holt K, Lince N, Hargey A, Struthers H, Nkala B, McIntyre J, Gray G, Mnyani C & Blanchard K 2012. Assessment of service availability and health care workers' opinions about young women's sexual and reproductive health in Soweto, South Africa. *African Journal of Reproductive Health*, 16(2):283-293.

Hussey J & Hussey R 1997. *Business research: A practical guide for undergraduate and postgraduate students*. London, UK: Macmillan Publishers Ltd.

Jewkes R, Morrell R & Christofides N 2009. Empowering teenagers to prevent pregnancy: lessons from South Africa. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 11(7):675-688. doi: 10.1080/13691050902846452

Leclerc-Madlala S 2002. On the virgin cleansing myth: gendered bodies, AIDS and ethnomedicine. *African Journal of AIDS Research*, 1(2):87-95. doi: 10.2989/16085906.2002.9626548

Littlejohn KE 2013. "It's those pills that are ruining me": Gender and the social meanings of hormonal contraceptive side effects. *Gender & Society*, 27(6):843-863. doi: 10.1177/0891243213504033

Macleod CI & Tracey T 2010. A decade later: Follow-up review of South African research on the consequences of and contributory factors in teen-aged pregnancy. *South African Journal of Psychology*, 40(1):18-31. doi: 10.1177/008124631004000103

MacPhail C, Pettifor AE, Pascoe S & Rees H 2007. Contraception use and pregnancy among 15-24 year old South African women: a nationally representative cross-sectional survey. *BMC Medicine*, 5:31. doi: 10.1186/1741-7015-5-31

Mkhwanazi N 2010. Understanding teenage pregnancy in a post-apartheid South African township. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 12(4):347-358. doi: 10.1080/13691050903491779

Mohan V & Shellard T 2014. Providing family planning services to remote communities in areas of high biodiversity through a Population-Health-Environment programme in Madagascar. *Reproductive Health Matters*, 22(43):93-103. doi: 10.1016/S0968-8080(14)43766-2

Morrell R, Bhana D & Shefer T (eds.) 2012. *Books and babies: Pregnancy and young parents in schools*. Cape Town, South Africa: HSRC Press.

Ngabaza S 2011. Positively pregnant: Teenage women's experiences of negotiating pregnancy with their families. *Agenda: Empowering Women for Gender Equity*, 25(3):42-51. doi: 10.1080/10130950.2011.610985

Nieuwenhuis J 2007. Introducing qualitative research. In K Maree (ed). *First steps in research*. Pretoria, South Africa: Van Schaik.

Nkani FN & Bhana D 2010. No to bulging stomach: Male principals talk about teenage pregnancy at schools in Inanda, Durban. *Agenda*, 24(83):107-113. doi: 10.1080/10130950.2010.9676297

Panday S, Makiwane M, Ranchod C & Letsoalo T 2009. *Teenage pregnancy in South Africa - with a specific focus on school-going learners*. Child, Youth, Family and Social Development, Human Sciences Research Council. Pretoria, South Africa: Department of Basic Education. Available at http://www.education.gov.za/LinkClick.aspx?fileticket=uIqj%2BsyyccM%3D&. Accessed 31 March 2016.

Pettifor A, O'Brien K, MacPhail C, Miller WC & Rees H 2009. Early coital debut and associated HIV risk factors among young women and men in South Africa. *International Perspectives on Sexual and Reproductive Health*, 35(2):82-90.

Polis CB & Curtis KM 2013. Use of hormonal contraceptives and HIV acquisition in women: a systematic review of epidemiological evidence. *The Lancet Infectious Diseases*, 13(9):797-808. doi: 10.1016/S1473-3099(13)70155-5

Republic of South Africa 1996. South African Schools Act, 1996 (Act No. 84 of 1996). *Government Gazette*, No. 1867. 15 November. Pretoria, South Africa: Government Printers.

Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D et al. 2014. *South African national HIV prevalence, incidence and behaviour survey, 2012* (launch ed). Cape Town, South Africa: HSRC Press. Available at http://www.hsrc.ac.za/uploads/pageContent/4565/SABSSM%20IV%20LEO%20final.pdf. Accessed 31 March 2016.

Singh S & Hamid A 2015. Reflections of a group of South African teenage mothers: Sexual health implications. *Health Education Journal*. Advance online publication. doi: 10.1177/0017896915574891

Smith KA & Harrison A 2013. Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa. *Sex Education*, 13(1):68-81. doi: 10.1080/14681811.2012.677206

Statistics South Africa 2014. *South Africa Unemployment Rate Rises in Q2, 2014*. Available at http://www.tradingeconomics.com. Accessed 13 September 2014.

Whipkey K, East L & Coffey PS 2014. "Female condoms are_____": Bringing local voices to decision-makers through a film contest. *Reproductive Health Matters*, 22(43):135-140. doi: 10.1016/S0968-8080(14)43752-2

Willan S 2013. *A review of teenage pregnancy in South Africa – Experiences of schooling, and knowledge and access to sexual & reproductive health services*. Cape Town, South Africa: Partners in Sexual Health (PSH). Available at http://www.rmchsa.org/wp-content/uploads/2013/08/Teenage-Pregnancy-in-South-Africa-2013.pdf. Accessed 5 April 2016.

World Health Organisation 2004. Violence against

Women and HIV/AIDS: Critical Intersections. Intimate Partner Violence and HIV/AIDS. *Information Bulletin Series*, 1:1-9. Available at http://www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf. Accessed 5 April 2016.