# Appropriate parental involvement is the 'jigsaw puzzle piece' missing in the fight against teenage pregnancy in South Africa

Inaugural lecture delivered by


## Professor Akim Jasper Mturi

Bachelor of Science (Chemistry & Statistics) – University of Dar es Salaam
Postgraduate Diploma (Demography) – Cairo Demographic Centre
Special Diploma (Population and Development) – Cairo Demographic Centre
Master of Philosophy (Demography) – Cairo Demographic Centre
Doctor of Philosophy (Demography) – University of Southampton

Professor of Demography and Population Studies
Faculty of Human and Social Sciences



21 July 2016

**Salutation**

Madam Campus Rector – Professor Mashudu Davhana-Maselesele

Campus Vice Rector (Teaching, Learning and Quality Assurance) – Professor Lumkile Lalendle

Acting Campus Vice Rector (Research and Planning) – Professor Eno Ebenso

Ambassador of Tanzania to South Africa – Her Excellency Ambassador Radhia N. Msuya and your team from the Tanzania High Commission in Pretoria

Executive Dean of the Faculty of Human and Social Sciences – Professor Marilyn Setlalentoa

Other Executive Deans Present

Colleagues and Students

Invited Guests

Ladies and gentlemen

**Preamble**

It would have been unusual for a demographer to give an inaugural lecture on teenage pregnancy twenty five years ago. This is due to the fact that demographic events were restricted to mainly births, deaths and migration. You become relevant to a demographer when you are born (i.e. first event) and when you die (i.e. last event). In between the two events, you will only be relevant if you decide to migrate from one place to another. At some point in time marriage was also considered important due to its strong influence on fertility. All this changed in 1994 after the Cairo International Conference on Population and Development (ICPD), which put less emphasis on demographic events and put more emphasis on the human rights approach. This was later reiterated by the Millennium Development Goals (MDGs). One of the areas that became very important to demographers was Sexual and Reproductive Health (SRH). Indeed many demographic training centres established modules on SRH. In addition, funds became available for more researchers including demographers to investigate SRH issues.

But this is not the only reason that motivated me to do SRH research. During the 20+ years of post-PhD training, as much as I am still a demographer at heart, I also practice as a social scientist. Over the years, I have been involved in research that addresses social problems of the populations such as adolescent SRH, teenage pregnancy, social aspect of HIV and AIDS and child-headed households. I have decided to share with you today my research findings as well as readings of other people's findings and suggest possible solution for the problem of teenage pregnancy.

**Introduction**

The title of my lecture is *Appropriate parental involvement is the 'jigsaw puzzle piece' missing in the fight against teenage pregnancy in South Africa.* This topic is based on research done under the Research Focus Area 'Population and Health' which has identified sexual and reproductive health as the area that still needs more attention so that life especially of young people can be improved. Teenage pregnancy is a complex problem hence it needs our wisdom of highest order in order to find an ever lasting solution. I am aware that many disciplines conduct research on teenage pregnancy. These include public health, nursing, medicine, population studies, psychology, social work, development studies, education, religious studies, just to mention a few. Therefore, I urge everyone for just a little while, to bear with me while I use the social science lens to look at the problem of teenage pregnancy.

Teenagers (in some cases even pre-teens) engage into premarital sexual activities with the exception of a few. Talking about exceptions, there are teenagers even at university level who are still virgins. This is evident in several research findings. For instance, Anyanwu, Goon and Tugli (2013) have reported for the University of Venda; Hoque (2011) for University of KwaZulu-Natal; Hoque, Ntsipe and Mokgatle-Nthabu (2012) for University of Botswana; I also found the same thing with Gaearwe (2014) for North-West University, Mafikeng Campus; among others. I would like to applaud all those teenagers who have decided to abstain from sex and wait for the right time. If every teenager decided to follow suit, I was definitely going to change the topic of this talk and the government was not going to have the headache they are having right now. However, the reality is that many teenagers are sexually active.

One of the programmes which has been widespread is the ABC (Abstain-Be faithfully-use Condoms) initiative. But as it is the case to most initiatives on sexuality, the main emphasis was and still is on prevention of HIV and other sexually transmitted infections (STIs). We cannot win a war by fighting it as a shadow of another war! The battle against practicing premarital sex has been lost and most of the initiatives to advocate abstinence from sexual activities have not been successful. I will highlight some of the problems which have caused this failure later in the lecture. In addition, B and C which were part of ABC, have also been very problematic to the young people.

Teenage pregnancy is a social and health problem in both developing and developed countries (Bonell, 2004; Loaiza and Liang, 2013; Nour, 2006; WHO, 2004). The effect of teenage pregnancy to schooling is enormous (Mturi, 2015a; Panday, Makiwane *et al.*, 2009). Furthermore, teenage pregnancy is "conceptualized as a social problem because it is regarded as an outcome which is brought about by social forces, and which is harmful to the women and children concerned" (Bonell, 2004: 255-256). Although many African countries have been trying to address the problem of teenage pregnancy, developed countries such as United States and United Kingdom are also battling with this problem. However, the nature and extent of teenage pregnancy is somewhat different in different countries.

Teenage pregnancy takes two forms in Africa and beyond: premarital pregnancies and pregnancies which occur within marriages. The majority of teenage pregnancies in countries such as Chad, Niger, Mali, Ethiopia, happen within marriages (UNFPA, 2013).

This is what is referred to in the literature as child marriage and it is usually driven by poverty (Nour, 2006). This is different in South Africa where the majority of the teenage pregnancies, most of which are unplanned, occur before marriage and in most cases the young mothers are still enrolled in schools (Mturi, 2015a; Willan, 2013). Of course there are exceptional cases. For example, Maponya (2013) of the Sowetan newspaper reported that a 13 year old girl in Limpopo who was in grade 6 at the time, was married to a 57 year old traditional healer. This is also practiced in Eastern Cape and KwaZulu-Natal where it is known as *ukuthwala* (Condit, 2011). However, in this lecture, teenage pregnancy is defined as a pregnancy that occurs to a girl that is 13-19 years old, not married and who is still enrolled in school. As stated later, I am aware of the existence of pre-teenage pregnancies which are worse than teenage pregnancies (Mturi, 2015c). It must be noted that most of the issues addressed in this lecture are also applicable to pre-teenage pregnancy.

There have been public concerns over teenage pregnancy. Morell, Bhana and Shefer (2012: 5-6) have outlined five reasons that caused national anxieties: 1) the notion that becoming pregnant is often a life-changing and limiting experience for young females 2) some of the girls who get pregnant are not yet 16 years old, therefore pregnancy will have been the result of statutory rape 3) teachers are in some instances responsible for learner pregnancies and there is increasing discomfort about sexual relations between teachers and learners 4) moral panic over what is viewed as a decline in moral values and 5) schools that ignore policy and law and continue to expel learners on the grounds of pregnancy. Others include economic reasons (i.e. burden on state resources), social reasons (i.e. limit life prospects), religious reasons (i.e. no religion that support teenage pregnancy), health reasons (i.e. especially for younger teenagers), and psychological reasons.

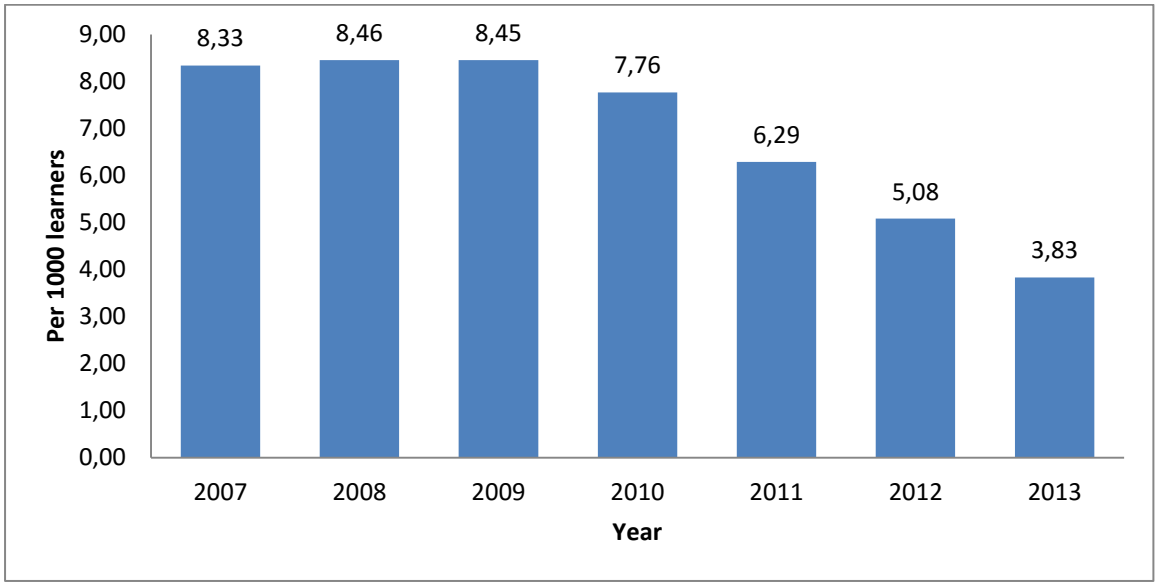
I argue in this lecture that there is massive effort in fighting the war against teenage pregnancy in South Africa. However, it has ignored one crucial point. That is, involvement of the family unit. I suggest that proper involvement of parents will not only fill the knowledge gap existing among teenagers but will also assist to implement well all other initiatives. And this will have a much better chance of reducing teenage pregnancy to acceptable levels.

**Levels of and Trend in Teenage Pregnancy in South Africa**

The first question to ask would be is high teenage pregnancy rates in South Africa are real or a myth? I checked this using data from the Annual Schools Survey from 2007 to 2013 to compute pregnancy rates (i.e. number of female learners still attending public schools who fell pregnant in a year in each grade divided by number of all female learners still attending school in that year and grade). The findings shown in Figure 1 depict that from 2007 to 2009 there were over eight learners who fell pregnant for each 1000 female learners. The rate declined consistently from 2010, by 2013 there were just under four pregnant learners for every 1000. The government has noted this dramatic decline of teenage pregnancy rate but also acknowledging that there is still more work to be done. The absolute figures in Table 1 of the pregnancies reported by public schools in the country show that there exist pre-teenage pregnancies, in some cases over 100 pregnancies a year. This is shocking! So

we need to stop celebrating the decline of teenage pregnancy rates and try to find solutions for this social ill.

**Figure 1: Pregnancy rates of learners still attending ordinary schools**




Source: Annual Schools Survey (2007-2013), Department of Basic Education

**Table 1: Number of female learners attending ordinary schools who fell pregnant by grade and year**

| Year | Grade 3 | Grade 4 | Grade 5 | Grade 6 | Grade 7 | Grade 8 | Grade 9 | Grade 10 | Grade 11 | Grade 12 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | 39 | 106 | 287 | 830 | 2027 | 5133 | 7727 | 12004 | 12141 | 9413 | 49707 |
| 2008 | 53 | 110 | 274 | 788 | 1885 | 4608 | 7803 | 12463 | 12219 | 9426 | 49629 |
| 2009 | 17 | 69 | 226 | 666 | 1556 | 3995 | 7483 | 12310 | 12824 | 10453 | 49599 |
| 2010 | 109 | 107 | 297 | 571 | 1403 | 3290 | 6343 | 11116 | 12201 | 9839 | 45276 |
| 2011 | 26 | 51 | 122 | 383 | 1041 | 2828 | 5465 | 8957 | 9988 | 7849 | 36702 |
| 2012 | 8 | 23 | 83 | 275 | 756 | 2111 | 4409 | 7343 | 8280 | 6678 | 29966 |
| 2013 | 199 | 211 | 250 | 364 | 663 | 1571 | 3293 | 5658 | 5653 | 4424 | 22286 |

Source: Annual Schools Surveys (2007 – 2013), Department of Basic Education

Another source of data on teenage pregnancy is from the General Household Survey (GHS) conducted each year by Statistics South Africa. Masondo's article which was on the front page of City Press on 6 September 2015, indicated that there were more than 99,000 teenage pregnancies in 2013 in the country. This was a rise from 81,000 in 2012 and 68,000

in 2011. It should be noted that whilst GHS includes all teenage girls (i.e those who are not in school and those who are in private schools), the Annual Schools Survey only deals with public schools. Although the General Household Survey give very different statistics to the Annual Schools Survey, one fact is clear that teenage pregnancy is very high in South Africa. The Minister of Basic Education, Honourable Angie Motshekga, when responding to questions posed in the National Assembly in 2010, endorsed that teenage pregnancy is still unacceptably high. The Minister of Health, Honourable Aaron Motsoaledi, has also been cited by the media in several occasions that he is not happy with the high rate of teenage pregnancy in South Africa. Furthermore, the president of the Republic, His Excellency Mr Jacob Zuma, has also aired his concerns on the problem of teenage pregnancy. Many more politicians and government officials have followed suit. What is consistent from the voices we hear is that teenage pregnancy is a problem in the country, but there is no consensus on the solution even among researchers.

**South African Policy Environment**

I would now like to talk about the policy environment. The South African government has progressive policies and initiatives to support teenagers in particular and young people in general. I outline below twelve government policies and initiatives in place, some of which are specifically for teenagers and some are general but very useful to teenagers.

1. *The South African Constitution* (Republic of South Africa, 1996a): The Constitution protects rights of all citizens including children to make decisions regarding reproduction and right to access health care services. This means falling pregnant is legal even for teenage girls.

2. *The South African Schools Act - SASA* (Department of Education, 1996): Permits learners to stay in school while pregnant and to return to school after childbirth. However, Willan (2013) has reported that only a third of teenage school girls who fall pregnant return to school, and of those who return many struggle to juggle between school work and child rearing.

3. *The Promotion of Equality and Prevention of Unfair Discrimination Act (No 4 of 2000)*: Supporting SASA, it stipulates that school learners who become pregnant should not be unfairly discriminated against.

4. *The South African Children's Act* (Republic of South Africa, 2005): Allows 12 year olds and above to access health care services including HIV testing, contraceptives and termination of pregnancy without parental consent.

5. *The Choice on Termination of Pregnancy Act* (Republic of South Africa, 1996b): Allows any pregnant girl to have a pregnancy terminated on request up to 12 weeks of gestation. Termination can also take place after 12 weeks but with conditions. However, my research has shown that these services are very unpopular to nulliparous teenagers in South Africa (Mturi, 2015b).

6. *The Sexual Offenses Act* (Republic of South Africa, 2007): It states that children can only consent to sex once they are 16 years old. Adults having consensual sex with children under 16 years but older than 12 years are considered to commit statutory rape (as amended in 2015).

7. *Child Support Grant*: CSG was established in 1998 for the purpose of alleviating poverty of children from not well to do families. This grant has been criticized, among other things, for encouraging girls to have children. But scientific evidence has not confirmed these allegations (Makiwane, 2010; Makiwane, Desmond *et al*., 2006; Udjo, 2009, 2013).

8. *Measures for the Prevention and Management of Learner Pregnancy* (Department of Education, 2007): This government document provides assistance around implementation of SASA with dual focus on prevention of pregnancy and management of pregnancy where it does occur.

9. *Integrated School Health Policy* (Department of Health and Department of Basic Education, 2012): This policy is an attempt to ensure that sexual and reproductive health and rights are addressed in schools.

10. *National Contraception Policy Guidelines* (Department of Health, 2012a): The guidelines, not specifically for only young people, recognize the need for improved service delivery, health care provider training and ensuring user-friendly clinics.

11. *Preventing Teenage Pregnancy* (Department of Health, 2012b): This government booklet assists teenagers to learn about sex and avoid teenage pregnancy by empowering them with knowledge.

12. *Life Orientation Programme in Schools*: Sexuality education was made part of the LO programme in 2002 for the purpose of making learners understand about sexual matters including physiology of their body. However, as I and Bechuke found in our recent research, implementation of this programme has a lot to be desired (Mturi and Bechuke, 2016).

As just shown, the list of policies and initiatives is long in South Africa which is positive sign of the government commitment to find solution to teenage pregnancy. However, coordination of these policies is weak, and in some cases, contradictions have been observed between different policy documents. I, therefore, argue that having conducive policy environment and allocating huge budgets for implementation of those policies are not necessarily changing the behaviour of teenagers. I will come back to this point when I suggest the way forward.

## A Historical Note and Predisposing Factors of Teenage Pregnancy

It is important to pause and reflect on how the country reached the point of having unacceptably high teenage pregnancy rates. The first point to note is that teenage pregnancy is largely affecting the Black population in South Africa. Can it be said that teenage pregnancy is higher among the Black population because their culture accepts this

phenomenon? The answer is no. Let us go back to the history before colonialization and apartheid was introduced in South Africa to verify this response.

Delius and Glaser (2002) have looked at the historical perspective of sexual socialization in South Africa since the 19th Century. Their analysis is based on three main ethnic groups namely isiZulu, isiXhosa and Sepedi; comprising more than 60% of the Black population in South Africa. Delius and Glaser (2002) have shown systematically that traditional system had measures in place to control teenage sexuality and pregnancy. For instance, there were discussions about sexual matters with young people even before initiation stage and there were techniques that were established to assist young people not to indulge in sexual activities and avoid teenage pregnancy. Those teenagers who operated against the acceptable norms faced severe punishment from the elders and public humiliation (Delius and Glaser, 2002). However, the society reached a point where these measures were dismantled by migrant labour, western education and urbanization. Delius and Glaser (2002), further provide a detailed historical account on how the traditional system crumbled which in turn increased teenage pregnancy. In other words, what is seen today in relation to teenage pregnancy was not the case before colonization hence we cannot say African culture accepts teenage pregnancy.

The establishment of the apartheid regime in 1948 made things worse. During the apartheid, services (such as education, healthcare and employment) were organized in racial lines. Blacks were the most disadvantaged group. In addition, family ties were disrupted because it was official that migrant labour for men excluded their families (women and children) which remained in the countryside (Mazibuko, 2000). Teenagers and children ended up being supervised by grandmothers and other relatives. The distortion of family structures created an opportunity for teenagers to live the life they want without strict supervision. As a result of the apartheid regime, most of the Black teenagers grew up in sheer poverty without a father figure. Unfortunately, teenagers were not also well informed about sexual and reproductive health services (such as contraception) that could help to reduce teenage pregnancy. It was therefore not surprising that the problem of teenage pregnancy escalated during the apartheid era. When South Africa became a democratic state in 1994, there was a lot of emphasis from the government to assist teenagers, by introducing relevant policies and programmes and making funds available for such programmes. However, it is not easy to fix behavioural issues in a short period of time.

Another cause of teenage pregnancy is the breakdown of the institution of marriage in South Africa. The fear that pregnancy will reduce the chance of being married, especially if the person who is responsible for the pregnancy is not the one to consider marriage, is non-existent. In some countries, teenage pregnancy reduces the chances of being married drastically if the father of the child is not interested in forming a family with the pregnant woman. For the case of South Africa, some authors have argued that teenagers will intentionally conceive so that they can prove their fecundity in order to increase their chance of being married (Preston- Whyte, Zondi *et al.*, 1990).

Another factor is that age at marriage is very high in South Africa. Given that the age at menarche is also decreasing, it means young women are exposed to pregnancy for a longer

period compared to the past, before they get married. Preston-Whyte *et al.* (1990) have also argued that high value placed on children by Black population is a major reason for high teenage pregnancy.

The following are more reasons for unmarried girls bearing children at such a young age: ignorance of the physiology of sex especially for rural girls; curiosity; peer pressure or feeling of competition; fear of attending clinics that are unwelcoming to young contraceptive users; and sometimes forced sex (Kaufman, de Wet and Stadler, 2001; Mturi, 2015a). Poor family planning services for young people accompanied by fear of side effects and infertility have been reported by various researchers to be a cause of young unmarried women to have children (MacPhail, Pettifor *et al.*, 2007; Mfono, 1998; Mturi, 2015a; Jewkes, Morrell and Christofides, 2009; Wood and Jewkes, 2006). There is also the argument that gender power dynamics in sexual control favours boys and this may influence early childbearing (Bhana and Anderson, 2013; Preston-Whyte *et al.*, 1990; Varga, 2003). Some argue that these girls bear children as a way of seeking financial support from boyfriends, attention and love, and eventually marriage (Kaufman *et al.*, 2001; Zwang and Garenne, 2006). And yet there are those who feel that these girls bear children in order to access social grants (Zwang and Garenne, 2006). This view has been supported by the media, but as stated earlier, has been contested by many researchers (Makiwane, 2010; Makiwane *et al.*, 2006; Udjo, 2009, 2013).

**Modes of Delivering Sexuality Education**

Teenage pregnancy rates can be reduced either by teenagers agreeing to abstain from sex or by using contraceptive methods for those who are sexually active. Either way, relevant and accurate information on sexual health is required. Sexual health, in this case, incorporates sexual development, sexual behaviour, use of contraceptive methods, and relationships. I would like now to discuss various communication modes on sexual health to teenagers in South Africa. I argue that the many challenges facing various communication modes have assisted to promote teenage pregnancy. I believe that this is the area that needs intervention if there is a good chance of winning the war against teenage pregnancy. This is because most of the women who fell pregnant when they were still teenagers alluded to the fact that they did not know much about falling pregnant before they conceived their first baby (Mturi, 2015a). It has been emphasized that sexuality knowledge will be meaningful to young people's sexual lives if they get it well before their sexual debut (Lebese, Davhana-Maselesele and Obi, 2011). I have identified seven popular modes of delivering sexuality education to young people in South Africa.

*i) Initiation Schools*

Traditional initiation schools have been established in many African countries for, among other things, imparting education to young people including sexuality education as they are introduced to adulthood. These schools also exist in South Africa especially in Limpopo, Eastern Cape, Free State, and Mpumalanga provinces. The literature indicates that the traditional initiation schools are still valued amongst different cultural groups such as

Southern Ndebele, Northern Sotho, Tsonga, Venda and Xhosa (Malisha, Maharaj and Rogan, 2008; Van Rooyen, Potgieter and Mtezuka, 2006; Vincent, 2008). Due to secretive nature of what is taught in these schools, it is not easy to assess the curriculum used regarding sexual health. But there has been a debate in South Africa, particularly in the media, regarding the effectiveness and relevance of the initiation schools due to the number of deaths that have been taking place to initiates and exposure to HIV infection through use of contaminated devices during circumcision. Furthermore, since the traditional initiation schools are only available in selected cultural groups, they cannot be used as the main mode of delivering sexuality education to teenagers in the country.

*ii) Clinics and health centres*

Clinics and health centres can be an excellent source of sexual health information for teenagers because health practitioners are trained to provide such services. These include use of contraceptive methods and counselling. However, I have found out that nulliparous teenagers especially those who are still attending schools do not benefit from those services (Mturi, 2015a). Many girls get sexual health information from clinics and health centres after falling pregnant when they attend antinatal and postnatal clinics. The reasons given for clinics and health centres not being popular as a source of sexual health information for teenagers include mistreatment of teenagers especially by nurses (Wood and Jewkes, 2006), lack of privacy, opening hours not suitable for school going teenagers, and fear that parents will know that they visited a clinic or a health centre and therefore, conclude that they are sexually active. As it stands, clinics and health centres will remain to be unpopular source of sexual health information for teenagers until something is done to change the *status quo.*

*iii) Respected adult members of the family*

The third communication mode on sexual health to teenagers is respected adult members of the family (Fuglesang, 1997). These are usually aunts and grandmothers for girls and uncles and grandfathers for boys. However, this practice usually works in rural areas where the extended family is still intact. In other words, urbanization and modernization have weakened this mode of communication even in those places where this culture used to exist. The South African literature indicates that this is perhaps the least popular mode of communication of sexual health.

*iv) Mass Media*

Many young people depend on mass media for information on sexual health. This includes internet, television, movies, radio, magazines, etc. The most popular national media campaign for young people is the Soul City project which is made up of television series, radio drama, booklets, adult education and youth life skills materials. As part of this project there is a pre-teen television drama series (Soul Buddyz) which covers health and developmental messages. The evaluation of Soul City activities has shown that they are effective education vehicle on sexual health for South African youth (Dickson-Tetteh and Ladha, 2000). Unfortunately, not all mass media outlets regulate the information sent out like Soul City. Internet and television are the types most criticized for providing information that is not suitable for young people. For instance, it is very easy for a teenager

to access pornographic materials from the internet using mobile phones or internet cafe. A lot of work is therefore needed in order to make mass media a reliable and relevant mode for delivering sexual health to young people.

*v) Peers and friends*

In South Africa, as it is in other countries, teenagers learn about sexual matters through their peers and friends. Research shows that teenagers feel more comfortable to discuss sexual matters with their peers than other people including parents and teachers (Olge, Glasier and Riley, 2008; Selikow, Ahmed *et al*., 2009). The most cited mechanism of learning sexual matters is through peer pressure to engage in sexual relations or sexual intercourse (Lebese, Davhana-Maselesele and Obi, 2010; Wood, Maforah and Jewkes, 1998). In some cases teenagers have been pressurized by friends to intentionally have a baby so that they can prove that they are fecund (Mturi, 2015a). Unfortunately, peers and friends do not always have correct information on sexual health (Lebese *et al*., 2010; Maluleke, 2007). Another mechanism through which teenagers learn from their peer is through peer educators. In this case, peer education can be defined as an approach in which teenagers are supported to promote sexual health-enhancing change among their peers. However, some researchers have questioned the effectiveness of peer educators, arguing that their ability to provide quality education may be compromised (Jaworsky, Larkin *et al*., 2013). In South Africa, peer education programmes are based in schools, youth centres and clinics. They include conducting workshops about HIV and AIDS, and sexuality (Dickson-Tetteh and Ladha, 2000). Although some peer education programmes are performing well, it is virtually impossible to have such a programme that will cater for every teenager in the country.

*vi) School-based curriculum*

Comprehensive sex education programmes have been found to help young people remain healthy and avoid negative sexual health outcomes (Kirby, 2007). One of the main negative arguments against comprehensive sex education is that talking about sex promotes sexual activity among young people (Di Mauro and Joffe, 2007). However, studies on this issue have shown that there is no evidence to support this allegation (UNESCO, 2009). In 2002, the then Department of Education's Sexuality Education Programme (SEP) became part of the Life Orientation learning area (Department of Education, 2002). Although the current Department of Basic Education has highlighted some successes of the programme, there is no evidence of behavioural change among the youth over the years. Part of the problems identified in the SEP is content based. For instance, the comparative assessment of ten countries in east and southern Africa done by UNESCO and UNFPA (2012) noted that sexuality and sexual behaviour is barely addressed in the South African programme. In the study I carried out with Bechuke (2016) of selected schools in Mahikeng, we concluded that teaching and learning of sexuality education is very problematic due to a series of problems. My opinion is that efforts should be made to improve SEP in schools so that it can be more effective to learners. But we should not depend entirely on this mode of delivery, something should be done at home to enhance and supplement what young people are taught in schools.

*vii) Parent-child communication*

The majority of children spend most of their time at home with parents. Usually parents are involved in children's life from birth and monitor each stage of their development. This includes parents' involvement in children's school work. But this is not true for sexual health. Indeed, Lebese *et al.* (2011) believe that "...the primary socialization of children starts at home, where parents have the role of educating their children about issues of sexual health." (p. 3). Why is it not happening then? For the few brave parents who attempt to discuss sexual health with their children, as alluded to by Bastien, Kajula and Muhwezi, (2011), is in the form of instruction, warnings, gossip and threats about sexuality than dialogue. Ladies can remember the statement like *now that you are grown up do not play with boys, you will fall pregnant* (popularly known instruction from the mother to the daughter who has just reported or observed to have her first menstruation period). This may be very misleading because a girl may indeed stop playing with boys but may have sex with them! The use of indirect language is very common in Africa for those parents who are able to discuss sexual health because direct talk on sexual matters between parents and their teenage children is not easy.

There are many reasons that cause parents to fail to discuss sexual health with their children as outlined below:-

- Parents are shy or embarrassed or uncomfortable (Kempner, 2003; Mturi, 2003);
- Cultural values and norms (Lebese *et al.*, 2011; Mfono, 1998; Soon, Kaida *et al.*, 2013);
- Many parents do not have information that young people need (Bastein *et al.*, 2011);
- In some cases, parents just find it difficult to initiate the conversation (Bastein *et al.*, 2011; Lebese *et al.*, 2010);
- Parents assume that children would learn about sexual health elsewhere; and
- Lastly, I found parents believe that their children are too young to hear about sexual matters, their children are not indulging into sexual activities as yet or they are concerned that discussing sexuality will lead to early sexual experimentation (Mturi, 2003).

**Parent-Child Communication is a Preferred Mode of Communication**

The next question to address is, given a choice, whom do the teenagers prefer to discuss sexual health matters with? Soon *et al.* (2013) found out that teenagers in Soweto "expressed their desire to talk with their parents and/or caregivers when they were struggling with a personal issue and wanted information and advice related to sex and relationships" (p. 166). However, Bastein *et al.* (2011), citing a Ghanaian study, have reported that "young people are reluctant to discuss sexuality with their parents since they prefer to discuss these issues with their friends, because they feel shy, and also because they may fear physical punishment for discussing sexuality" (p. 11). The same finding was observed by Lebese and her colleagues (2011) for teenagers in Limpopo. However, the same Limpopo teenagers, as already alluded to, prefer to start discussing sexual health early in

their life with people they trust most i.e. their parents. In addition, the main reason for not wanting to discuss sexual health with parents is because they are embarrassed to do so (Lebese *et al.*, 2010).

It is my view that teenagers want parents to be in the equation but they just do not know how. The issue to address is therefore how can parents be assisted to discuss sexual health with their teenagers without either part being embarrassed? The first step has to do with changing mind-set of both parents and teenagers since cultural values and norms have been identified as one of the stumbling blocks. Secondly, parents should be given confidence to do so. Thirdly, parents should be equipped with correct information on sexual health and know when and how to discuss which topic. Parental involvement can also be in the form of monitoring teenage behaviour at night and during their free time and assisting with homework especially on sexuality education. This is easy said than done. However, if we agree that this is the 'jigsaw puzzle piece' missing in the fight against teenage pregnancy, we can definitely make a plan.

I know that the family structure in South Africa has been under scrutiny partly because of what happened during the apartheid era. Some people might think that what I am proposing will not work because of dysfunctional family structures in the country. It is arguable to some extent that this issue has been exaggerated. There are two things which I assert have a negative effect to the family structures in South Africa: firstly, the age at first marriage is very high and secondly, prevalence of divorce is also very high. But the parent-child co-residence does not portray family structure to be a serious problem. For instance, Jhamba and Mmatli (2016) when analyzing the 2007 Community Survey data showed that among children with both parents alive, 43% co-resided with both parents, 35% co-resided with their mothers only, and 6% co-resided with their fathers only. This means 84% of the children were co-residing with at least one parent. This figure is quite high for introducing a programme that promotes parent-child communication.

Research shows that there are numerous aspects of parent-child communication that determine its effectiveness and ability to influence behaviour outcomes including frequency and content of the message, how the message is communicated, communication style and tone of discussions (Bastein *et al.*, 2011). Few intervention studies conducted in South Africa have given positive results even in rural settings. For instance, the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) is a community randomized controlled trial of a programme integrating microfinance with participatory education addressing HIV and gender awareness (Phetla, Busza *et al.*, 2008). The structured sessions were designed to stimulate awareness and discussions on issues related to gender inequalities, intimate partner violence and the role of culture in shaping behavioural norms. This intervention programme improved parents' motivation and skills in engaging with young people on sexuality matters through confronting cultural norms and taboos (Phetla *et al.*, 2008). There are countries in Africa, such as Rwanda (Bushaija, Sunday *et al.*, 2013) and Tanzania (Fuglesand, 1997), in partnership with development partners have put similar programmes in place. I argue that it is possible to escalate such interventions to the national level.

**Concluding Remarks**

Madam Rector, ladies and gentlemen, as I conclude, please allow me to suggest how the war against teenage pregnancy can be won by introducing programmes that will influence parent-child communication. The government needs to establish an inter-ministerial Task Team to deal with teenage pregnancy and the main task should be to establish sensitization campaigns about parent-child communication. Some lessons can be learnt from the national programmes implemented in the US such as the National Campaign to Prevent Teen and Unplanned Pregnancies and the National Coalition of Sexual Health. The Task Force should include all key Departments (such as Health, Basic Education, Higher Education and Training, Social Development, Treasury, etc.), non-governmental organizations (NGOs), faith-based organisations (FBOs), community-based organizations (CBOs) and civil society. There is a need to have a secretariat and a budget that will make sure that all decisions and activities are implemented to the satisfaction of the Task Team. The terms of reference (TOR) of the Task Team should include, but not limited to:-

1) Consolidate the policies discussed above and give guidelines on implementation of those policies;

2) Proper interpretation of policies and remove space for anybody to interpret any how;

3) Establish and implement proactive advocacy strategies so that the policies and initiatives can be known to teenagers; and

4) Design and implement ways that will assist parents to take part in all initiatives meant to deal with teenage pregnancy.

If the society succeeds to pass the age appropriate information about sexual health to teenagers, it will be a major step in the right direction for reducing unplanned pregnancies and births. This will happen because more teenagers will understand a need to postpone initiating sexual activities. And when they are sexually active, they will know how to prevent falling pregnant and contracting sexually transmitted infections including HIV. Further, unplanned pregnancy does not necessarily lead to birth. Those who will conceive unintentionally will seek abortion services and wait for the right time to have a baby. I am very convinced that this is how to deal with the problem of teenage pregnancy and unplanned births.

**References**


Anyanwu, A.C., D.T. Goon and A. Tugli (2013). "Socio-demography and sexual experiences of University of Venda students: Implications for health." *African Journal for Physical, Health Education, Recreation and Dance*, 19(2): 459-478.

Bastien, S., I.J. Kajula and W.W. Muhwezi (2011). "A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa." *Reproductive Health*, 8(25), 17 pages.

Bhana, D. and B. Anderson (2013). "Gender, relationship dynamics and South African girls vulnerability to sexual risk." *African Journal of AIDS Research*, 12(1): 25–31.

Bonell, C. (2004). "Why is teenage pregnancy conceptualized as a social problem? A review of quantitative research from the USA and UK." *Culture, Health & Sexuality*, 6(3): 235-272.

Bushaija, E., F.X. Sunday, D. Asingizwe, R. Olayo and B. Abong'o (2013). "Factors that hinder parents from the communicating of sexual matters with adolescents in Rwanda." *Rwanda Journal of Health Sciences*, 2(2): 13-19.

Condit, P. (2011). "Child marriage: Ukuthwala in South Africa." www.genderacrossborders.com Accessed on 13 March 2016.

Delius, P. and C. Glaser (2002). "Sexual socialisation in South Africa: A historical perspective." *African Studies*, 61(1): 27-54.

Department of Education (1996). *South African Schools Act No. 84 of 1996.*

Department of Education (2002). *Revised National Curriculum Statement Grades R – 9 (Schools) Policy: Life Orientation.* Pretoria: Department of Education.

Department of Education (2007). *Measures for the Prevention and Management of Learner Pregnancy; Choose to wait for a brighter future.* Pretoria: Department of Education.

Department of Health (2012a). *National Contraception and Fertility Planning Policy and Service Delivery Guidelines.* Pretoria.

Department of Health (2012b). *Preventing Teenage Pregnancy.* Pretoria.

Dickson-Tetteh, K. and S. Ladha (2000). "Youth health." In: *South African Health Review 2000*, Ntuli, A. (ed.), pp 393-409. Durban: Health System Trust.

Di Mauro, D. and C. Joffe (2007). "The religious right and reshaping of sexual policy: An examination of reproductive rights and sexuality education." *Sexuality Research and Social Policy*, 4(1): 67-92.

Fuglesang, M. (1997). "Lessons for life-past and present modes of sexuality education in Tanzanian society." *Social Science and Medicine*, 44(8): 245-254.

Hoque, M.E. (2011). "Sexual practices among male undergraduate students in KwaZulu-Natal, South Africa." *South African Journal of Epidemiology and Infection*, 26(3): 157-160.

Hoque, M.E., T. Ntsipe and M. Mokgatle-Nthabu (2012). "Sexual practices among University students in Botswana." *Gender and Behaviour*, 10(2): 4646-4656.

Jaworsky, D., J. Larkin, G. Sriranganathan, J. Clout, J. Janssen, L. Campbell, S. Flicker, D. Stadnicki, L. Erlich and S. Flynn (2013). "Evaluating youth sexual health peer education programs: Challenges and suggestions for effective evaluation practices." *Journal of Education and Training Studies*, 1(1): 227-235.

Jewkes, R., R, Morrell and N. Christofides (2009). "Empowering teenagers to prevent pregnancy: lessons from South Africa." *Culture, Health and Sexuality*, 11(7): 675-688.

Jhamba, T. and K. Mmatli (2016). "Household and family dynamics in South Africa." In: *Social Demography of South Africa: Advances and Emerging Issues*, C.O. Odimegwu and J. Kekovole (eds.), pp 169-190. New York: Routledge.

Kaufman, C.E., T. de Wet and J. Stadler (2001). "Adolescent pregnancy and parenthood in South Africa." *Studies in Family Planning*, 32(2): 147–160.

Kempner, M.E. (2003). "True integration of prevention programmes requires broad focus on sexual health." *Academic Research Library*, 31(3): 44-51.

Kirby, D. (2007). *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent teen and Unplanned Pregnancy.

Lebese, R.T., M. Davhana-Maselesele and L.C. Obi (2010). "Sexual health dialogue between parents and teenagers: An imperative in the HIV/AIDS era." *Curationis*, 33(3): 33-42.

Lebese, R.T., M. Davhana-Maselesele and L.C. Obi (2011). "Teenagers' experience of sexual health dialogue in the rural villages of the Vhembe District, Limpopo Province." *Health SA Gesondheld*, 16(1): Art, #502, 10 pages.

Loaiza, E. and M. Liang (2013). *Adolescent Pregnancy: A Review of the Evidence*. New York: United Nations Population Fund.

MacPhail, C., A.E. Pettifor, S. Pascoe and H.V. Rees (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.

Makiwane, M. (2010). "The Child Support Grant and teenage childbearing in South Africa." *Development Southern Africa*, 27(2): 193-204.

Makiwane, M., C. Desmond, L. Richter and Udjo, E. (2006). *Is the Child Support Grant Associated with an increase in teenage fertility in South Africa? Evidence from National Surveys and Administrative Data*. Human Sciences Research Council, Pretoria.

Malisha, L., P. Maharaj and M. Rogan (2008). "Rites of passage to adulthood: Traditional initiation schools in the context of HIV/AIDS in the Limpopo Province, South Africa." *Health. Risk & Society*, 10(6): 585-598.

Maponya, F. (2013). "Limpopo child bride: Sold into marriage, kept their by the system." www.dailymaverick.co.za Accessed on 13 March 2016.

Masondo, S. (2015). "Teen pregnancies hit 99,000 a year." City Press of 6 September 2015, page 1.

Mazibuko, R.P. (2000). "The effects of migrant labour on the family system." Masters (Education) dissertation submitted to the University of South Africa.

Mfono, Z. (1998). "Teenage contraceptive needs in urban South Africa: A case study." *International Family Planning Perspectives*, 24(4): 180-183.

Morell, R., D. Bhana and T. Shefer (2012). "Pregnancy and parenthood in South African schools." In: R. Morell, D. Bhana and T. Shefer (eds.), *Books and / or Babies: Pregnancy and Young Parents in Schools*, pp 1-27. Cape Town: HSRC Press.

Motshekga, A. (2010). "Reply by Minister of Basic Education, Angie Motshekga, on questions posed in the National Assembly for written reply." www.gov.za Accessed on 23 March 2016.

Mturi, A.J. (2003). "Parents' attitudes to adolescent sexual behaviour in Lesotho." *African Journal of Reproductive Health*, 7(2): 25-33.

Mturi, A.J. (2015a). "Predisposing factors and consequences of childbearing among young unmarried women in North West, South Africa." *African Population Studies*, 29(2): 1954-1970.

Mturi, A.J. (2015b). "Why young unmarried women bear children? A case study of North West province, South Africa." Population Horizons Working Paper № 02, Oxford Institute of Population Ageing, University of Oxford.

Mturi, A.J. (2015c). "Is South Africa on track to win the war against teenage pregnancy?". Paper presented at the 10th Population Association of Southern Africa (PASA) annual conference that took place in Durban, South Africa on 8-10 July 2015.

Mturi, A.J. and A.L. Bechuke (2016). "The relevance and effectiveness of life orientation programme in schools for delivering sexuality education: The case of Mahikeng, South Africa." Paper prepared for the British Society for Population Studies annual conference, Winchester, 12-14 September 2016.

Mturi, A.J. and L. Gaearwe (2014). "Gender differentials in sexual behaviour among students in Mahikeng, South Africa." *African Population Studies*, 28(1): 526-537.

Nour, N.M. (2006). "Health consequences of child marriage in Africa." *Emerging Infectious Diseases*, 12(11): 1644-1649.

Olge, S., A. Glasier and S.C. Riley (2008). "Communication between parents and their children about sexual health." *Journal for Contraception*, 77(10): 283-288.

Panday, S., M. Makiwane, C. Ranchod, and T. Letsoalo (2009). *Teenage Pregnancy in South Africa – With a Specific Focus on School-Going Learners.* Pretoria: Department of Basic Education.

Phetla, G., J. Busza, J.R. Hargreaves, P.M. Pronyk, J.C. Kim, L.A. Morison, C. Watts and J.D.H. Porter (2008). "'They have opened our mouths': Increasing women's skills and motivation for sexual communication with young people in rural South Africa." *AIDS Education and Prevention*, 20(6): 504-518.

Preston-Whyte, E., M. Zondi, G. Mavundla and H. Gumede (1990). "Teenage pregnancy, whose problem?: Realities and prospects for action in KwaZulu/Natal." *South African Journal of Demography*, 3(1): 11-20.

Republic of South Africa (1996a). *The Constitution of the Republic of South Africa, 1996.* Act 108 of 1996. Pretoria: Government Printers.

Republic of South Africa (1996b). *Choice on Termination of Pregnancy Act No. 92 of 1996.* As ammended in 2003.

Republic of South Africa (2005). *Children's Act & Regulations: Act 38 of 2005.* As ammended by the Children's Amendment Act, No 41 of 2007. Juta & CO. Ltd.

Republic of South Africa (2007). *The Criminal Law (Sexual Offenses and Related Matters) Amendment Act 32 of 2007.*

Selikow, T-A., N. Ahmed, A.J. Flisher, C. Mathews and W. Mukoma (2009). "I am not 'umqwayito': A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa." *Scandinavian Journal of Public Health*, 37(suppl 2): 107-112.

Soon, C.N., A. Kaida, B. Nkala, J. Dietrich, A. Cescon, G. Gray, and C.L. Miller (2013). "Adolescent experiences of HIV and sexual health communication with parents and caregivers in Soweto, South Africa." *SAHARA J: Journal of Social Aspects of HIV/AIDS*, 10(3-4): 163-169.

Udjo, E.O. (2009). "Trends in the age pattern of fertility, 1995–2005, in the context of the child support grant in South Africa." *Development Southern Africa* 26(2): 289–299.

Udjo, E.O. (2013). "The relationship between the Child Support Grant and teenage fertility in post-Apartheid South Africa." *Social policy and Society,* doi:10.1017/S14747464130000390.

UNESCO (2009). *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators.* Paris: UNESCO.

UNESCO and UNFPA (2012). *Sexuality Education: A Ten-Country Review of School Curricula in East and Southern Africa.* Paris: UNESCO and New York: UNFPA.

UNFPA (2013). *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy.* 2013 State of the World Population. New York: United Nations Population Fund.

Van Rooyen, L., F. Potgieter and L. Mtezuka (2006). "Initiation school amongst the Southern Ndebele people of South Africa: Depreciating tradition or appreciating treasure?" *International Journal of Adolescence and Youth*, 13: 13-41.

Varga, C.A. (2003). "How gender roles influence sexual and reproductive health among South African adolescents." *Studies in Family Planning,* 34(3): 160–172.

Vincent, L. (2008). "'Boys will be boys': Traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa." *Culture, Health & Sexuality*, 10(5): 431-446.

WHO (2004). *Adolescent Pregnancy: Issues in Adolescent Health and Development.* Geneva: World Health Organization.

Wood, K. and R. Jewkes (2006). "Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa." *Reproductive Health Matters,* 14(27): 109–118.

Wood, K., F. Maforah and R, Jewkes (1998). "'He forced me to love him': Putting violence on adolescent sexual health agendas." *Social Science and Medicine*, 47(2): 233-242.

Willan, S. (2013). "A review of teenage pregnancy in South Africa - Experiences of schooling, and knowledge and access to sexual and reproductive health." Unpublished report submitted to Partners in Sexual Health.

Zwang, J. and M. Garenne (2008). "Social context of premarital fertility in rural South Africa." *African Journal of Reproductive Health,* 12(2): 98–110.

**Professor Akim Jasper Mturi – A Biographical Sketch**

Professor Akim Jasper Mturi was born on 14 July 1957 in Usangi, Tanzania. He obtained the Bachelor of Science (Chemistry and Statistics) in 1986 at the University of Dar es Salaam, Tanzania. In 1987, he joined the Cairo Demographic Centre (CDC), Egypt, where he studied for three years. He obtained the following qualifications at CDC: Postgraduate Diploma (Demography); Special Diploma (Population and Development); and Master of Philosophy (Demography). He obtained the Doctor of Philosophy (Demography) degree in 1996 at the University of Southampton, UK.

The career of Prof Mturi began from a humble beginning. He was teaching chemistry at Lomwe Secondary School in 1979 and 1980, before joining Tazama Pipelines Ltd (1980-1983) as a Plant Operator. After completion of his first degree, he joined the University of Dar es Salaam as a Tutorial Assistant in the Department of Statistics in 1986 where he worked until 1995. He was then recruited as a Research Fellow at the University of Southampton where he worked until 1997. He moved to Lesotho in July 1997 where he worked at the National University of Lesotho as a Lecturer/Senior Lecturer until 2001. From July 2001, he was a Senior Lecturer at the then University of Natal (now University of KwaZulu-Natal), Durban, and he became Associate Professor on 1 January 2003. He also worked as Director of the Applied Population Sciences Training and Research (APSTAR) at the University of KwaZulu-Natal (2005-2006). He left the UKZN in 2007 to join the Human Sciences Research Council (HSRC) in Pretoria as Chief Research Specialist where he worked until 2008. Just before joining the North-West University (Mafikeng Campus) in March 2010 as a full Professor of Demography and Population Studies, he worked at the Organization for Social Science Research in Eastern and Southern Africa (OSSREA) as Deputy Executive Director and Director of Research (2008-2009). During the period August 2011 to October 2014, he was the leader of the Research Niche Area 'Population and Health' which was promoted to be a Focus Area under his leadership. Currently, he is the Director of the School of Research and Postgraduate Studies in the Faculty of Human and Social Sciences.

He is the founding president of Population Association of Southern Africa (PASA). He is also an active member of various other academic and professional bodies such as International Union for the Scientific Study of Population (IUSSP), Union for African Population Studies (UAPS), Population Association of America (PAA), and African Studies Association of Australasia and Pacific (ASAAP). He has been a member of the World Health Organization (WHO) Specialist Panel for Social Science and Operations Research on Reproductive Health for over ten years. He has been external examiner for a number of universities including University of Botswana, University of Ghana, University of KwaZulu-Natal, University of the Witwatersrand, and University of Fort Hare.

Professor Mturi has published widely in demography, population studies and other social sciences. He has published over 30 articles in accredited local and international journals, 12 chapters in peer-reviewed books and monographs, co-edited one book (published by Edwin Mellen Press of New York in 2014) and co-authored one International Labour Office (ILO) monograph in 2003. He currently serves on the Editorial Board of one journal (*Population Horizons* of the University of Oxford) and has been Guest Editor of various journals. He has read about 40 papers in major conferences and has reviewed two books.