

Teenage pregnancy

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HIV & AIDS and STI National Strategic Plan 2007-2011

“Teenage females have been underemphasized as a target group, even though pregnancy levels are high in this age group [p 33]. Although current HIV prevention programmes in South Africa have invested significantly in this age group, they are yet to demonstrate the desired impact. Continued investment in and expansion of carefully targeted evidence-based programmes and services focusing on this age group remain as critical as ever [p34].”

Indicator

Teenage pregnancy

Definition

The percentage of teenage girls (15 – 19 years) who have ever been pregnant.

Percentage of teenage girls (15-19) who have ever been pregnant

Province	1998	2003
Eastern Cape	18%	14%
Free State	13%	15%
Gauteng	10%	12%
KwaZulu-Natal	17%	2%
Limpopo	20%	17%
Mpumalanga	25%	13%
North West	13%	14%
Northern Cape	18%	15%
Western Cape	16%	14%
South Africa	16%	12%

Sources:

Department of Health. 1998. South African Demographic and Health Survey 1998. Pretoria: Department of Health.
Department of Health, Medical Research Council & OrcMacro (2007) *South Africa Demographic and Health Survey 2003*.
Pretoria: Department of Health.

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Commentary

Knowledge of the status of teenage pregnancy in South Africa is crucial to promote adolescent health. Factors that can contribute to the number of teenagers who fall pregnant are, for example, gender power imbalances (associated with significantly older partners in particular¹), early sexual debut², barriers to contraceptive use (seldom used at sexual initiation³), and misinformation on sexual health matters. Pregnancy at a very young age may result in pregnancy complications that can lead to the death of the young mother and/or her baby. Other associated consequences include increased risk of infant morbidity, as well as the possibility of emotional and financial strain for the mother.

Teenage pregnancy is by definition indicative of unsafe sex, and should be understood in the context of the HIV/AIDS epidemic. The National Strategic Plan on HIV & AIDS and Sexually Transmitted Infections (NSP) identifies youth aged 15 – 24 years as a specific target group for all interventions, particularly those aimed at the prevention of infection.⁴

A key target of the NSP is to reduce the rate of new HIV infections by 50% by the year 2011. The NSP identifies the strengthening of behaviour change programmes to prevent sexual transmission of HIV, and the implementation of interventions targeted at reducing HIV infection in youth, as two key objectives. The plan also identifies young women as a key target group for interventions aimed at reducing HIV infection. This would include strengthening and evaluating life skills and HIV prevention programmes in schools, and ensuring the quality delivery of these programmes. In addition to targeting educational institutions, NSP interventions include implementing parenting programmes that promote positive communication with children and youth on sexuality and HIV, and increasing access to youth friendly public health services. The NSP promotes abstinence, (especially delaying first sex), and safer sex practices, as part of its HIV prevention and intervention package.

Although the South African Demographic and Health Survey (SADHS) 2003 pre-dates the implementation of the NSP, it provides an indication of the prevalence of teenage pregnancy. In 2003, 12% of teenagers aged 15 – 19 years had ever been pregnant or were pregnant at the time of the SADHS.⁵ This is lower than the reported teenage pregnancy rate of 16% in the 1998 SADHS. The proportion of teenagers who have been pregnant rises rapidly with each year of age from the 15 years (2%) to 19 years (27%).

There was considerable variation in provincial teenage pregnancy rates in 2003: the rate is highest in the Limpopo province (17%), followed by the Northern Cape (15%) province. The DHS report cautions that the KwaZulu-Natal rate of 2% in 2003 (compared with 17% in 1998) is implausible, and may be due in part to fieldwork problems in that province.

Strengths and limitations of the data

Two nationally representative South African Demographic and Health Surveys (SADHS) have been conducted to date. These cover the population living in private households. The first was conducted in 1998, and the second in 2003. The main survey targets women aged 15 and 49 years.

Both the 1998 and 2003 surveys use two-stage nationally representative probability samples, drawn from Census enumeration areas. The sample is first stratified by the country's nine provinces, and then by urban and non-urban areas. The final sample yielded approximately 12,000 households for the 1998 survey and 10,000 households for 2003.

There was a marked decline in the response rate to the survey. The overall response rate for the women's questionnaire was 75% in 2003, far lower than the 92% in 1998. Western Cape had the highest number of women who refused to be interviewed. The response rate for the adult survey (which includes men) was 71% in 2003, again lower than the 90% response rate in 1998.

The SADHS 2003 report suggests an over-representation of urban areas and of the African population group, and an under-representation of Whites and Indian females. It also highlights problems with age misreporting.

Key demographic and adult health indicators from the SADHS 2003 have data quality problems, which may be the result of poor fieldwork. These include child mortality, fertility and hypertension prevalence estimates. These indicators are either inconsistent with other data sources or difficult to interpret. Findings that are not sufficiently robust for decision-making are indicated in the report.

The numerator for this indicator is the number of adolescent girls aged 15 – 19 years who had participated in the SADHS 2003, who had ever been pregnant, and the denominator is the number of adolescent girls aged 15 – 19 years who had participated in the survey.

Household survey data, such as the DHS, is self-reported, and this is likely to affect the reliability of the estimates. Teenage girls who become pregnant may elect to undergo terminations or give babies up for adoption, and may not disclose to enumerators that they have been pregnant. Antenatal clinic attendance cannot be used as a proxy for pregnancy for these reasons.

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References

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- ² Baumgartner JL, Geary Waszak C, Tucker H & Wedderburn M (2009) The influence of early sexual debut and sexual violence on adolescent pregnancy: A matched case control study in Jamaica. In: Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABSSM III Implementation Team

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(2009) *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?* Cape Town: HSRC Press.

³ Ibid – see note 1.

⁴ Department of Health (2007) *HIV & AIDS and STI Strategic Plan for South Africa 2007 – 2011*. Pretoria: Department of Health.

⁵ Department of Health, Medical Research Council & OrcMacro (2007) *South Africa Demographic and Health Survey 2003*. Pretoria: Department of Health.