Responsible Reproductive Choice in the 21st Century

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Procreation and Abortion

By

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This book, in particular Chapters 10 & 22, started life as my DPhil Thesis: *Value, Utility and Autonomy: a Moral-Critical Analysis of Utilitarian Positions on the Value of Prenatal Life.* Dissertation presented for the degree of Doctor of Philosophy (DPhil) at the University of Stellenbosch. Promoter: Prof AA van Niekerk. April 2005.

Cover design by Lara Schachat

I dedicate this book to the memory of my parents,
and to my teachers, mentors, and colleagues,
with whom I have had hours of fruitful discussion and debate.

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PREFACE

In an ideal world, this book would not have been justified. All pregnancies would be responsibly planned, teenagers would not have sex and conceive, all children would be wanted, welcome and affordable, rape and coerced sex would be unknown, and the deliberate termination of pregnancy would be necessary only in exceptional circumstances. This ideal world does not exist, least of all in the developing world and in mixed economies like South Africa. Worldwide, more than 120 million unintended pregnancies occur each year, and in excess of 70 million are deliberately terminated annually; in South Africa approximately 200 000, of which more than half are illegal and unsafe, therefore undocumented. That is why this book is crucial and opportune: to reflect on current reproductive practices and indeed, indirectly, on the future of humanity. Opportune, also, against the backdrop of the momentous reversal of *Roe v Wade*, following which legislative changes and challenges are escalating as we speak, and which is likely to have a world-wide ripple effect. The primary focus is on the South African situation, against a universal backdrop.

The past seven decades have witnessed a worldwide shift in the legalisation of termination of pregnancy and the acceptance of female reproductive rights. It has, for example, been lawful to terminate early pregnancies in South Africa since the promulgation early in 1997 of Act 92 of 1996. The act states that termination of pregnancy is one of the woman's exclusive reproductive rights. The universal question, however, is whether it is *also morally justifiable. Procreation & Abortion* tackles this 'eternally contested' controversy in a unique way by reflecting widely on the topic, arguing primarily from the perspective of the moral significance of ante-natal life against the ethical backdrop of respectfulness of human life. The writer hopes to give readers a better understanding of the complex dilemma by discussing the topic from a variety of angles – historical, social, emotional, and legal. The author's goal is not to advocate for termination of pregnancy (TOP; abortion), but to produce logical arguments to show that TOP is one of the choices a woman has when conception is unplanned. He introduces a novel concept — that of a 'moral calculus' or 'hearing' to evaluate the moral legitimacy of each instance of proposed TOP. A graded, ever-increasing intrinsic potentiality of the foetus as it develops and actuates its potentiality

to further develop implies increasing moral value. The moral scale is balanced with contingent potentiality – a vast array of factors that may influence the actuation of potentiality. There is only one cut-off point beyond which a 'right to life' may possibly be argued, and TOP is morally unacceptable: the attainment of survivability outside of the uterus – though, even this is not absolute but dependant on contingencies.

Termination implies serious moral consequences for the woman. However, the moral implications of continued pregnancy and parenthood may be far greater and stretch into the distant future.

This book does not offer answers to all questions concerning this 'eternally contested' issue. Hopefully, *Procreation & Abortion* provides a framework for constructive reflection.

INTRODUCTION

In an ideal world, this book would not have been written. Pregnancy would be planned, human reproduction would be undertaken with responsible consideration, the interests of offspring would be taken to heart, humans would have only the children they can afford and care for, teenagers would not conceive, all children would be welcome, cherished and loved, and the deliberate termination of pregnancy would only be necessary in the most exceptional circumstances. However, this ideal world does not exist, least of all in South Africa.

Just how far human society deviates from the ideal is illustrated by the number of deliberate terminations of pregnancy (TOPs)[1] conducted annually: globally, more than seventy million; in South Africa around 200,000, more than half are illegal and unsafe. In the USA, more than 20% of all pregnancies are terminated. Globally, more than 60% of all unintended pregnancies end in TOP

My purpose is to investigate and reflect on responsible reproductive choices in detail. Termination of unwanted or undesirable pregnancy (TOP) is one such option. The work comprises 23 chapters divided into four sections. Each chapter can be read independently of the rest but contributes to the entirety.

In Part 1, and as background to the ensuing discussion, common questions about pregnancy and reproduction are examined, and social phenomena discussed: why we have children; are children in South Africa planned and affordable; the problem of teenage pregnancies; the question of whether we should view procreation as a right, a duty or as a privilege; the notion of responsible parenthood; the relatively new tendency towards deliberate childlessness; and the changing social milieu within which these issues are enacted.

Like all other living creatures, humankind is biologically (that is, by nature) but also socially programmed to reproduce and will continue to do so regardless of whether children are planned, wanted, welcome or not. Where more specific reasons are posited, they turn out to be primarily selfish in nature.

Data shows that most pregnancies in South Africa (and almost half in the USA) are unplanned. From a perspective of how children are looked after, by far most South African children are 'unaffordable' and pregnancies, from that point of view, 'undesirable': two-thirds of all children under six years of age live in the 40% poorest households in South Africa. In the province of KwaZulu-Natal (KZN), nearly 80% of children under six live in poverty; in the Eastern Cape and Limpopo more than 70%. Toddler death rate (mortality under two years old) in South Africa remains at 30 per 1000 live births, and 20% of children under five years of age are growth and developmentally stunted due to malnourishment. These data become even more disturbing considering that between 10-20% of pregnancies are terminated and can be added to the 'unintended' group.[2]

Thousands of women of 19 years and younger annually give birth in South Africa, even children as young as 10 years old. Poverty is both a cause as well as a result of children falling pregnant. Pregnant learners' futures are severely impaired: only one-third return to school, and of them only one-third make Grade 12. Juvenile pregnancy shifts the reproductive curve to the left, women's fertile years begin earlier, last longer, and predispose to increased fertility and larger families.[3]

Reproduction is regarded as a fundamental natural human right, but there are corresponding obligations and limitations to this right. In some societies, reproduction is regarded as a duty that women owe to society. The ideal, however, is that it be seen as a privilege, leading to the notion of responsible parenthood.

There is a significant and increasing group of women who are deliberately childless. Some of them are 'anti-natalists' who attach a negative value to childbirth. According to 2019 data, close to 20% of all South African women born between 1962 and 1966 had never been pregnant – a doubling in a period of four years.

We live in a rapidly changing and altered social milieu, and this affects our perceptions of relationships, pregnancy, reproduction, and termination of pregnancy. The practical recognition of each person's right to decide on matters relating to him/herself – personal autonomy, freedom or self-determination – and the development of social and human rights, including the right of the woman to decide whether she wants to undergo a termination of pregnancy has radically changed our social environment. The legal grounding and recognition by society of these rights means that the woman is the sole decision-maker on the fate of her pregnancy. The woman has the

right to decide how and within what type of relationship she wants to express herself sexually.

In Part 2, the moral status of human and especially prenatal life is analysed against an ethical backdrop of an ethics of responsibility. The key question is whether respectfulness of human life can always be absolute – with a concomitant right to life, or to the continuation of life. Markers or developmental cut-offs indicating the attainment of a certain level of moral status of prenatal life are also examined, before which TOP may be regarded as morally defensible, but after which the opposite may apply.

To start with, my conception of an ethics of responsibility is presented, followed by a discussion of the moral status of human life. Moral value in this context is synonymous with respect for, and a right not to be interfered with; in absolute terms, a right to life, or at least to be allowed to continue to live. This discussion is continued with arguments to show that from legal and moral points of view there are restrictions on a right to life, or absolute moral respect. The emphasis then shifts to moral intuitions: the nature, origin, and role of moral intuitions in our daily moral decision-making. For many of us, religious views direct our moral intuitions regarding the status of prenatal life. If the moral status of prenatal beings increases as they grow and more of their potentiality actuates, the question arises whether there are specific pointers indicating the attainment of a particular moral status. I discuss a number of these markers and show that with few exceptions they have little moral usefulness: conception (or better, the individualisation of a particular being), survivability (when the foetus, should he/she be born, can persist outside of the uterus), and birth (strictly speaking, of course, the new-born is no longer a foetus).

In Part 3, termination of pregnancy is discussed extensively.

Arguments in favour centre around two concepts: Firstly, that the prenatal being does not possess any intrinsic or developmental characteristics based on which he/she can lay claim to a ‘right to life;’ secondly, that sovereignty over her body and its associated rights trump any moral ‘rights’ that the embryo or foetus may have. The two strongest arguments against TOP are the undeniable humanity of the prenatal being, and its potentiality. Prenatal development takes place in a continuum. This is the same being that (after individualisation) persists, and which from conception/individualisation onwards has the intrinsic potentiality to develop into a fully-fledged person with all the characteristics and attributes of humanity.

An alternative approach to the TOP debate is based on reproductive justice. This feminist argument moves away from the sterile, polarised right-or-wrong paradigm within which the TOP debate traditionally takes place. By refocusing on reproductive justice, the argument shifts to three rights of the woman: to terminate, to maintain the pregnancy, or to raise the child who is then born. Motherhood has greater and longer-lasting moral implications than termination.

The next section focuses on the development of legislation that regulates TOP in different jurisdictions and regions. In jurisdictions where TOP is legal, free access usually available until about 12-14 weeks pregnancy duration, and more limited access to 20-24 weeks. After 20-24 weeks, termination is most often limited. In most South American (Latin American) and African countries (except for South Africa and a few other countries) there is no legal access to TOP – not even for strong motivations such as pregnancy following on rape. Most illegal TOPs, complications due to unsafe terminations and mortality occur in these areas. The implications of the 2022 US Supreme Court reversal of Roe v Wade (1973) and Planned Parenthood v Casey (1992) are discussed. Selective termination due to foetal disorders, and of female foetuses based on prenatal sex determination is controversial. An accepted legal indication for late-stage terminations is the risk of foetal 'abnormality.' Activists for the rights of the disabled object because it discriminates against disabled persons and disability. Even conducting prenatal investigations to diagnose these disorders is criticised. However, there is consensus on the moral unacceptability of prenatal sex determination for consequent selective termination of female foetuses, common in some countries.

This discussion is followed by a global review of the current situation regarding TOP. Between 2010-2014, approximately 56 million TOPs were performed worldwide annually – almost 90% of these in developing countries where the unavailability of effective contraception, and the resulting incidence of unintended pregnancies are dominant causes. Between 2014-2019, this figure had risen to about 73 million annually. Nearly 50% of these TOPs occur in unsafe circumstances. The global termination rate (number of TOPs per 1000 women aged between 15-44) is 35/1000. Only 37% of the world's approximately 1,64 billion women in their reproductive years worldwide reside in countries with free access to TOP (restrictions on late-stage terminations excluded). Both surgical and many medical methods have been used with varying efficacy over the centuries. Modern methods include evacuation of the uterus with a sharp curette, suction evacuation with a blunt curet, and medical methods: the

anti-progesterone drug mifepristone and the prostaglandin agonist misoprostol that have revolutionised TOP.

What is the status and social acceptability of TOP in South Africa? Act 92 of 1996 which legalises TOP was promulgated in January 1997. Since then, 1,2-1,5 million legal terminations have been done in South Africa, and an equal number (or more) illegally. Although the initial aggressive activism with the implementation of the act has over time subsided, and society is more liberal, anti-TOP groups still exist and most of the population remains opposed to termination, even for strong indications. There is also considerable opposition among medical students, decreasing in later years of study. The number of nurses willing to undertake TOP is on the decline, and there are fewer than three hundred clinics where the state offers these services. Nurses undertaking TOP are victimised, stigmatised, and even assaulted. Women undergoing TOP are exposed to social action and stigmatisation — one of the reasons why so many terminations are still being done illegally. Some women experience negative emotions and symptoms shortly or even long after TOP, and a 'post termination stress syndrome' (PTSS) has been described.

In the concluding section, I argue for a justified, rational, moderate position on TOP based on the premise that consequent to its humanity and the respectfulness of human life inherent to our social constructs, all human embryos/foetuses share *some* intrinsic moral significance. This does, however, not necessarily imply a right to the continuation of its life. Parallel to foetal growth and development, and as the possibility of further development increases, as potentiality morphs from possibility to probability, its moral significance gradually increases, equating at separation survivability – viability – to a right to its continued existence, that is, not to be terminated. Up to this point, and even beyond, under very specific and unusual circumstances, moral significance is relative, not absolute.

When intrinsic potentiality is not optimal to result in eventual independent existence, moral significance may be limited. But even with optimal genetic and developmental potentiality, contingencies external to the being – extrinsic potentiality – determine the actuation of intrinsic potentiality.

This gradualist position denies absolutist positions in the TOP standoff, which, however, remains 'eternally contested', not meaning that we should back off and 'agree to disagree', but continue the debate. The novel concept of a 'moral hearing' or 'calculus' is proposed, in which intrinsic potentiality and consequent moral significance is pitted against extrinsic, that is,

contingent potentiality in each case of proposed TOP. Admittedly, this may have more theoretical and academic than practical, real-life merit.

I believe this book will interest many readers. The text is written with ordinary readers without any medical, philosophical, or ethical background in mind. Yet the contents, style and presentation are such that a variety of professionals may want to read it: social workers, therapists, doctors, medical students, nurses, and ministers of religion. There is ample substance to be of value to the professional or academic reader. The intention is not to pontificate or offer answers but hopefully to stimulate reflection.

Notes

1 I prefer to use this term rather than the 'standard' term 'abortion' which may have pejorative, ideologically based negative and alternative meanings. A bad aftermath or outcome of any matter is sometimes referred to as an 'abortion'. I feel uncomfortable reasoning and analysing a practice I perceive as neutral while, by definition, it has attributed negative connotations.

2 Unplanned does not equate to unwanted and certainly not unloved; the USA *Planned Parenthood* organisation reports that 50% of American women will face an unwanted pregnancy in their lives.
https://www.plannedparenthood.org/learn/pregnancy/considering-parenthood

3 An estimated 120 000 learners fall pregnant annually in South Africa. This figure rose during the COVID-19 lockdown period. Cabinet announced a Teenage Pregnancy Policy planned to be implemented in January 2022 to assist pregnant learners to return to school.

PART 1

CHAPTER 1

WHY DO WE HAVE CHILDREN?

Summary: Like all other living creatures, humankind is biologically (that is, by nature) but also socially programmed to reproduce and will continue to do so regardless of whether children are planned, wished, welcomed or affordable. Where specific reasons for wanting children exist, they are primarily selfish in nature.

One of the obvious consequences of human relationships is that when people enter into a more or less steady liaison, married or not, and engage in regular heterosexual relations, absent effective contraception, pregnancy usually ensues. Pregnancy may also be the result of short-lived relationships or even, these days, of no relationship with donor sperm and even donor ova, in vitro fertilisation, and surrogate motherhood. What motivates us to have children? Reasons why people want to have children can be summarised as follows:[1]

- *Desire, duty, traditions, inheritance, and social pressure:* Prospective parents idealise their anticipated family life as full of joy and gratification, and often want to perpetuate what they experienced as children. They want to create, nurture, raise, shape, and experience the wonder of life – and at the same time want to experience that happiness afresh. They have a need to love unconditionally, to be reminded of a carefree (for some) childhood playing with dolls and balls, and to the unqualified love of a child. By doing so, they can add meaning to their own lives, and correct the mistakes their parents made with them. At the same time, they want to perpetuate the family name (traditionally, the paternal), values and traditions in a new generation. Dating back from ancient times, parenting — especially fatherhood — has been associated with social status; in many societies this still applies. Sometimes there is an inheritance involved, especially with farms built up over generations, also with business conglomerates. South Africa's old and new rich and landholders are dwarfed by for example the rich British and European traditions with aristocrats, nobility, and royalty whose genealogies span centuries.

For them, reproduction is also a duty; the dynasty must survive. And on a more ordinary social level: social pressure to be seen as 'normal;' to drop children off at school and participate in conversations about children and parenting; to attend PTA meetings and be involved in school activities; to gather with peers around the rugby or hockey field or netball court on a Saturday morning to encourage Jane or John Jr. In some societies, children are considered social wealth, as a 'blessing,' partly because children can be expected to share workloads and look after their ageing parents, attract tithes, and, in certain traditions, ensure their parents become 'ancestors.'

- *Human nature:* The most fundamental natural urge of any species from the unicellular amoeba to the most complex mammal is to reproduce. Whether lower species feel an urge to reproduce, or indeed any satisfaction after action is impossible to know. Amoeba, for example, simply divides into two new cells (asexual vegetative reproduction). Sexual attraction, the craving for and actual sexual gratification form the bait to (sexual) reproduction and in a manner and with a 'purpose' that is obscure to me, to the evolutionary adaptation, improvement, and survival of the species. Sexual intercourse most often does not occur with pregnancy in mind, but to satisfy inherent cravings. So considered, pregnancy is simply something that 'happens,' 'coincidentally,' in many societies and situations, mostly unplanned and often unaffordable and undesirable. To beget children is a non-reflective continuation of what humans did in their natural state.

I suggest there are therefore only two main reasons why we want to have children: on the one hand, because of its pre-intellectual naturalness (in other words, as animals we do what all animals do, and as humans what all other humans do); on the other hand, where reasons can be raised, they are predominantly selfish in nature. The ability and urge to reproduce are hallmarks of living creatures. We are therefore biologically but also socially programmed (conditioned) to reproduce, and we do so.[2]

Women will bring forth children whether they are wanted, planned, affordable or not, and whether children's needs can be responsibly and accountably met, or not. It does seem strange that the social contract that underpinned the development of modern societies and governments controls much of our lives, yet not this important function.

Notes

1 https://wehavekids.com/having-baby/Most-Common-Reasons-Why-People-Want-Children

2 Other features of living organisms/creatures include the intake of food, a metabolic process of breathing whereby energy required by the cell/organism for its other functions is released with the uptake of oxygen and the formation of waste products such as carbon dioxide and other products to be excreted, growth, movement, sensitivity to immediate environmental changes and some response to it, and the varying ability to control its 'internal environment' – the composition of the plasma of the cell, and of the fluids within more complex creatures – optimally to enable other cellular functions.

CHAPTER 2

ARE CHILDREN WANTED, PLANNED AND AFFORDABLE?

Summary: Most pregnancies in South Africa are unplanned. The male parent's details are provided in less than 40% of all registrations of births. From a perspective of how children are looked after, by far most South African children are not within our means and undesirable: two-thirds of all children under six years of age live in the 40% poorest households in South Africa. In KZN, 80% of children under six live in poverty; in the Eastern Cape and Limpopo more than 70%. Infant mortality rate (mortality in under-one-year-olds) remains at 25/1000[1] live births, and 20% of children under five years of age are growth and developmentally stunted due to malnutrition. These data become even more disturbing considering that between 10-20% of pregnancies are terminated and can be added to the 'unintended' group.

According to the 2018 official publication of Statistics South Africa[2], approximately one million births were recorded in South Africa (2,1% more than 2016) during 2017, and just over one million in 2018,[3] with annual increases of about 2%. According to the Births and Deaths Registration Act (Act 51 of 1992), births should be registered with the Department of Home Affairs within 30 days through completion of form DHA-24. Timely registration took place in less than 88% of births in 2017, a tendency that has prevailed though decreased through to 2020. No information about the fathers had been captured on the forms in 62% (554 298) of births; similarly, so too through to 2020[4]. Many of these one-parent-family children are not planned or wanted[5], although of course that does not mean they were received without love: the most common name for both boys and girls was Enzokuhle (to do good), and the most popular middle names for girls were Precious, Princess and Angel, and for boys, Junior, Blessing, and Gift. Although children may be received and nurtured with love, the socioeconomic realities of many of these mothers/families are overwhelming in terms of their support base, ability to look after their children and their own further developmental possibilities. The 2016 *South African Early Childhood*

Review, an informative report on the plight of South African children six years and younger[6], paints a dark and disturbing picture. Two-thirds of these children live in the poorest 40% of households that are characteristically large (with many children) and unemployed (dependent on insufficient state grants).[7] Statistics South Africa identified three poverty levels in 2012:

- Upper level: income only sufficient for basic nutritional and non-nutritional needs (2014 figure: below R923 per person per month; 2021, adjusted at 6% inflation per annum, R1 335).
- Bottom level: income sufficient for basic nutrition at the expense of other non-nutritional needs (2014: below R594; 2021: R890 per person per month).
- Nutrition level: income insufficient to meet basic nutritional needs (2014: below R397; 2021: R624 per person per month).[8]

Because children live mostly in large, poor, unemployed families, their real poverty across all poverty levels is worse. Thus, 78% of children under six in KZN live in poverty; in the Eastern Cape, the figure is 75% and in Limpopo 74%. To illustrate the depth of this problem: the total number of children in the 0–5-year-old age bracket is approximately seven million. The younger the child the greater also the impact on her life and development: the first one thousand days of a child's life are to a great extent determinant for her future development. Poverty is perpetuated into the later life of the child: approximately 7 500 000 of the 19 600 000 children (38% of 0-17-year-olds) reside in the poorest quintile (20%) of the population, mostly in rural areas with elevated levels of poverty, unemployment, poor healthcare and general social services and schooling. One-third of all South African children six years and younger suffer from malnutrition; 59% of all children live below the upper poverty line. There is moreover a vicious circle of poverty, large families, and child neglect.[9] However, the child's problems already begin during pregnancy: this group of mothers receives no or little prenatal care because many of them (especially in the three mentioned provinces) live in rural environments. Yet there is progress: complete immunisation by age one year has risen from 70% (2002) to 90% (2014), and the number of women receiving any postnatal care whatsoever has risen from 5% (2009) to 74% (2014), even if statistics of this nature should be approached with caution. Nevertheless, the average infant mortality rate[10] in South Africa is currently still just below 25/1000 live births, with small annual decreases of less than 3% per annum[11], and as many as 20% of under-five-year-olds are stunted developmentally and in

terms of growth, with negative consequences in their later schooling and career possibilities.

In a 2011 study in suburban Cape informal settlements, 39% of women suffered from clinical depression during pregnancy; the corresponding rural figure was 47%. Depression is often accompanied by anxiety and has many causes, including the circumstances of the pregnancy, its desirability and socio-economic impact: the challenge of giving your child a good life amid your personal struggle to survive. Thus, both mother and child suffer, both are harmed, their future hopes shattered. The sad reality is that poverty in the poorest quintile of the population is common and affects the lives of many children.

It is reasonable to wonder if many of these pregnancies should not have been terminated[12] ... does it make any sense to bring children into the world if their only certain fate will be hardship and suffering? I hasten to add that this comment is neither intended, nor should it be interpreted as racist or discriminatory; it is a rhetorical question meant to probe and stimulate the reader to reflection. Although most terminations are in the disadvantaged sections of society, it is ironically also in these components of the population where the greatest *resistance to* termination transpires.

Being poor does not morally disqualify one from becoming a parent, nor does it necessarily mean having a child is irresponsible. Poverty is a systemic socio-economic dilemma in South Africa, and the poor can hardly bear the responsibility of their own poverty. Poverty has its roots in the history of colonialisation and apartheid which have deprived people of colour of equal human rights and the opportunities and ability to elevate themselves. Since the abolition of apartheid, corruption and state capture have diverted funds which could and should have improved the lives of many of the poorest to the pockets of greedy officials, so-called 'tender-preneurs' and ruthless businesspersons.

Notes

1 Though it has decreased from about 30/1 000 in 2017.
2 http://www.statssa.gov.za/?p=11472 and consequent links.
3 Compared with just over 3,6 million births in the USA in 2020 – with a population of 5,5 times that of South Africa.
4 This is partly due to the provision of clause 10 of the Births and Deaths Act which prohibits any details of unmarried fathers on the registration forms; this was deemed

to be unconstitutional in 2021 and will therefore be amended. For more details, see http://www.statssa.gov.za/?p=14902

5 Official estimates put the figure of 'unwanted' pregnancy at close to 63% of all pregnancies.

6 Hall K, Sambu W, Berry L, Giese S, Almeleh C and Rosa S. (2016). South African Early Childhood Review 2016. Cape Town: Children's Institutes, University of Cape Town and Ilifa Labantwana http://ilifalabantwana.co.za/wp-content/uploads/2016/05/SA-ECD-Review-2016-low-res-for-web.pdf

7 These are pre-COVID data.

8 https://www.statista.com/statistics/1127838/national-poverty-line-in-south-africa/

9 "Children in the poorest 20% of households are least likely to live with both parents: only 15% have both parents living with them, compared with 74% of children in the wealthiest 20% of households.

Less than one-third (29%) of African children live with both their parents, while the vast majority of Indian and White children (85% and 78%, respectively) reside with both biological parents. Almost a quarter of all African children do not live with either parent, and a further 46% live with their mothers but not their fathers. These figures are striking for the way in which they suggest the limited presence of biological fathers in the home lives of large numbers of children.

Younger children are more likely than older children to have co-resident mothers, while older children are more likely to be living with neither parent. While 12% of children aged 0 – 5 years (a total of 875,000) live with neither parent, this increases to 27% (1.6 million) of children aged 12 – 17 years."

Hall K (2019). Statistics on children in SA. UCT.

http://childrencount.uct.ac.za/indicator.php?domain=1&indicator=2

10 Number of children dying within their first year of life, per 1000 live births in the same year.

11 https://www.macrotrends.net/countries/ZAF/south-africa/infant-mortality-rate

12 The proverbial 'second prize;' the first would be prevention of unwanted pregnancy.

CHAPTER 3

TEENAGE PREGNANCIES: THE IMPACT OF PREGNANCY ON THE LIVES OF CHILDREN WHO HAVE CHILDREN

Summary: Although the figures from different publications are ambivalent and difficult to reconcile, tens of thousands of women of 19 years and younger give birth annually in South Africa; some, as young as 10 years old. In one study, it was found that 24% of female learners in one KZN school were pregnant at the time of study. Poverty is both a cause as well as a result of childhood pregnancy. Pregnant learners' futures and developmental possibilities are severely impaired: only one-third return to school, trail their peers, and of them, only one-third pass Grade 12. Pregnancy also poses many social disadvantages, exposes them to abuse, promiscuity and consequent pregnancies, and encourages sexually risky (risk averse) behaviour. Notwithstanding the difficulties of comparing and making sense of figures from various sources, the underlying message is unequivocal: a disturbingly high rate of teen and adolescent pregnancies.

Youth pregnancy is a major challenge to our country and our education system, and an important reason women cannot escape the poverty spiral.[1] An extensive review published in 2013 found that 30% of teenagers aged 13-19 reported to 'ever having been pregnant'.[2] According to Statistics South Africa (SSA), 1302 South African teenage girls (10-14-year-old children) had babies in 2017, down to 499 in 2020. The fathers in this group were older: 17-27. It is promising that the adolescent group (10-19-year-old) had dropped from 16% (2011) to 11% of all pregnancies, although the actual figure of 110 000 in that year is still disturbing.[3] However, the figures may be ambivalent, and the official figures are optimistically faulty. For example, a study conducted in May 2017 shows a 10-19-year-old figure of almost 14%. According to a Department of Basic Education report tabled in Parliament in August 2021, more than 36 000 babies were delivered to scholars aged 10-19 in the first quarter of 2021, almost 130 000 in 2019, and more than 136 000 in 2020. COVID-19 lockdowns with children not

attending school has contributed to a sharp rise[4], and child abuse, rape and statutory rape, and gender-based violence are underlying causatives.

The factors that lead to teenage pregnancies relate to poor socioeconomic conditions affecting the most vulnerable, and include:[5]

- Gender inequality.
- Gender based violence.
- Gendered expectations of how teenagers should act.
- Sexual taboos and permissiveness.
- Poverty.
- Schools in deprived areas, schools with no school fund contributions (implying poorer communities).
- Rural children, especially schools on private property (such as farm schools).
- Learners from mixed schools and schools with greater age distributions.
- Parents who are unemployed or working away from home.
- Children who have been orphaned due to acquired immune deficiency syndrome (AIDS).
- Personality factors such as low self-esteem, feelings of hopelessness and lack of future vision and of control over life.
- Peer pressure.
- Older men targeting young girls (*sugar daddies; 'blessers'*).
- Poor general and life orienteering education and skills, especially about relationships, sex, contraception, and poor scholastic progress before pregnancy.
- Lack of access to condoms (or ignorance about and/or unwillingness and/or inconsistent use of) and other forms of contraception, and TOP.
- Poor sex education and ignorance about fertility.
- Judgmental attitudes among some health care workers and teaching staff.
- Relationship problems.

African countries top the list of countries with the highest prevalence of teen pregnancies (many the result of teen marriages), taking the first twenty-three places with Niger at the top. The USA consistently tops the list of developed countries with some seventeen births per one thousand women aged between 15-19, annually.

The South African Bill of Rights guarantees access to quality education for all (as far as the state can afford it), and the Schools Act (Act 84 of 1996) prohibits discrimination against pregnant learners. Nevertheless, pregnancy often means the end of a learner's school career,[6] condemning her to a life of mediocrity from which she cannot escape, often to prostitution and human immunodeficiency virus (HIV) infection. This is more likely with a flawed support framework, stretched household finances, absence of carers for the baby (other than herself), a previously poor scholastic performance, and because of stigmatisation. School principals and managers are ignorant of, and/or deliberately and wilfully disregard the protective regulatory provisions mentioned above. The Schools Act obliges school attendance from ages 7 to 16, regardless of whether a pupil is pregnant or not, and the Bill of Rights prohibits discrimination of any kind. Pregnant pupils are nevertheless often illegally expelled. The Department of Education's 2007 guidelines on teen pregnancy[7] stipulate that no pupil may return to school in the year in which she gives birth, and that these mothers may be 'requested' to leave school for a period of up to two years (presumably to care for the baby), after which it is unlikely that she will ever return and may be destined to a life of hardship and mediocrity. Parental, particularly maternal, support, adequate finances, previous good academic achievement and seniority (being in grade 12), predispose to resuming schooling.

There is official recognition of the problem of teen pregnancy and an attempt, at this stage impossible to assess, to address the issue; Cabinet announced a Teenage Pregnancy Policy planned to be implemented in January 2022 to assist pregnant learners to return to school.

Below is a more-or-less chronological extract of statistics on teen pregnancy in South Africa:

- According to a comprehensive University of Cape Town (UCT) publication that provided information from different projects, the prevalence of teen pregnancy in South Africa in 1984 was 30%, and it dropped to 23% in 2008.[8]
- Heartening is that the under-seventeen figure has dropped from 13% to 5% over the same time (most pregnancies occur in the 18-19 age group).
- In 2003, the highest incidence of pregnancy in 15-19-year-olds was in Limpopo at 16,6%.
- In 2004, 51 of every 1000 female South African pupils were pregnant; four years later, it had increased to sixty-two.

- Between 2005 and about 2011, there was a general increase in teenage pregnancies.
- In 2008 it was estimated that 20% of 18-year-olds had already given birth, and by age 20 the figure had doubled.
- The UCT research cites the 2009 prevalence of teen pregnancy in the different population groups at:
  - Black: 71/1000.
  - Coloured: 60/1000.
  - Indian: 22/1000.
  - White: 11/1000 (the latter in line with developed countries).
- In 2010, some schools reported as many as twenty pregnant learners each.
- In 2011 it was reported that fifty-seven pupils were pregnant from a single school in Giyani, Limpopo.
- The same study showed that 25% of female youth stated that they had ever been pregnant.
- A school in Mpumalanga reported in 2011 that 70 of its learners were pregnant.
- A similar figure (70 out of 290 female pupils, thus 24%) was reported by a school in KwaZulu-Natal (KZN) in 2010.
- In 2012, 4,5% of 13-19-year-old women in South Africa were pregnant.
- Apparent 'good news' notwithstanding, there was a concerning increase of 78% in teen births *under the age of eighteen* in the 2017/18 year in Mpumalanga (a total of 5 609!).[9]
- The figure in some African countries is much more, in the order of one hundred per one thousand. The figure in Italy, in contrast, is only seven per 1000.
- SSA data from the 2017 *General Household Survey* showed that nationwide, 6,9% of 15-24-year-olds had declared that they had given birth to a living baby in the preceding year, down from 8,4% three years earlier. What makes these figures slightly suspicious is the unlikely low incidence in Mpumalanga (4,6%) against the Eastern Cape's 9,8%.[10]

The figures are ambivalent and at times difficult to reconcile, in part because of incompatible frames of reference, in part because of inconsistencies in the quality of underlying data. Nevertheless, teenage pregnancy is a serious and increasingly severe problem, tens of thousands of young girls' hopes of a better life are being destroyed, and thousands of babies and children are likely to be exposed to great hardships.