

SECOND CARNEGIE INQUIRY INTO POVERTY
AND DEVELOPMENT IN SOUTHERN AFRICA

Poverty and contraception: Family
Planning in the Western Cape
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POVERTY AND CONTRACEPTION - Family Planning
in the Western Cape

The best definition of Family Planning is that it equals Responsible Parenthood which in turn implies handling fertility with responsibility; not bringing a new life into the world without due consideration.

In 1968 Pope Paul VI in his encyclical Humanae Vitae, affirmed the principle of Family Planning. "Responsible parenthood may mean a decision, made for grave motives and with due respect for the moral law, to avoid for the time being, or even for an indefinite time, a new birth."

In many countries family planning is regarded as an essential component of integrated health and welfare services for all citizens and most people agree that everyone has a right to information on conception and contraception as well as access to readily available contraception services. In other words contraception is considered one of the necessities of life.

FAMILY SIZE

"The rich get richer and the poor get children." This phrase has passed into the vocabulary of those interested in population and fertility to confirm the fact that the poor tend to have large families. This is further emphasised by the large family: poverty: large family vicious circle, implying that any factors promoting small families will also reduce poverty and at the same time factors reducing poverty will lead to smaller families.

There is no simple definition of poverty and we do not have an adequate understanding of the behaviour which results in such high fertility. Janet Askham in "Fertility and

Deprivation" looks at various models for explaining the differences in various types of behaviour, and summarises "it is hypothesised that a variety of situational factors, such as economic insecurity, poverty, low status and powerlessness, combine to give a group which has poor chances of controlling its environment and which has the norms which arise out of these relatively poor life chances.

More specifically the sorts of characteristics of such a group are likely to be:

- (1) beliefs concerning the individual's powerlessness to alter his environment, a belief that his life is shaped by forces beyond his control;
- (2) a present-time orientation, a belief that it is impossible to plan for the long-term future;
- (3) feelings of inferiority in relation to other groups or individuals who in certain ways have control over him and will on occasions act in a paternalistic way towards him but will do nothing fundamentally to improve his situation;
- (4) adherence to the view that taking things as they come is better than planning ahead;
- (5) an inability to take decisions to construct "rational" plans for desired ends;
- (6) a pessimistic or fatalistic attitude towards the outcome of a particular situation or towards the future in general;
- (7) disbelief in the efficacy of individual effort, and the belief that one should accept things as they are and not attempt to change them. There may even be a positive evaluation of the present situation and a negative evaluation of change."

Can one see the large family as a result of adaptation to the lower-class situation of deprivation, insecurity and powerlessness where planning ahead does not seem relevant?

How many couples see fertility behaviour as an area in which they have a choice?

Since choice involves some experience of alternatives it is a case of "they don't know what they could have from life"? The correlation between poverty and fertility is not a simple one. Certainly improvement in education and the general standard of living leads to better motivation, better acceptance of family planning and a reduction in family size.

INFANT MORTALITY bears relationship to both poverty and contraception. The Infant Mortality Rate is closely related to the overall level of well-being in a community and reveals how well a society is meeting the needs of its people and demographic patterns around the world show a clear coincidence between high fertility and high infant mortality. Many observers have therefore concluded that mortality must play a similar causal role in determining fertility. Thus parents who expect their children to die, insure against such loss by having more children than they would if all the children had a good chance of surviving. By the same token, once they come to believe that all the children have a reasonable chance to survive to adulthood, parents reduce their family size goals accordingly.

Poverty related malnutrition is considered by WHO to be the worst medical problem in the world today. High fertility increases the demand for food and so compounds the problem. The major killers of infants are malnutrition, infection, immaturity and low birth weight, with malnutrition often setting the stage for death from another cause. In many societies malnutrition is seen to be the main cause of infant deaths because the causes of neonatal deaths are often a product of malnutrition of the mother. But poverty itself does not cause babies to die, and decent health need not await universal affluence. In many countries acceptance

of contraception resulting in fewer babies, well spaced, born to mothers over 20 and under 30, has lowered the infant mortality. Clearly efforts to eliminate the scourge of avoidable infant mortality must be matched by efforts to give parents the means to control their fertility and persuading them that it is in their own and their societies' best interest to do so.

THE TIMING OF PREGNANCIES is the aspect of fertility which has the greatest impact on the economic and social situation of the family. The frequency of early first births causes concern both because of increased health risks to females and children and because of the relationship between early first birth and large family size.

Early age at childbearing is associated with an increased risk of pregnancy complications, maternal and infant mortality and birth defects. These conditions constitute important public health problems and a drain on available resources, leading to further deprivation of the community.

Early pregnancy interferes seriously with the woman's social development and limits her future life options. Her education is interrupted or discontinued, limiting her chances of a career, her earning capacity and even her marriage chances. At an early age she becomes dependent on others, more often than not "the welfare", and eventually this becomes an accepted way of life.

Evidence from the USA suggests that women who have early first births experience more closely spaced subsequent births, face greater marital instability, are more poorly educated and have fewer assets and lower incomes later in life.

Recognising the relationship between age at first birth, large family size and economic hardship, several governments have attempted to raise the age at which men and women may legally marry in order to delay first births; eg. in China the age for a male is 23 years and a woman 22 years, whereas in S.A. the age for a man is 18 and a woman 15 years.

It is useful to look at the figures for various categories of births to determine which aspects of fertility influence the figures for different race groups in city, semi-rural and rural environments in the Western Cape.

Because early births, births to the over 35s and births of the order of 5 and over, together constitute "at risk" births, these categories are examined in Tables I to III. Table IV indicates to what extent these "at risk" births influence the total births. Unfortunately figures were not obtainable for all races from all the areas, but the figures for Coloured births are complete.

Table I. Births to mothers under 20. %of total births

	<u>White</u>	<u>Coloured</u>	<u>Black</u>	
City of Cape Town	7.9%	15,29%	16,4%	1982
Cape Divisional Council	5,8%	17,16%	13,5%	1982
Area 03	4,5%	20,9%	10,7%	1983
Area 04	4,4%	24,6%	21,4%	1983
Area 05	-	27,34%	-	1983

It appears that there is a slightly higher percentage of early births for Whites in the city as compared with the country areas. The Blacks show a marked increase in the country areas, but the figures for Coloureds show the most striking increase in the country areas. This marked difference between country and city may be due to better educational and work opportunities in the city as well as greater acceptance of contraception. The contraceptive

services may be more readily available, with greater privacy.

Some of the health workers in country areas complain that their young people come to the city to work, become pregnant and then return home to have the baby. All possible casual factors need to be examined in an effort to prevent early births.

Table II. Births to mothers over 35. % of total births

	<u>White</u>	<u>Coloured</u>	<u>Black</u>	
Cape Divisional Council	5,5%	7,16%	8,96%	1982
Area 03	4,4%	6,2%	9,9%	1983
Area 04	5,6%	6,3%	11%	1983
Area 05	-	6,30%	-	1983

Table III. Parity 5 and more. % of total births

	<u>White</u>	<u>Coloured</u>	<u>Black</u>	
Cape Divisional Council	2,79%	10,36%	17%	1982
Area 03	2,5%	8,9%	11,2%	1983
Area 04	2,5%	11%	17,4%	1983
Area 05	-	10,1%	-	1983

Clearly the over 35s do not present a great problem but the percentage of births of high order to Black women in the rural areas is disturbing. This may be because they have been slower to accept contraception and are less motivated to accept the small family norm. But the main reason for higher order births may be replacement of earlier infant deaths. These figures are analysed by health personnel at local level with due regard to this fact and the number of live children is taken into account when action is planned. Furthermore the reasons for such infant deaths are explored and used in the educational programmes.

Table VI. "At risk" births. % of total births.

	<u>Whites</u>	<u>Coloureds</u>	<u>Blacks</u>	
Cape Divisional Council	14%	34,5%	39,5%	1982
Area 03	11,4%	36%	31,8%	1983
Area 04	12,5%	41,9%	49,8%	1983
Area 05	-	43,7%	-	1983

These figures illustrate the enormous contribution of "at risk" births to the total number of births. Elimination of these births would not only benefit the lives of the women and children concerned, but there would be a reduction in the strain on community health and social services and in the long run the demographic effect would be felt at all levels - education, employment, housing and all other resources.

These "at risk" births are overwhelmingly due to early births, therefore the overall problem is one of timing of the first birth rather than the family size. This is not a new problem. Moster (1977) found that nearly 40% of the women interviewed in his study had given birth to their first child when in their teens. Prenuptial conception is a common occurrence and all the disadvantages of early pregnancy - health, social and economic, are compounded by the fact that the woman is still single.

Why should there be such a high percentage of early births and what can be done about it?

Public attitudes and policy with regard to contraception is still confused, especially as it effects young people and the legal position in S.A. is far from clear.

Professor S.A. Strauss states that in his opinion anyone supplying contraceptives to a minor below the age of 18, although contravening the Children's Act does not commit a punishable offense. But he feels that a person who

prescribes contraception without parental consent might accordingly be held to interfere with parental authority. Parental involvement in clinic services is clearly the answer. It seems obvious and rational to use the services provided, so why are they not used?

Personal experience with mothers in a rural area showed that mothers are prepared to look after their daughters' children but they are not prepared to take them to a clinic for contraception. This reluctance is part of the inability to plan for the future, taking things as they come, accepting the evil you know rather than the one you don't know.

Daughters become pregnant without any positive action on the part of their mothers who can therefore not be blamed. They can plead ignorance of a daughter's sexual behaviour. But if a mother were to take her daughter to the clinic or even advise her to use a contraceptive, she would acknowledge her daughter's behaviour and would seem to approve. How much easier to plead fear of what the contraceptive "will do to my child." Besides, looking after the baby is seen as being kind, helpful, hard working and self-sacrificing, part of her role as a mother.

(It is significant that throughout this educational project the health workers spoke about contraception for the 16 and 17 year olds whilst the mothers spoke about "my daughter of 14.")

Motivation of the "older women" in this area through group discussions and personal counselling has already had a marked positive response. All clinic and motivational staff are advised and encouraged to involve parents directly through family counselling, using parent advisory groups, parent discussion and training groups.

Teenage counselling and preparation for parenthood remains our most important task, but will not have the desired effect unless it is combined with parental involvement in clinic services for minors.

Many problems of the poor can be tackled by supplies of the right nutritional food, public health education, reduction of unemployment and the provision of welfare services and public amenities. But these measures can only be effectively applied in the context of environmental and community development. For any community development programme to succeed it must also include family planning.

Real poverty is often due to a lack of parenting resources resulting in children who suffer from emotional deprivation and lack of affection rather than the lack of material goods.

Successful family planning comes about as a result of both an individual's decision to use contraceptives and an environment that provides support for this decision and assures ready access to information and services.

Contraception is a necessity of life. Without contraception the deprivation of the poor is inescapable.

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Quoting (in context) from these preliminary papers with due acknowledgement is of course allowed, but for permission to reprint any material, or for further information about the Inquiry, please write to:

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