Black fertility patterns — Cape Town and Ciskei

MARY ROBERTS, M. R. RIP

Summary

The reproductive and contraceptive experience of 491 Black women in urban and rural areas (Cape Town and Ciskei) is presented. The ‘average woman’ in the sample was 31 years old and first became pregnant by the age of 19.8 years; she had had 3.5 pregnancies, 2.9 living children and wished for 3.9 children. Family size was related to the level of education, degree of urbanization and age of the mother. A sizeable minority of the women experienced at least 1 miscarriage or the death of at least 1 child. Most of the women (65.5%) used some method of contraception between pregnancies, and 57% were using contraception when interviewed. All but 20.7% of those using contraception were receiving an injectable progestogen (Depo-Provera). In urban areas a significant minority used oral contraceptives or sterilization for contraception. Very few women used an intra-uterine contraceptive device.

The results of our survey suggest that it is more difficult for the poor to maintain their desired family size. There is a need for family-planning services to be accessible to all, and especially to teenagers. The strongest motivation for a decrease in family size probably results from the settled family life and job opportunities which characterize urban life.


The study areas

The studies were carried out in an urban township near Cape Town (Crossroads) and an urban township near East London (Mdantsane), a settled rural area (Newlands) and a resettlement camp (Potsdam), all situated in Ciskei.

Crossroads is a large shanty-town near D. F. Malan airport, Cape Town, which houses 20 000 people. The inhabitants originally came from Ciskei or Transkei, most being legal contract workers who have spent an average of 18 years in this urban area, but some being long-term ‘illegal’ workers in Cape Town. In the main, the male residents are migrants (having brought their wives and families to Cape Town within the last 10 years), but there is a spillover of families from the three overcrowded townships housing ‘legal’ Blacks. A sizeable minority of the heads of households are women, and many wives have temporarily come from the rural areas, often bringing sick children for medical treatment. The character of Crossroads is therefore that of an urban migrant community.

Mdantsane is the largest township in Ciskei, located about 12 km from East London and established as a township in 1966. By 1978 it was the nineteenth largest urban centre in South Africa, officially housing 66 000 people. The present population comprises at least 200 000. The living conditions are very crowded and the unemployment rate is high, but most of the time the women live a settled family life. Most employed workers living in Mdantsane commute daily to East London. The character of Mdantsane is that of an urban settled community.

Newlands is a settled rural community in the Ciskei with a population of about 5 700. Some families farm for a living, but most breadwinners commute to work outside the area while still living a settled family life.

Potsdam is a recently established resettlement camp in a rural area to the north of Mdantsane housing the dependents of migrants. The estimated population is 8 000. The inhabitants have no arable land, and there are virtually no local employment possibilities. It is planned that 500 000 Blacks will live in the dormitory area reaching from Mdantsane to Potsdam, and that they will work in the greater East London area stretching to Berlin. The character of Potsdam is that of a rural migrant community.

Subjects and methods

The survey at Crossroads was conducted in October 1981; 201 women were interviewed at an outpatient clinic by two female community workers on weekdays, and 104 men were interviewed during weekends by a male bank employee. The Ciskei survey was completed in January 1983. In Mdantsane a community worker selected volunteer housewives who visited widely scattered houses and interviewed 183 women and 4 men. The Potsdam and Newlands surveys were carried out by a village health worker and a qualified teacher who interviewed 61 women and 2 men in Newlands and 46 women in Potsdam.

Questions were asked about age, age at first pregnancy, age at last pregnancy, number of pregnancies, number of living children, desired number of children, contraception used to space pregnancies, present use of contraception, number of years...
of schooling, satisfaction with one's partner and weekly income. Because there were too few male respondents for statistical analysis, only the figures for women were used for this purpose. Cross-tabulations were performed for all variables for the Crossroads and Mdantsane women only. In some of the tables given in this article some columns do not total 100% because of incomplete questionnaires.

Results

Demographic characteristics

The sample age pyramids for the urban areas were similar to one another and to that of the settled rural area, except that Newlands had a larger percentage of people older than 40 (24%) compared with 13% in Crossroads. By contrast, there was a remarkable lack of women in the 30 - 40-year age group at Potsdam (11% compared with 31% for the rest of the sample). The most obvious explanation is that these women were working in the town to support their families. The average age for the sample was 31 years.

Age at first pregnancy (Table I)

The average age at first pregnancy was 19.8 years. The vast majority first became pregnant when 15 - 24 years old (with only 10% of pregnancies occurring in women over the age of 25 years in Mdantsane and 22% in Potsdam). By the age of 20, 49% of the women had had their first pregnancy, the proportion being highest in the resettlement area of Potsdam (55.7%).

Number of pregnancies

The average number of pregnancies for the sample was 3.5; 57.8% of all the women had had 3 pregnancies or fewer, 30% had had between 4 and 6, and 10% had had more than 7. In Potsdam 15.7% of the sample had had 7 or more pregnancies compared with 8.8% of the urban women.

For Crossroads there was considerable spread from the median, the maximum number of pregnancies increasing from 3 (in those aged between 15 and 19 years) to 10 (in those aged between 45 and 49 years), the minimum remaining at 0 (in those up to the ages of 35 - 39 years). The Mdantsane pattern was similar, but had a somewhat smaller spread.

Number of living children

The average number of living children (Table II) of members of the sample was 2.9 (lowest in Mdantsane 2.6), 68% of the sample having 3 or fewer children. The number of living children increased with the age of the respondent, while the proportion of surviving children dropped as the number of pregnancies rose.

In the Crossroads series nearly two-thirds (61.1%) of the women who had had 4 pregnancies had miscarried in at least 1 pregnancy or had experienced the death of at least 1 child (Table III). Three-quarters (76.9%) of the women who had had 6 pregnancies had experienced a similar loss. The Mdantsane series showed a better survival rate, except for the larger families, where the numbers were small (only 10 families had 5 children and only 4 families had 6).

Number of children desired

The average number of children desired for the whole sample was 3.9 (Table IV). In the rural areas the figure was 4.3, as opposed to 3.3 for Crossroads and 2.9 for Mdantsane. The median number of children desired (4) was the same for all areas. The percentage of women wanting 3 or fewer children was 37.4% and was highest in Mdantsane (50%), while 22.5% in Mdantsane and 39.1% in Potsdam wanted 5 or more. There was a preference for larger families in the resettlement area. Women in Mdantsane wanted smaller families than those in Crossroads, perhaps in accordance with the settled urban family life which characterizes Mdantsane. In general, younger women wanted fewer children than older women. For example, in the 30 - 39-year age group only 20% wished for fewer than 4 children whereas in the 20-24-year age group 60%, and in the 15 - 19-year group 63%, wished for fewer than 4. This is probably because the older women belong to a rural culture, while the younger ones are more urbanized and westernized.

The study compares the number of children wanted with the number of living children. It was found that among women with up to 4 living children more children were desired, whereas among those with more than 4 living children the number living is the number desired. However, a substantial number of respondents wished for no further children. For example, in Crossroads 31% wanted the same number as they had and 9.1% wanted fewer; therefore, 40.1% of the sample wished to have no more. In Mdantsane 26.4% wanted the same number as they had and 6.7% wanted fewer, therefore 33.1% wanted no more.

In many cases the desire is for significantly fewer children. For example, 9.7% of respondents with 3 children and 6.1% with 4 children wanted only 1 child. Therefore, while there is a general
desire to have a family of 4 children, there is also a need for easily accessible family-planning services.

**Education**

Of the sample 15.7% were illiterate, having had a maximum of 2 years of schooling, but there was a considerable variation in illiteracy rates, from 9% in Mdantsane to 26.1% in Potsdam. The median education level of all the areas was Standard 5. In Potsdam 15.2% had completed a maximum of 1 year of schooling, and an equal number had completed only 3 years; 29.8% of the sample had attained Standard 6 or higher and 3.7% had matriculated. Almost all the matriculants came from Mdantsane and Newlands, reflecting the higher standard of education in settled communities.

As expected, the more educated generally had fewer pregnancies than the less educated. Thus, the median level of education of those who had had 8 pregnancies was Standard 1, and of those who had had 5 pregnancies Standard 5. Those who had attained Standard 6, 7, 8 or 9 had far fewer pregnancies than the less educated, most of the respondents at this educational level having had only 1 or 2 pregnancies. By contrast, almost all respondents who had only passed Standard 1 or 2 had had 3 or more pregnancies.

**Contraception used to space births (Table V)**

Of the sample 65.5% used some method of contraception between pregnancies, most commonly injectable Depo-Provera (34.4% of the sample). Virtually the same percentage (34.3%) did not use any form of contraception for spacing, this figure being highest in Potsdam (65.2%). In the migrant areas, fewer women were using contraception for family spacing. Oral contraceptives were seldom used except in Mdantsane (20.2%). While Depo-Provera dominated at all ages, methods used for family spacing differed greatly according to age; many of the older women but hardly any of the younger women had used breast-feeding as a spacing method. There was a tendency for oral contraceptives to be used more by older than by younger women. In the Mdantsane sample 78.5% of the 15-19-year-olds used some method of contraception between pregnancies, the commonest being withdrawal (35.7%); only 21% used Depo-Provera. In Crossroads only 44.4% of those aged 15-19 years used contraception to space pregnancies. In the 40-44-year age group fewer than 50% of women were protected against pregnancy.

**Contraception currently used (Table VI)**

Depo-Provera was still the major method used (44%); 43% used no method of contraception. This last figure was highest in Potsdam where 71.7% were unprotected, and lowest in Mdantsane and Newlands where 27.5% and 31% respectively were unprotected.

Seventy-two per cent of the women in Mdantsane and 58.1% in Crossroads were currently using some method of contraception. Depo-Provera was the only method in use in Potsdam. Oral contraceptives were used in the urban areas (11.2% in Crossroads and 16.9% in Mdantsane) but by only 3.4% in Newlands. Of the total sample 3.7% had been sterilized. Only 1.6% of the women were using an IUCD and in 3.3% of cases partners used condoms. Again use of Depo-Provera dominated in all age groups. The percentages of women using recognized methods other than Depo-Provera were 29% (Crossroads), 28% (Mdantsane), 25.8% (Newlands) and 0% (Potsdam), giving an overall percentage of 20.7. Oral contraceptives and sterilization were used more by older women, sterilization becoming a significant birth control method by the time women in the urban and settled rural areas reached the age of 35 years (18% of women in the age group 35-39 years were using this method).

No significant correlation was found between marital satisfaction and the other factors. Most respondents stated that they found their spouses satisfactory. In Mdantsane, 10% stated that they found their spouses unsatisfactory compared with 20% in Crossroads.

Levels of income were not analysed because the data were considered unreliable.

**Discussion**

'sSeveral attempts have been made to develop economic and socio-economic theories to explain under what conditions people actually decide to reduce the number of children that they will have. Three stages can be distinguished in attitudes towards having children:

1. A positive desire to have many children.
2. A positive desire for a limited number of children but an absence or insufficiency of positive motivation necessary for satisfying this desire.
3. Positive motivation sufficiently strong to limit the number of children.'
The attitudes a couple may have in this respect have been associated with urbanization and industrialization. It is more difficult in every way for the poor to maintain their desired family size. The cultural, economic and social pressures on and expectations of the poor are different from those of the affluent.

Important findings from this survey were the number of children lost through miscarriage and the high child mortality rate. This rose with the number of pregnancies. The desire for more children may partly stem from a desire to compensate for this loss. This desire is more evident among women in the resettlement area, older women who already have large families, and women with a low standard of education. Perhaps the wives of migrant men wish for more children to compensate for the loneliness and anxiety of being separated from their spouses for most of their lives.

It is known that delaying the first pregnancy until the mother is over 20 years of age reduces pregnancy and neonatal losses. In the rural (particularly resettlement) areas, mothers are migrant workers and must leave their children in the care of others, a situation not conducive to good mothering, adequate nutrition or the survival of the child. Employment for the breadwinner in a place where his wife and children can live with him will ensure that more pregnancies result in live children. Employment for the woman so that she can feed her children has a similar result.

The median family size in all areas for women aged 30 - 34 years is 3 children, a surprisingly low figure. Only the older women have more children, but we do not know whether the 30-year-old women will have further pregnancies in their thirties and forties.

The desired family size must be reduced both from the point of view of the family (because incomes per person are so low), and from the point of view of the population. Factors influencing fertility are income, education, urbanization and work opportunities for women. Religious and ethnic groupings are less important. Conditions must be created so that the family can live together where there is employment for the breadwinner. This will reduce the loss of children and therefore the desire for a large family.

This study shows that women with little education have large families and want more children. In order for women to find an alternative role to childbearing, education and job opportunities must be available to young women. Urbanization helps women of all ages achieve this goal.

The overall percentage of women in this survey using contraception is high. Surprisingly, all but 20.7% used Depo-Provera, although both injectable and oral contraceptives are readily available in all areas. Nursing staff may favour one method, but it seems that the women prefer the injectable to the oral contraceptive. Most women probably find it unacceptable to protect themselves against pregnancy daily, when they are separated from their spouses for all but a few weeks of the year. Therefore contraception may not be accepted by the wives of migrants, or by women who have lost their partners through desertion or death. This attitude may also prevail among women who have lost children or have had miscarriages.

The results indicate that women should be able to discuss their needs in order to attain their desired family size. Informal, accessible counselling and contraceptive services, especially for teenagers, are desirable.

The settled family life and job opportunities which normally characterize urban life are probably the strongest motivating factors for keeping down family size. The best contraceptive may well be a stable family life in conjunction with adequate employment opportunities.

We wish to thank Mrs Mampi Romotsamai, Mrs Mavis Makeleni and Mr Clayton Mdinga for conducting the Crossroads survey, and Dr Trudy Thomas and her helpers for organizing and carrying out the Ciskei survey. We wish to thank Professor D. A. Davey, Dr Esther Sapire, Dr Magriet Kemp and Mrs Amanda Roux for valuable advice.

REFERENCES