A literature review on the socio-economic context of pregnant women and girls in the Western Cape with the primary goal to inform crime prevention strategies

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Prepared by: **Sandra Marais**

Ilse Eigelaar-Meets

Prepared for: **CSIR**

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A literature review on the socio economic context of pregnant women and girls in the Western Cape with the primary goal to inform crime prevention strategies

1. Introduction

As part of an initiative to develop safety plans for 24 police precincts (see Table 1) within the Western Cape Province the CSIR developed 14 key areas for possible project development and implementation [Support for pregnant women and girls; Dealing with substance abuse; Early childhood development; Domestic violence; Community mobilization; Victim support and dealing with trauma; Recreational programmes for children and families; Feeding and health programmes; Schooling; Diversion programmes; Gun violence prevention and gun reduction; Child abuse; Effective and trusted law enforcement and; Community reintegration]. The purpose of this report is to present an in-depth discussion on the first identified key area, *Support for Pregnant Women and Children.*

Table 1: 24 Targeted police precincts in the Western Cape

1. Cape Town Central	2. Gugulethu
3. Khayelitsha	4. Nyanga
5. Philippi	6. Mitchells Plain
7. Elsies River	8. Kleinvlei
9. Bishop Lavis	10. Philippi East
11. Kraaifontein	12. Langa
13. Vredenburg	14. Bellville
15. Worcester	16. Kuils Rivier
17. Grassy Park	18. Manenberg
19. Vredendal	20. Harare
21. Lingelethu West	22. Paarl
23. Mfuleni	24. Delft

With the focus on support for pregnant women and girls, this report takes as point of departure the ideal type of a well-functioning family unit settled within a supportive and involved community. In building its argument the report first argues for the pregnant woman and child as the primary agent for crime prevention within a family-based crime prevention strategy. Subsequent to a discussion of the risk factors related to the single mother due to her socio-economic context, the concept of well-functioning families as a crime prevention strategy is introduced with a specific focus on the role of the father. As final agent in a crime prevention strategy focusing on support mechanisms for pregnant women and

girls, risk factors embedded in the community characteristics are considered. Finally the report concludes with a discussion focused on support mechanisms that will assist pregnant women and girls during her pregnancy and then during early motherhood to build a home environment that will aid in the creation of a functional family necessary for the physical, psychological and social development of a child.

2. Fertility rates in South Africa

In reviewing literature on the fertility rate in South Africa there seems to be general agreement amongst researchers that fertility began to show a decline among all major population groups in South Africa prior to the end of apartheid (HSRC, 2003; Moultrie & Timæus, 2003). By analyzing 1996 and 2001 Census data as well as the 1998 Demographic and Health Survey, Moultrie and Timæus (2003) show a declining fertility rate for South Africa since the 1960s. The above authors as well as the HSRC report on Fertility (2003) place this marked fertility transition as among the most advanced in Sub-Saharan Africa. More recent data confirm this slowdown in fertility with a total number of 1 199 712 births registered for the year 2006-2007 by the Department of Home Affairs. This represents a decline of 10% in registered births (1 346 119) for the same period in 2005-2006. Although part of this figure could be attributed to late registrations, it is accepted that the data do confirm a continuing slowdown in fertility rates (Statistics South Africa[a], 2007:8).

With the community survey conducted by Statistics South Africa in 2006, women aged between 12-50 years were asked to provide information relating to their last born child and to the total number of children they have ever had (including those children that have died). The age specific fertility data show that fertility peaks at the age groups 20-24 and 25-29. For the age group 15-19, there were approximately 54 births per 1 000 women. Regarding differences in fertility for the different population groups in South Africa the 2007 Community Survey shows the Black African population as the group with the highest fertility rate [2,7 children per women], followed by the Coloured population group [2,3 children per women] with the lowest rate [1,4 children per women] for the Asian and White population groups. The total fertility rate estimated from the age specific fertility rates is 2,5 children per women (Statistics South Africa[b], 2007:56-57).

In spite of a general decline in fertility, teenage pregnancies[1] are still a major concern for government, communities and researchers. According to Ehlers (2003:17) approximately 17 000 babies are born to mothers younger than 16 years of age in South Africa annually. For the Western Cape there are reports showing that 2 000 schoolgirls fell pregnant in 2008 (Cape Argus, 26 June 2009:14). According to the South African Human Rights Commission teenage pregnancies accounts for one third of all births in South Africa (2007:7). Earlier statistics provided by the South African Demographic Health Survey (1998) found that 35,1% of all teenagers had been pregnant or had a child by the age of 19 (HSRC, 2003:14; Jewkes et.al., 2001:733). In a cross-sectional household study of 16-20 year-olds living in Soweto, Umlazi and Khayelitsha, Richter (in Jewkes et al, 2001:734) found 66% that of respondents reported to have had sex, with a mean age for sexual initiation of 16.4 years.

According to the HSRC (2003:14) teenage pregnancies are more prevalent among Coloured and African girls, particularly those with little or no education. The use of contraception amongst young girls and boys is another aspect that needs mentioning. In her study testing adolescent mothers' knowledge and perceptions of contraceptives among teenage mothers in Tswane, South Africa, Ehlers (2003:19) found that the majority of participants lacked information on contraceptives. Reasons provided for not using contraceptives, included that their mothers did not approve, they were ignorant about contraceptives, they were afraid to go to the clinic because their mothers might find out, they feared picking up weight and/or never being able to have children and their boyfriends opposed their use of contraceptives. For the teenage mothers that did indicate to have used contraceptives, the lack of practicing and/or maintaining effective contraception resulted in impregnation.

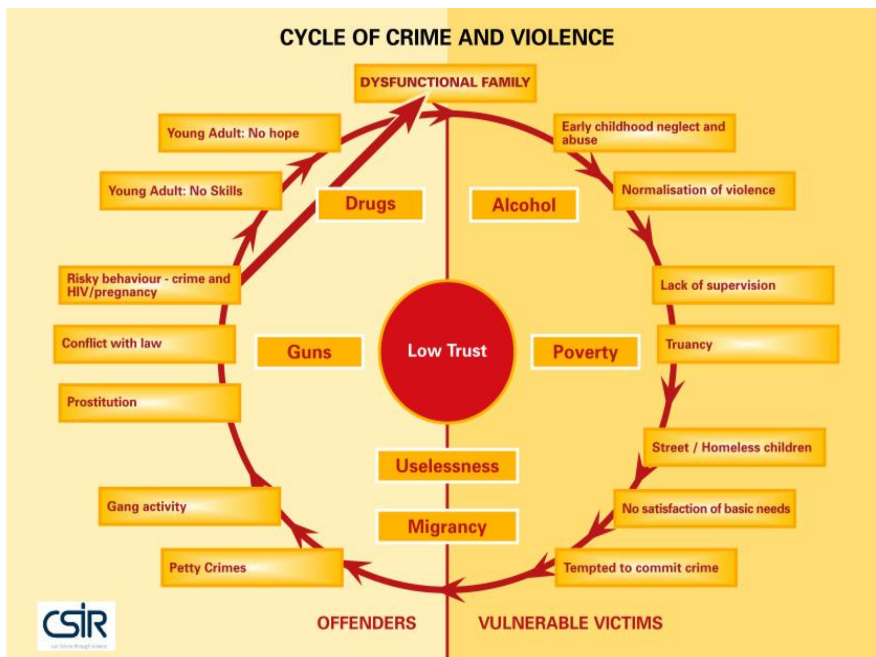
3. The focus on pregnant women and girls as an agent for crime prevention

Why a focus on pregnant women and girls as active agents in developing crime prevention strategies? In the model developed by the CSIR (2009), illustrating the cycle of crime and violence, the 'dysfunctional family' is illustrated as the point where neglect and abuse of children starts, showing a transgression from the initial victim to offender completing the cycle as a member within a dysfunctional family

[1] A teenage/adolescent mother is any mother age 19 or younger at the time of the birth of her baby, irrespective of the pregnancy outcome or her marital status (Ehlers, 2003:15)

carrying the legacy to its descendants (see diagram 1 for illustration of cycle). Although prevention strategies targeted at different phases within the 'crime cycle' has shown various levels of success, the most successful strategies have proved to be those that focus on the family and directly address identified risk factors. *Family based crime prevention can directly address [those] risk factors, with substantial success. The more risk factors they address, perhaps the better (Sherman, 2009, Chapter 4:33)*. The focus here is thus on **primary prevention,** that is, interventions focused on the prevention of crime before it occurs (Krug et al, 2002:15). A focus on the pregnant woman and girl presents a platform for primary prevention strategies as it presents the opportunity for early access to the family set-up in which the child is to be born.

Diagram 1: Cycle of Crime and violence



Barbara Holtmann (CSIR)

A great wealth of literature exists on defined risk factors leading to criminal behaviour. The remainder of this section will attempt to categorize risk factors relating to the pregnant women/girl and therefore influence the level of functionality of the family, as well as support systems, or the absence thereof related to the new born infant. For the sake of the argument risk factors are organized according to the

ecological model put forward in the WHO World report on violence and health on the level of the individual [pregnant woman and girl], the family, and the community (Krug et al, 2002:15).

4. Risk factors related to the individual [pregnant women and girls]

4.1 Teenage pregnancies

As indicated earlier, the high rate of teenage pregnancies is to be approached as an aspect of great concern considering the far-reaching consequences for the young mother and her child. This is especially a matter of concern for African and Coloured teenage mothers who are among the poorest and most disadvantaged groups in the country. A teenage pregnancy often results in the mother leaving school and terminating her opportunities for personal development, consequently rendering her more vulnerable to poverty, exploitative sexual relationships and violence, as well as a low self-esteem (HSRC, 2003:14). According to Community Agency for Social Equity (CASE) estimations are that one in every eight (13%) young women has been forced out of the education system as a result of pregnancy. The Department of Health (1999) presents the following statistics on the pregnancy rate for girls within the age group 15-19 years for the different population groups - African: 17, 8% (13,4% urban; 21.1% non-urban); Coloured: 19,3%; White: 2,2% and Asian 4,3% (National Population Unit, 2000:2). The majority of teenage pregnancies are neither planned nor wanted, with the father of the child seldom taking responsibility for the financial, emotional and practical support of the child. Sexual activity at a young age also increases the risk of HIV infection and transmission (HSRC, 2003:14).

In their study on relationship dynamics and teenage pregnancy, Jewkes et al (2001) identify indicators of social circumstances and relationships of the teenagers with their boyfriends, focusing on the first ever and current relationships. Using a multiple regression model the researchers identified the following factors that was most strongly associated with teenage pregnancy: Having frequent sex (once a week or more) without injectable contraceptive protection; having a larger household size; not living in a brick house; not living with the biological father; talking openly about sex with a boyfriend; and perceptions that most friends are pregnant. Other risk factors identified are: Age of boyfriend with pregnant teenagers significantly more likely to have boyfriends who had already left school and the fear of being beaten. Pregnant teenagers were significantly less likely to cite love as the main motivation for sex and more likely to identify fear and experience of coercive sex. Two thirds of the teenagers indicated to have

been beaten by a boyfriend, with pregnant teenagers reporting more episodes abuse (Jewkes et al, 2001:736-738).

Research has also shown that the parent/child relationship has a significant impact on teenage pregnancy risk. When discussing the parent/child relationship, Miller and Benson (2001) refer to three concepts of parental support, that is, parent/child support (connectedness), control (regulation), and parent/child communication. In terms of parental/child connectedness, research show that parent/child closeness is associated with reduced adolescent pregnancy risk through teens remaining sexually abstinent, postponing intercourse, having fewer sexual partners, or using contraception more consistently. Parental control/regulation has also been shown to be related to teenagers' sexual behaviours in ways that would lower their risk of pregnancy (not having sex, later sexual activity, or having fewer sexual partners). Lastly in relation to parent/child communication about sexual issues, studies have found that open, positive and frequent parent/child communication about sex is associated with adolescents not having sexual intercourse, postponing sexual activity or having fewer sexual partners. Some studies have also shown a positive association between parent/child communication and adolescent contraceptive behaviour.

4.2 Alcohol abuse

Alcohol consumption can be considered as probably one of the most important risk factors to pregnant [teenage] mothers in South Africa due to its deeply-rooted nature in the South African society. According to Matzopoulos (2008), the annual per capita alcohol consumption is estimated at between 10.3 and 12.4 liters (including homebrewed alcohol) equating to spending of R41 billion in 2006. Although probably underestimated due to poor reporting rates, household surveys indicate that approximately 50% of males and 20-30% of women in the country currently consume alcohol. In terms of individual consumption rates it is estimated at approximately 20 liters of absolute alcohol per drinker per year, among the highest in the world (Marais et al, 2009).

Alcohol abuse is an important risk factor to control when developing crime prevention strategies, specifically in the South African context. Not only does it give rise to numerous negative impacts for the abuser but also for the broader society. Matzopoulos (2008:1) sites the large numbers of school-age adolescents that misuse alcohol resulting in absenteeism, academic failure, increased likelihood of drug abuse and risky sexual behaviour, again leading to higher risk to HIV infection and teenage pregnancies.

Alcohol consumption also carries great risks for the pregnant [teenage] mother due to the harm it inflicts to the unborn child. The maternal use of alcohol during pregnancies may result in a child being born with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorders (FASD) which is one of the leading causes of preventable birth defects and developmental disabilities globally (Marais et al, 2009). Not surprisingly, given the general high consumption rate in the country, South Africa has the highest measured FAS rates in the world with the highest rates recorded for the Western and Northern Cape Province in excess of 40 cases per 1000 of school entry children compared to less than 20 cases per 1000 school entry children in Gauteng Province. In a large epidemiological assessment of alcohol consumption during pregnancy undertaken in South Africa (1996), findings from more than 600 women attending routine antenatal clinics in three distinct geographical regions in the Western Cape showed that 1 in 4 women are drinking heavily and placing their unborn child at high risk of FAS (editorial notes, South African Medical Journal, September 1999). These figures are in sharp contrast to the average FAS rate for the USA quoted as between 0.05 – 2.0 per 1000 children and the average rate for the developed world as 0.97. Prevalence rates among selected high risk groups in the USA are between 2.3 and 8.5 per 1000 live births (Marais et al, 2009).

The birth of a baby with FAS has great consequences for both the mother [and father] and the child. The mother has to learn how to cope with a child suffering from developmental disabilities. The World Report on Violence and Health (2002:69) specifically refer to the impact of factors such as low birth weight, prematurity, illness and physical or mental handicaps as factors that may make the child more vulnerable to abuse. Abused children are again prone to later delinquent behaviour (Krug et al, 2002). The consequences for the affected child are also great with the primary disabilities associated with FAS being intellectual and behavioural impairments that lead to the secondary disabilities of not coping as well as others of the same age and having poor social judgment and emotional problems (Rendall-Mkosi et al, 2008). They are neither able to comprehend the consequences of their actions, nor are they able to generalize completely what they learn in one situation to another. Moreover, they are easily influenced by others due to poor judgment ability (Mitten, 2004, Section 9:1).

4.3 Socio-economic environment of the [teenage] mother

As noted above the impact of teenage pregnancies have far-reaching consequences for the young mothers, especially for those from the African and Coloured communities who are among the poorest and most disadvantaged groups in the country. Although the Western Cape has the lowest

unemployment rate in the country (18%, well below the national average of 26%) when compared to other provinces, the inequality in terms of race is clear, with black Africans of working age showing the highest percentage of unemployed persons (23%), followed by Coloured individuals, with Whites showing the lowest number at only 2% (Stats SA, Provincial Profile, 2004). In this context of both high national and provincial unemployment rates, not being able to at least complete her secondary educational career, nor pursue further educational opportunities, leaves the teenage mother more vulnerable to poverty.

It is also important to note that young girls in South Africa often find themselves in abusive relationships. This can be attributed to the patriarchal nature of the South African society together with its violent political history. The use of physical violence as a first line strategy to gain or keep a position of ascendance or resolve conflict is common. In trying to understand why young girls tolerate abusive relationships, the young people's everyday reality has to be understood. Especially for the African and Coloured communities a great number, if not most, grow up in townships or rural areas with little recreational facilities and opportunities for advancement. With a high unemployment rate, employment prospects after completing their schooling career is also limited. It is in this context that sexual relationships are often a replacement for recreational facilities and a form of gaining the respect (building self-esteem) among their peers. For young women sex also holds opportunities for material gain as it is used as a currency for exchange, particularly with older men (Jewkes et al, 2001:735).

Although unemployment figures show a near equal rate for men and women in the Western Cape [6% and 6.2% respectively] (Statistics South Africa[b], 2004), women often find themselves in a more vulnerable situation as the primary care givers of children, with little or no support from the fathers (HSRC, 2003:16). Many mothers in the South African context also find themselves as single parents, left with the burden of caring for the child/children and earning the means to do so. With higher unemployment rates and lower income levels for women than for men, these households are materially worse off and more vulnerable to impoverishment, than domestic formations headed by or formed around a man or a conjugal couple (Jones, 1999:13). Research show that there is a strong relationship between female headed households and the incidence of poverty (Dungumaro, 2008). According to Chant (in Dungumaro, 2008) there are several persuasive factors that attribute to the prevailing perception of the feminization of poverty. These include disparities in rights, entitlements and feminization of labour. These have been described as the 'triple burden' that has to be carried by

women, i.e. (i) the disadvantage that women experience in the labour market and other means of income, (ii) dual tasks as child minder and breadwinner which results in time constrains and (iii) higher dependency since in most cases women in these households are single earners as opposed to male headed households who are mostly joint earners (Dungumaro, 2008).

In terms of childcare, poverty often implies a household environment characterized by overcrowding and unstable family composition as the family frequently changes as family members and others move in and out. Studies from a range of countries show that these factors increase the risk of child abuse and chronic neglect. In terms of family structure and resources Krug et al (2002) state that physically abusive parents are more likely to be young, single, poor and unemployed and to have less education than their non-abusive counterparts. In both developing and industrialized countries, poor, young, single mothers are among those at greatest risk for using violence towards their children. Although not such a strong risk factor but one to be considered is the parents' own history of child abuse. Data seems to suggest that parents who were abused as kids are also more at risk to abuse their own (Krug et al, 2002:67).

An interesting view on single female-headed households, and of interest to this discussion, is a study by Jones, (1993) amongst women in Bathurst in the Eastern Cape. The study found that some women appear to weigh up the cost benefits of singlehood relative to conjugality, and then choose singlehood. From the study it would seem that on the one hand the economic circumstances of women-led households were boosted, relative to others, due to certain economic benefits which accrue to them in particular, often not accounted for in research on domestic economy. On the other hand, male partners tend to bring to their families extra costs and they usually control the expenditure and consumption. It would seem that for these reasons the women in the Bathurst study took a view that they had a better chance of domestic stability and economic security if they set up their own homes and entered into a co-operative housekeeping and child-rearing partnership with other women. *They were more assured of support for themselves and their children; they were in a better position to prioritise basic needs and to control consumption and expenditure; they spread responsibility for generating income between a number of co-operating partners; they distributed the risk of unemployment between themselves and other women, and they were better able to control the number of children they had to rear* (Jones, 1999:25). Off course such an organization as described here presupposes some form of existing social network amongst the women of a specific community.

5. Well-functioning families as a crime prevention strategy

The importance of families in forming and developing their members has been described by a large number of studies worldwide. According to the WHO (2002:33) violence in adolescence and adulthood has been strongly linked to parental conflict in early childhood and to poor attachment between parents and children and the level of family cohesion. Geronimus (2003) confirms this, placing parental behaviour together with the family environment as central factors in the development of violent behaviour in young people. Poor monitoring and supervision of children by parents and the use of harsh, physical punishment to discipline children are strong predictors of violence during adolescence and adulthood.

Given the social reality of families at risk, (the) parent(s) often find themselves unable to cope with the pressure of raising their children. The effect of rapid social changes, economic hardship together with the breakdown of traditional methods of raising children have left parents feeling overwhelmed, unskilled and powerless in communities that are largely under resourced. Although children are born with their own genetic make-up and potential and their development influenced by many people and experiences, the child's early family environment plays a pivotal role in the ultimate development of the child's potential. Thus, despite the many structural changes of families and their various environmental challenges, the family continues to be the primary institution through which children pass en route to adulthood (www.theparentcentre.org.za). A family characterized by its strength, stability, consistency and supportive family, creates an environment that allows for the optimal development of its members as it:

- Helps reduce behavioural problems, risk of getting into trouble with the law and other developmental challenges;
- Contributes to a better quality of life – with improved health, coping mechanisms, problem-solving capacity and higher self-esteem
- Increases academic performance and school attendance rate;
- Increases the spirit of caring and generosity, i.e. ubuntu - not just for household members but also society at large;
- Lowers stress for adults, thus increasing levels of productivity;

- Instills a sense of pride and connectedness to community and society, which are great ingredients for productive and pro-social citizens.

(ChildrenFIRST, 2004:12)

5.1 The issue of fatherhood

One aspect that often greatly impacts on the stability of a family is the absence of a responsible and involved father figure. The absence of and the lack of male responsibility in reproductive decision-making and health, as well as in childbearing and child rearing is a very real issue in South Africa today (HSRC, 2003:16). This lack of involvement in fertility and family issues has been greatly attributed to the migrant labour system as the point where the issue of the absent father initially arose (ChildrenFIRST, December 2004:2; HSRC, 2003:16). *Men had to go away to work to earn money; women stayed home in rural areas where they had to care for children. Often, absent fathers stopped sending money home and women had to take on the role of childrearing without the support of the fathers. The situation eventually prevailed also in African townships outside of the homelands, with women taking the main or even exclusive responsibility for children* (HSRC, 2003:16).

Other factors that are cited as shaping the current social role of fatherhood are (i) the high unemployment figure, (ii) the slumping of marital rates and (iii) bio-medical interventions to control fertility from the mid-1970's[2] (ChildrenFIRST, December 2004:18). According to Hunter (ChildrenFIRST, December 2004) men place a high value on fathering children and on the social roles of fatherhood, but while biological fathering is relatively easy to achieve, fulfilling the social role of fatherhood is much more challenging. He writes: *Yet, even when a man accepts paternity he is unlikely to be able to afford to pay inhlawulo (damages for impregnation) and almost certainly not ilobolo (bridewealth). Still more unlikely is that a young, unemployed, man will be able to fulfill a provider role and support his child. Abandonment – usually seen as a male, particularly African male, phenomenon – has to be seen in this context* (ChildrenFIRST, December 2004:18).

Marriage plays a central role in the concept of families, historically forming the basis of family life. As in many Sub-Saharan African societies marriage has been known to happen early and universally among adults. For the South African case however it would seem that changes in the socio-economic landscape

[2] Note the reference to a decline in fertility numbers cited by Moultrie et al, even before these bio-medical interventions (p.2)

also left its mark on this historical institution of which the most noteworthy are delays in entering into marriage and generally low marriage rates (ChildrenFIRST, December 2004:146). The decline in marriage rates in itself is probably not that significant; however, when viewed against current fertility rates the importance of this trend for the existence of family structures which includes a father, mother and children becomes very clear. When comparing marital and fertility rates it would seem that marriage has lost its value as a determinant of fertility. (HSRC, 2003:14). In a recent survey by the South African Institute of Race Relations (Fast Facts survey on South African families) it was found that an estimated 40% of South Africa's 18 million children are being raised by single mothers. The survey found that 52% of African parents in urban areas were single [primarily mothers], followed by Coloureds [30%], Whites [24%] and Indians [7%]. Africans were found to have the highest number of living absent fathers [50%], followed by Coloureds [37%], whites [11%] and Indians [8%] (Sunday Times, 12 July 2009; John Kane-Berman, 2009:5).

The absence of fathers within family structures is a fact of great concern and one that needs to be addressed when speaking of well-functioning families. A recent study in the UK, where 24% of children are raised by single parents, found behavioural problems, underachievement at school, mental health problems, alcohol and drug abuse and the inability to form lasting relationships as the most common negative effects of single parenting (Sunday Times, 12 July 2009). It is in the light of all of this that there has been a recent call for the inclusion of the father when searching for solutions to a well functioning family as an aspect for inclusion in crime prevention strategies.

6. Risk factors embedded in community characteristics to consider in developing crime prevention strategies

In the above section individual risk factors relating to the pregnant woman and girl important to consider when devising crime prevention strategies was discussed. The section to follow presents some risk factors inherent to the community of which the pregnant woman and girl forms a part. Although a relatively young discipline, the science of crime prevention offers more than a century of research on community characteristics related to higher risk for violent crimes. In classifying community risk factors one framework is to distinguish by community composition, social structure, oppositional culture, legitimate opportunities, criminogenic commodities and social and physical disorder within the community. The remainder of this section will draw on a report by Sherman et al (1997) to briefly discuss each of these risk factors.

6.1 Community Composition literally refers to the community profile of a specific community. Unmarried or divorced adult males, teenage males, non-working adults, poor people, persons with criminal activities and single parents have all been identified in the literature as groups whose presence is associated with higher rates of violent crime in a community. According to Sherman the literature is however unclear on whether higher numbers of these types of individuals automatically result in a higher total of individual risk factors, or whether there is a tipping point associated with the concentrations of such groups of people (Sherman et al, 1997, chapter 3:3).

6.2 The *Social Structure* of a community refers to the manner in which community members interact with each other. For example, children of single parents might not be at greater risk of crime because of their family structure. But a community with a high percentage of single parent households may put all its children at greater risk of delinquency by reducing the capacity of a community to maintain adult networks of informal control of children (Sherman et al, 1997, chapter3:4). This social structure of a community would also include aspects such as the level of social capital existing within a community, that is, the degree of cohesion and solidarity that exists within a given community (Krug et al, 2002:69).

Social Capital as concept is however broader than just the existence of forces that bind a community together. It also includes resources outside the individual or community members that could be accessed, in this case by the pregnant woman and girl, to assist her during her time of pregnancy and later as mother (i.e. clinic services, educational services for the mother and baby, economic support services, etc.). According to Geronimus (2003:89) the well-being of children and families, and by extension, the vitality of communities, is likely to be enhanced when the adults charged with the primary care of children have reliable social resources outside themselves.

6.3 Another aspect classified by Sherman is the existence of an *Oppositional Culture* in a community. In communities with high crime rates, the pattern of the rising of an oppositional culture resulting from a lack of participation in mainstream economic and social life has long been identified: Bad becomes good and good becomes bad. *Given the apparent rejection of community members by the larger society, the community members reject the values and aspirations of that society by developing an "oppositional identity". This is especially notable in terms of values that oppose the protective factors of marriage and family, education, work and obedience to the law"* (Sherman, 1997; Chapter 3:4).

6.4 High rates of youth violence are also linked to areas where there is a concentration of *Criminogenic Commodities*. Commodities that are linked to high crime rates are for instance alcohol, drug and gun use as well as high concentration of outlets where drugs and alcohol is sold (Sherman, 1997; Chapter 3:5).

6.5 The last risk factor classified by Sherman is that of *Social and Physical Disorder*. According to the author recent work on the "broken windows" theory of community crime causation suggests some support for the theory. This theory holds that in communities where both people and buildings appear disorderly, the visual message that the community is out of control may attract more serious crime. This may be as a result of spiraling fear of crime among conventional people, who subsequently use the area less and thus provide less informal control. Communities that deteriorate over time are observed to suffer increased rates of violence (Sherman, 1997; Chapter 3:5).

7. Discussion

The central theme of this paper is an argument for the important role of pregnant women and girls as active agents within crime prevention strategies. The investment in the physical, psychological and social health of pregnant women and girls directly impacts on the physical, psychological and social health of the unborn, newly born and young child with the ultimate goal of preventing possible later delinquent behaviour in the child. This focus on pregnant women and girls could possibly be interpreted as an indirect approach to crime prevention as the focus for intervention is on one group (pregnant women and girls) with the measurable outcome in another (that is the unborn and newly born child). The focus of such intervention strategies would thus be to create support structures that would assist those pregnant women and girls most at risk during pregnancy and early motherhood, and to help them build a home environment that will aid in the creation of a functional family necessary for the physical, psychological and social development of a child.

Given the various risk factors discussed in the above section, it is clear that the development of an intervention programme with the focus on pregnant women and girls at risk will have to comprise of various strategies focused on the different areas of risk, i.e. the individual, the family and the community. Considering the far reaching consequences for the pregnant girl, specifically those living in high risk areas characterized by poverty and often in dysfunctional set-ups, the first approach to an intervention strategy would be preventative in nature. Given the context wherein the greater majority of teenage pregnancies occur, research seems to strongly suggest the need for intervention strategies

that go beyond merely information sharing on contraceptive use and safe sexual practices. Strategies should concentrate on information together with support structures within the different areas. Young people need to understand the consequences of their actions and the available alternatives. They need to be empowered to realize that they have choices and believe in their ability to make informed decisions.

Research has shown that pregnant women and girls need support as well as information on the different aspects associated with the development of their unborn and born child. For instance, pregnant women and girls should be informed *and understand* the harmful impact of alcohol and drug abuse on their unborn child. On an institutional level this is a task that stretches beyond, but does not exclude, the health sector (specifically clinics) but should also involve NGO's and schools. Together with the sharing of information there is a strong need for the restoring of well-functioning families and assisting parents to take up their parenting rolls to raise children driven by values that contribute to society.

The strong link between delinquent behaviour and parental conflict in early childhood, and poor attachment between parents and children and the influence of this on family cohesion, is of great concern given the current state of families in South Africa. This is evident from formal statistics together with daily reports of child abuse, neglect and abandonment. Child neglect and abuse figures for the City of Cape Town are alarming with 1 670 cases reported in 2006/07, 3 599 new cases in 2007/08 and 3 324 in 2008/09. Cape Town Welfare alone had to deal with a total of 336 cases in the period January-March this year [2009], compared with 256 cases in 2008 and 135 in 2007 (Weekend Argus, 13 June 2009:1).

The crisis in which the South African family finds itself is clearly depicted by statistics on family composition and the shrinking of marital figures. 70% of African women between the ages of 20 and 24 who have given birth have never married. The figure for Coloured women is 64%, for whites 19% and Indians 12% (Kane-Berman, 2009:5). The absence of fathers is a stark reality for a very large percentage of children in the South African society. Intervention programmes focusing on re-establishing the importance of well functioning families have to include a central focus of involving fathers in the pregnancy and rearing of their children. Another important point in a programme focusing on the re-establishing of the South African family is assisting parents in taking up their parenting rolls by teaching them parenting skills that will enable them to rear children that are founded with a secure environment

and driven by positive values and discipline. The importance of the family in the fight against crime is probably best illustrated by John Kane-Berman when he writes about the family as *"the key institution for socialization and the transmission of values"* (Kane-Berman, 2009:5).

When focusing on risk factors embedded in the characteristics of communities it is important to realise the potential in terms of support, both structural and emotional, as well as acting as a source of informal control. Community values need to be established that mirror and support those embedded in a well-functioning family and will result in support structures for pregnant women and girls: Supporting them in taking responsibility for their pregnancy and later for the responsible rearing of their children. Institutions that can play a supportive role in the moral regeneration of a community are the family, schools, youth clubs, sport clubs and religious organizations.

8. Recommendations

Principles for prevention programmes

- Preferably target co*mprehensively*, i.e. do not focus only on the individual, but also on risk factors in the family and community.
- Focus on *Primary Prevention* – the most successful strategies have proven to be those that focus on the family and directly address identified risk factors, in our case risk factors affecting pregnant women and girls. The earlier you start with prevention the better, and the rewards are much greater later on.
- Programmes/projects should be *long term*. It takes time to establish a programme and for people to trust and accept the legitimacy of a programme.
- Introduce intervention strategies that go beyond mere information sharing - concentrating on *support structures* within the different areas have a bigger chance of succeeding.
- *Programme impact* should be monitored and evaluated.
- *Short- and long term goals* should be formulated.
- *Institutions* that can play a supportive role in the moral regeneration of a community are the family, schools, youth clubs, sport clubs, religious organizations. These institutions should become involved.

- Do not underestimate the power of *social networks* in a community.

Important issues that need to be focused on

- Healthy pregnancies, mother and child bonding and nutrition
- Nurturing skills
- Information on the effects of alcohol on the unborn child
- Parenting skills - assisting parents in taking up their parenting rolls by teaching them skills that will enable them to rear children in a secure environment with positive values and discipline
- Strengthening of families and family cohesion
- Handling conflict with your partner, your parents and your child
- How to prevent child abuse, neglect and abandonment of children
- Absent fathers - Intervention programmes focusing on re-establishing the importance of well functioning families have to include a central focus on involving fathers in the pregnancy and rearing of their children
- Teenage pregnancies – why does this happen and how to support pregnant teenagers
- Early childhood development - programmes with mothers/parents on the importance of early stimulation of the child, of crèches and of sending the child to grade R
- How to create a safe environment for the child
- How to be an involved father figure
- Taking responsibility for your life and life choices

9. Examples of intervention programmes tested/active in the Western Cape

A) Intervention project (Medical research Council and Foundation for Alcohol Related Research)

The effect of Brief Interventions on the drinking behaviour of pregnant women, in a population with risky drinking behaviour – a cluster randomized trial

Background

With the high rate of alcohol consumption in South Africa and with Fetal Alcohol Syndrome the highest in the world for the Western and Northern Cape, the findings of this study is of great value specifically as possible intervention programme within a broader crime prevention strategy.

Aim of the intervention programme:

The main objective of the intervention was to test the effectiveness of a series of brief interventions with pregnant women on their alcohol consumption and drinking behaviour during pregnancy.

Setting:

Women from disadvantaged and high risk backgrounds attending state health clinics in a rural district, Western Cape Province, South Africa

Outcomes:

- Both the intervention and control groups demonstrated declines in alcohol consumption, although results showed that assessment plus brief intervention (intervention group) was more effective than assessment and written material alone (control group). In addition it was found that women who are honest about their drinking are ready to change their drinking habits.

- 60% of the women in the intervention group had stopped drinking by the last follow-up visit just before birth. One third of the group reported a change in their drinking behaviour after the first brief intervention session.

- Importance of support given to pregnant mothers. There is an indication that the success of the intervention was strongly influenced by the information and support given by the trained field worker. Regular contact with the same person developed into a trusting relationship and this in turn facilitated informed decision making by women.

Conclusion:

Given the importance of alcohol abstinence during pregnancy, the impact of brief interventions has shown to be a powerful tool in the primary care settings among these risky drinking women from a rural area in South Africa. Provision of information and an understanding, supportive attitude seems to be the crucial agents for behaviour change.

B) Home visitation programmes with a focus on parent training in reference to the Parent Centre in Cape Town

Background

Home visitation programmes bring community resources to families in their homes. This type of intervention has been identified as one of the most promising for preventing a number of negative outcomes, including youth violence and child abuse. During the home visits, information, support and other services to improve the functioning of the family are offered. The focus of home visitation programmes is the enhancement of parenting skills and raising the level of coping of parents. This is accomplished by presenting the parents with information on child care and child development (both pre- and post-natal), helping parents to improve their skills in managing their children's behaviour, and creating a social network that lends emotional support to the mother and father during and after pregnancy.

The Parent Centre Cape Town

Information from webpage: www.theparentcentre.org.za

The Parent Centre was established in 1983 and provides education and training workshops, home visiting programmes, community talks, support groups as well as parental counseling. Currently the centre is based in Cape Town and have a number of special projects/progammes in Hanover Park, Mitchells Plain, Khayelitsha, Gugulethu, Nyanga, Crossroads, Imizamo Yethu (Houtbay), and Phillipi.

Vision

The Parent Centre strives to contribute to a society in which every parent/caregiver is able to raise resilient and well-balanced children in ways in which they can develop their full potential, protected from victimisation and abuse in communities free from violence.

Mission

The Parent Centre is a non-profit organisation working mainly in the Western Cape. Through primary prevention, they aim to:

- Facilitate the safety and healthy emotional development of the child from birth to early adulthood;
- Promote the well-being and self-esteem of the parent/caregiver;
- Prevent child abuse, victimization and neglect;
- Contribute to the prevention of teen pregnancy, substance abuse and HIV and AIDS;
- Enhance the child's capacity to be resilient, caring, competent and creative member of society; and
- Encourage the establishment of a loving, nurturing environment that strengthens the family and society.

This is done by working directly with parents, caregivers and educators – and indirectly by collaborating with other people and organisations which support and work with parents.

Services

- Individual counseling programme
- Parenting skills training programme
- Teenage parenting programme
- Support groups for mothers and toddlers, mothers and babies and teenage mothers
- Community education and awareness
- Training of trainers
- Behaviour management training programme
- Parent infant home visiting intervention

C) MOSAIC (Training, Service and Healing Centre for Women)

Information from webpage: www.mosaic.org.za

MOSAIC is an NGO active in the Western Cape Region, and educates the public about abuse, and counsels abused people and their families. They conduct support groups, workshops and training courses on abuse/assertiveness/conflict resolution, counseling skills and the Protection Order procedure. Mosaic delivers a range of social support services and projects to clients (mainly women and girls) caught up in gender violence and those infected and/or affected by HIV/AIDS. All support services have been determined by the clients' real and perceived needs and by various community leaders and forums, are free, culturally appropriate and easily accessible to clients.

Main services and programmes

1. Court support services

Mosaic offers support services to the Department of Justice. People who visit their office at the court, may expect the following services:

- Crisis counselling
- Education and information on domestic violence and abuse
- Court Processes and Procedures
- Assistance with the completion of Application forms for Protection Orders
- Assistance with the writing of affidavits for traumatised applicants
- Referrals to other service providers, as needed
- Information on Sexual and Reproductive Health, HIV, and where to access these services

2. Social Services

Caring for, protecting and empowering abused people.

- Individual, couple and family counselling for survivors and perpetrators
- Support groups
- Awareness talks and workshops on abuse and domestic violence
- Referrals to other resources
- Networking, campaigning and partnering
- Material assistance
- Youth and men's programmes
- Hotline against trafficking of people: 0800 555 999

- Legal and human rights education
- Sexual and reproductive information and rights

3. Sexual and reproductive health rights

Providing access to sexual and reproductive health care for abused people

You have the right to:

- Enjoy sexual health
- Make choices about your own body
- Decide if and when to have sex
- Say no or yes to sex
- Choose your partner
- Choose a contraceptive that you think will be right for you
- Access to contraceptives for safe sex and other reproductive health services
- Choose whether or not, and when, to have children
- A sexual relationship free of violence and coercion
- Access to unbiased information about reproductive health and
- sexuality education in order to make informed choices
- Be treated in a dignified and confidential manner when seeking reproductive advice

4. Training services

Mosaic offers training programmes enabling:

Life skills

- Assertiveness, parenting, coping with anger, conflict and loss

Job skills

- Catering, baking and small business skills
- Counselling skills for the helping professionals
- Integrated management of domestic violence
- Implementing a court support project

Permaculture skills

- Planting vegetables for better nutrition
- Legal and human rights education

SIMELELA CENTRE FOR SURVIVORS OF SEXUAL VIOLENCE

The Simelela Centre provides a comprehensive 24 hour service for survivors of sexual violence in Khayelitsha, Cape Town. The Centre offers a 24 hour, 365 day service which includes forensic examinations and medical intervention – with strong emphasis on HIV prevention – counselling, as well as social and police support.

Vision:

Simelela aims to facilitate the physical and psychological healing of survivors of sexual violence, and to empower and restore to them the dignity undermined by acts of sexual violence.

Mission

To engage in a multi-disciplinary strategy, together with multiple role-players, that respondents to the physical, psychological, social and criminal justice repercussions of sexual violence, and to challenge the myths and misconceptions surrounding the scourge of sexual violence in a bid to ultimately eradicate it.

Key focus areas

The Centre offers the following services to women, men and children, 24 hours a day, every day of the year.

Emergency Medical Care

- Forensic examination
- STI treatment
- Post Exposure Prophylaxis (PEP)
- Emergency contraception
- Voluntary testing for HIV

Follow up Medical Care

- Pregnancy tests at 6 weeks
- HIV testing at 6 and 12 weeks

- Referring HIV positive patients
- Referring survivors for unwanted pregnancies

D) Fatherhood project

Information from webpage: www.hsrc.ac.za/RPP-Faterhood-1.phtml

Background

The Fatherhood project, was an action research project with the aim to promote fatherhood - men's care and protection of children. This project was developed in reaction to unacceptable high levels of child abuse, including sexual abuse, much of which is perpetrated by men, and father's absence from a large number of families. The primary funder for this project is Save the Children, Sweden.

Objectives of the project

- To provide public information about men, fathers, family life and children's development.
- To generate public discourse by persuading government as well as non-governmental, community and faith-based organisations, and the popular and professional media, to focus their attention more on fatherhood and the need for men's care and protection of children.
- To prompt increased funding for the inclusion of men and fatherhood-related projects by national and international donors in the government, non-government and private sectors.
- To encourage organisations, donors and the government to include fatherhood-related activities in their programming.
- To stimulate research on the effects on men, children and families of increased male involvement in childcare.

Aims of the project

- Provide information about men, fathers, family life and child development;
- Influence social experiences and perceptions about men and their care for children;
- Rally peer professional support to enable men to be more involved in children's lives;
- Create a sense of shared responsibility for children's development among men and women;
- Engender broad based and long term commitment to men's involvement with children;
- Identify and address barriers to men's engagement with and protection of young children; and

- Embark on focused research around fathers and caregiving with a view to developing community-based interventions.

How we hope to affect men:

- To encourage men's positive responses to the care and protection of children;
- To sensitise men to the effect that their involvement has on the well-being of children as they grow up;
- To enable men to become actively engaged in childcare;
- To support men in responsive, responsible and committed fatherhood;

Note: The current status and activities of the Fatherhood project could unfortunately not be determined. The last newsletter posted on the website was dated October 2007. There does however seem to still be an active office in Durban, contact could however not be established.

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