SOCIAL INTERACTION OF TEENAGE MOTHERS DURING AND AFTER THEIR PREGNANCY

***De VILLIERS FPR*,** BA, MMed, FACP, PhD, FCPaed
***KEKESI J*,** MB ChB, MMed
Department of Paediatrics and Child Health, Medical University of Southern Africa

Correspondence to: Prof FPR de Villiers, Department of Paediatrics and Child Health
PO Box 221, MEDUNSA, 0204, South Africa, Tel No:+ 27-12-521-4445
Fax No: + 27-12-521-3627, e-mail: johnchild@medunsa.ac.za

Keywords: adolescent, pregnancy, social interaction, post-partum

SUMMARY

Extensive attention has been given to adolescent sexuality and teenage pregnancy in the past 30 years, yet many teenagers still fall pregnant. A teenager who becomes a parent is at a significant disadvantage in becoming a contributing adult, both psychosocially and economically. The objective of the study was to describe the social interaction of teenage mothers at Ga-Rankuwa Hospital during and after their pregnancy.

Seventy teenage mothers were interviewed using an interview schedule. Thirty-four of them stayed with both parents, 19 with the mother only and the rest with relatives or their partner's mother. Only one was married (by customary law), and most (59%) had known their partner for 12-24 months. Fifty-two talked to someone when they discovered that they were pregnant, nine were too scared to do so and the other nine were unaware of the pregnancy until it was discovered by a family member. Most (58) wished to return to school within a year, seven wished to find work (after first looking after the baby), and two wished to get married.

In conclusion, the majority of teenagers who fall pregnant do so while still at school. Teenagers are at risk of unwanted pregnancies. Few first tell their mothers about the pregnancy, although most talk to someone soon after discovering that they are pregnant. Most, however, retain the support of their families during and after the pregnancy.
(SA Fam Pract 2004;46(2): 21-24)

INTRODUCTION

Despite the extensive attention given to adolescent sexuality and teenage pregnancy in the past 30 years, many teenagers are still falling pregnant.[1,2] "For many teenagers, sex has become morally equivalent to other casual, free time activities that they enjoy together, and until we confront this problem effectively, children will increasingly risk disease and early death", wrote Rollo May, a psychiatrist, who continued, "the Victorian nice man or woman was guilty if he or she did experience sex; now we are guilty if we don't."[3]

At times, teenagers feel that they are unique and invulnerable to harm. Someone else may become pregnant after intercourse, but not them.[4] They are constantly being exposed to sexual titillation on television, in movies, and in popular music on the radio and in music video clips.[5] Furthermore, some teenage pregnancies are not entirely unplanned and the ambivalent feelings that some teenagers have may deter them from seeking contraceptives and from using them consistently.[6]

A teenager who becomes a parent is at a significant disadvantage in becoming a contributing adult, both psychosocially and economically.[7,8,9] Premature sexual intercourse results in high rates of sexually transmitted diseases, adolescent pregnancy and abortions,[10] also in the Western Cape, where the median age at intercourse is 15,1 years.[11]

Children of teenage mothers are at an increased risk of cognitive and psychological deficits. The combination of cognitive, emotional, academic and social problems amounts to "massive school failure" for these "children of children"[1] These problems are attributable to poor parenting, lower socioeconomic status and disadvantaged neighbourhoods.[1,12] A few studies find a higher likelihood of abuse of children by teenage mothers.[1]

The aims of the study were to describe the social interaction of the teenage mothers of babies born at Ga-Rankuwa Hospital during and after their pregnancy.

METHODS

A descriptive survey was carried out in the Neonatal and Obstetric Units of Ga-Rankuwa Hospital over a six-month period. Teenage mothers (13 to 19 years) who delivered in hospital were identified from the maternity register; they were interviewed between 24 and 72 hours after delivery (if delivered vaginally), and between

72 and 96 hours after delivery (if by caesarean section). Many were discharged within 24 hours, thus many eligible subjects were not available for inclusion. Mothers who were too ill to be interviewed, for example those with eclampsia and postpartum depression, were excluded. The subjects were interviewed (by JK) using an interview schedule, seeking demographic data and social interaction during pregnancy and after delivery, such as who she lived with and who provided financially, membership of community organisations, length of relationship with the father of the child, whom they confided in about the pregnancy, who will look after the baby and their long term plans. The schedule was used in a pilot study on ten mothers and adjusted where necessary; they were subsequently included in the study. The interview schedule was written in English and translated into Tswana. Most of the subjects, even those belonging to other ethnic groups, were able to communicate in Tswana. A few were interviewed in English. Four mothers were excluded because they could speak neither language. Informed consent was obtained from all subjects. The study protocol was approved by the Research, Ethics and Publications Committee.

RESULTS

Interviews were conducted with 70 teenage mothers (between 13 and 19) with a mean age of 17,5 years (± 1,28, SD). Most (57; 81%) were 17 years or older, 10 (14%) were 16 years old and one each was 13 (she had been sexually molested), 14 and 15 years old.

Almost half (34; 49%) lived with both parents, 19 (27%) with their mother only, and 12 (17%) with a relative. In four cases the teenage couple lived with the parents of the baby's father. One teenage mother lived with her single father. The people whom subjects lived with and the financial provider tended to be the same.

Thirty-seven subjects were involved in different community organisations. Twenty belonged to a church fellowship, seven each to a music group or sports team, and three to a dance group. Of the 33 who were not involved in community organisations, 15 had a hobby (either reading or gardening) and 18 had no outside interests.

Eleven (16%) of the subjects had been pregnant before. Five of them stated that they were going to start using contraceptives consistently. Only one of the 70 was married, in which case it was by customary law, i.e. lobola had been paid. The length of time that they had known their partners is shown in **Table I**; this time includes the period of the pregnancy. In two cases there was no relationship: one had been sexually molested, and in the other case the period of contact was so brief as to preclude calling it a relationship. The majority of the subjects (59%) had known their partners for 12-23 months, almost a quarter had known them for 24-35 months, while 10% had known them for more than three years.

Fifty-two (74,3%) talked to someone when they discovered that they were pregnant, while 18 (25,7%) told no-one. Nine of the 18 were scared to talk to someone and the other nine were not aware that they were pregnant. The family discovered them to be pregnant within a period of three to seven months of gestation. Of the 52 who had told someone, 17 (32,7%) told their partner first, 12 (23,1%) told their mother first and 23 (44,2%) told friends, neighbours or the partner's mother. How long the mothers took to talk to someone after they missed their periods is shown in **Table II**; about a third took two months, about a quarter took less time (i.e. only one missed menstrual period), while another quarter took three months. The other nine subjects took between four and six months before they were willing to confide in anybody.

In 60% (42) of the cases, the subject's mother, together with the teenager herself, would take care of

Table I: Length of Relationship

Time (months)	Number	Percentage
None	2	2,8
Less than 12 months	4	5,7
12-23 months	41	58,6
24-35 months	16	22,9
36-47 months	5	7,2
More than 48 months	2	2,8
Total	70	100,0

Table II: Time taken to tell someone about the pregnancy

Time	Number	Percentage
<2 months	12	23
2 months	17	32
3 months	14	27
4 months	4	8
5 months	3	6
6 months	2	4
Total	52	100

Table III: Future plans of the subjects (N = 70)

Plan	Number	Percentage
Back to school within the following year	58	82,8
Look after baby for some time, then look for a job	7	10,0
Study part time while working	2	2,9
Get married	2	2,9
Don't know	1	1,4

the baby. Other would-be caretakers were the partner's mother (6; 9%) and other relatives (20; 29%). Two subjects did not who would take care of the baby at the time of the interview. The mothers were asked what they planned to do after discharge **(Table III)**, and although only 55 were at school at the time of pregnancy, 58 wanted to go back to school full time and two wanted to study part time. Ten percent wanted to look for work after they had cared for the baby for an appropriate amount of time; two planned to get married.

DISCUSSION

In many countries, having children outside of marriage is considered to be a social problem and the children are termed illegitimate.[13] When this happens to teenagers, the matter is considerably worse.[2] There are, however, circumstances in which this may not be as serious a problem. The increasing incidence of premarital childbearing in Africa has been variously explained. Firstly, traditional social controls over the sexual behaviour of teenagers by the extended family is becoming less binding,[13] and traditional mores are changing rapidly due to contact with Western cultures. Secondly, unmarried women may use sexual relations and pregnancy to achieve marriage. Thirdly, in some societies, premarital fertility is widespread and culturally acceptable.[13] Lastly, in certain communities in South Africa, there is a custom that a woman needs to prove her fertility by having a baby before marriage can be considered. Nevertheless, as we have shown, teenage pregnancy is common in our area, whether the practice is considered harmful for the teenage mother, her infant, or the family within which she finds herself or not.

The opinion exists that, due to the deficiencies of quantitative research studies on teenage pregnancies, which are usually cross-sectional and focus on a number of negative outcomes without an alternative perspective, the negative consequences of teenage pregnancies are exaggerated. This point of view stresses that teenage mothering is a rite of passage to adulthood, especially where middle-class aspirations do not apply.[14]

In 1994, 31% of the mothers at Paarl Hospital were teenagers,[15] adolescents constituted 26% of the deliveries at St Barnabas Hospital in the Transkei,[16] and 356 (24%) of the 1 470 admissions to the neonatal unit in Ga-Rankuwa Hospital were born to mothers younger than 19. The neonatal unit admits ill babies: well babies stay with their mothers in obstetric wards. Eighteen percent of the 355 patients with incomplete abortions admitted to the Ga-Rankuwa Hospital's Obstetric Unit were 15 to 19 years old and 54 (85,7%) of those had been induced.[17] The mean age of the mothers in our study was 17,5 years, compared with 16,6 years in McAnarney's study.[18]

Teenage fathers are increasingly living apart from their children;[1,9] this leaves most teen mothers with the burden of raising their children single-handedly or having to leave the children in the care of grandparents in order to earn a living. Some cannot find work because of a lack of education and have to rely on welfare.[1,16] Emotional problems such as depression, drug and alcohol abuse are all risks for the mother.[19]

Family break-up was shown to contribute to a high incidence of teenage pregnancy in South Africa in a study of Durban Zulu schoolgirls.[20] In the present study, about half the mothers did not stay with both parents. Other studies have shown that teenagers reared by single mothers are more likely to become pregnant than those from a family of married parents.[1,2,21]

Only 37 (52,9%) of the teenage mothers were involved in some community organisation or other; of note is that the majority of them (20) were involved in churches. The church plays an important role in the lives of most communities in South Africa. For example, Craig and Richter-Strydom,[20] as well as Vundule et al.[22] more recently, found that the youth in their studies displayed a marked commitment to the church. However, none of our subjects mentioned the church as a source of information of any kind. Churches are important institutions where teenagers can be reached and educated, but this seems not to be taking place. The church frequently takes care of the sick and hurting. Some people wish to be morally responsible, yet are constantly aware of their own sexuality. The question arises whether the church could do more to help and support this group of people?

In our study there was only one mother who had never attended school, compared with Kulin's finding of 17,6%.[23] Six of the 15 who were not at school at the time of conception already had a child to look after. In the USA, when a teenage pregnancy is allowed to continue, the girl is likely to have an early repeat pregnancy, especially if the first pregnancy resulted in an interruption of schooling.[2,24] Eleven of the mothers had been pregnant before. Roberts and Rip, in their study of black fertility patterns in Cape Town and the Ciskei, found that the average number of pregnancies in 49% of the teenagers studied was 3,5.[25] In this study, one mother was pregnant for the third time and 10 (14,3%) for the second time.

"As an increasing percentage of adolescents reach their sexual debut at younger ages, effective contraceptive methods ... become even more critical. The potential for a reduction in unintended pregnancies in adolescents and a reduced need for abortions is a welcome prospect."[26] Of the 36 (51,4%) who had never used contraception, 18 mentioned that they never thought that they would fall pregnant. This attitude has been described before.[4] The fact that many young people who become pregnant have access to suitable facilities but do not utilise them, is due to experimentation, rebellion and a certain degree of risk-taking behaviour, as well as unresolved emotional issues regarding sexuality.[2,4,11]

Almost all the mothers in our study were unmarried. It has been argued that this should not be seen as a problem.[13,14] Most subjects (59%) had a sexual relationship with their partners for 12 to 23 months (period of pregnancy inclusive) and

only 6% had a shorter relationship. This contrasts with the study that showed that half of adolescent pregnancies occur in the first six months after the initiation of sexual activity.[27] It is also of interest to note that four (5,7%) actually wanted a child and stopped taking contraceptives. In Craig and Richter-Strydom's study[20], none of the pregnant girls interviewed had wished to become pregnant, while in Flisher's study[11], 20,0% had wanted to become pregnant.

Eighteen (25,7%) of the teenage mothers did not talk to anyone about their pregnancy. Nine were unaware that they were pregnant until it was discovered by a family member. Of the 52 who talked to someone, only 12 talked to their mother first, while 17 talked to their boyfriends. This probably indicates the tremendous amount of emotional upheaval that teenagers go through during this time. At the time when they need their parents the most, they are unable to reach them due to fear and confusion.[1,2] Thirty-one (31) talked to someone about their pregnancy two to three months after missing their first menstruation, which is still early enough for good antenatal care.

Adolescents report infrequent communication between them and their parents about sex. When communication occurs, it concerns societal expectations and sexual safety. Mothers tend to communicate more often than fathers, and more often to girls.[28] Teenagers rate communication with parents about sexual matters as unimportant, especially if they experience little communication.[28] If parents do not talk to their children about sex, it should not be surprising that so many delayed broaching this delicate, and to some shameful, subject for so long.

Two mothers mentioned that they would like to get married. More wanted to go to school in the following year than were attending school at the time of conception. The fact that they were already lagging behind at school did not seem to deter them from wanting to study further. Craig and Richter-Strydom state that teenagers are ambivalent about what they want, as well as unsure about how to get it.[20] In the aforementioned study, 62% of the girls wanted to look after the baby themselves, 60% wanted to go back to school after the pregnancy and 54% hoped to obtain professional, postmatric qualifications.[20]

Few studies on adolescent pregnancy consider the possibility that, apart from social problems, psychological or psychopathological problems or drug abuse may be present in the pregnant teenagers.[29] Our study was not designed to consider this matter, but it would be a fruitful avenue for research.

Responsible sexual behaviour is based on openness rather than repression and on teaching youngsters that saying no is more grown up than assuming that everybody does it.[5] Promoting abstinence for teenagers and at the same time advocating safer sex through the use of condoms is a mixed message, but it is necessary and realistic.[30] In the absence of intervention programmes, a sizable proportion of adolescent mothers will become pregnant again within one year of giving birth.[24]

Teenagers are at risk of unwanted pregnancies. The majority of them fall pregnant while still at school, which results in the disruption of their education. Most tell someone of the pregnancy soon after discovering that they are pregnant, but few talk to their mothers first. Most retain the support of their family after the pregnancy.

See CPD Questionnaire, Page 45

REFERENCES

1. Davis S. Pregnancy in adolescents. *Pediatric Clin North Am* 1989;36:665-77.
2. Nash ES. Teenage pregnancy – need a child bear a child? *S Afr Med J* 1990;77:147-51.
3. Post GS, Botkin SR. Adolescents and AIDS prevention – The pediatrician's role. *Clin Pediatr* 1995;34:41-4.
4. Brauerman PK, Strasburger VC. Contraception. *Clin Pediatr* 1993;32:725-33.
5. Elsenberg L. Preventive paediatrics: the promise and the peril. *Pediatrics* 1987;80:418-9.
6. Stevens-Simon C, Boyle C. Gravid students. *Arch Pediatr Adolesc Med* 1995; 149:272-5.
7. Cromer BA, Brown RT. Update on pregnancy, condom use, and prevention of selected sexually transmitted diseases in adolescents. *Curr Opin Obstet Gynecol* 1992;4:855-9.
8. Fielding JE, Williams CA. Adolescent pregnancy in the United States: a review and recommendations for clinicians and research needs. *Am J Prev Med* 1991;7:47-52.
9. Miller KA, Field CS. Adolescent pregnancy: critical review for the clinician. *Semin Adolesc Med* 1985;1:195-212.
10. Creatsas GK. Sexuality: Sexual activity and contraception during adolescence. *Curr Opin Obstet Gynecol* 1993;5:774-83.
11. Flisher AJ, Roberts MM, Blignaut RJ. Youth attending Cape Peninsula Day Hospital: sexual behaviour and missed opportunities for contraception counselling. *S Afr Med* J 1992;82:104-6.
12. Nord CW, Moore KA, Morrison DR, Brown B, Myers DE. Consequences of teenage parenting. *J Sch Health* 1992;62:310-8.
13. Shell-Duncan B, Wimmer M. Premarital childbearing in northwest Kenya: challenging the concept of illegitimacy. *Soc Biol* 1999;46(1-2):47-61.
14. Smithbattle L. Developing a caregiving tradition in opposition to ones past: lessons from a longitudinal study of teenage mothers. *Public Health Nurs* 2000;17(2):85-93.
15. De Villiers VP. Tienderjarige swangerskappe in die Paarl Hospitaal. *S Afr Med J* 1985;67:301-2.
16. O'Mahony D. Schoolgirl pregnancies in Libode, Transkei. *S Afr Med J* 1987;71:771-3.
17. Kekesi J, De Villiers FPR. Characteristics of teenage mothers delivering at Ga-Rankuwa Hospital. *Geneeskunde* 1999;42(3):40-5.
18. McAnarney ER, Lawrence RA, Aten MJ, Iker HP. Adolescent mothers and their infants. *Pediatrics* 1984;73:358-62.
19. Hechtman L. Teenage mothers and their children: risks and problems: a review. *Can J Psychiatry* 1989;34:569-5.
20. Craig AP, Richter-Strydom LM. Unplanned pregnancies among urban Zulu schoolgirls. *S Afr Med J* 1983;63:452-5.
21. Van Coeverden de Groot HA. The Cape Town teenage clinics. *S Afr Med J* 1987;71:434-8.
22. Vundule C, Maforah F, Jewkes R, Jordaan E. Risk factors for teenage pregnancy among sexually active black adolescents in Cape Town. *S Afr Med J* 2001;91:73-80.
23. Kulin HE. Adolescent pregnancy in Africa : a programmatic focus. *Soc Sci Med* 1988;26:727-35.
24. Fielding JE. Trends in births to adolescents. *N Engl J Med* 1978;299:893-5.
25. Roberts M, Rip MR. Black fertility patterns – Cape Town and Ciskei. *S Afr Med J* 1984;66:481-4.
26. Hillard PJ. Family Planning in the teen population. *Curr Opin Obstet Gynecol* 1993;5:798-894.
27. Zabin LS, Kantner JF, Zelnik M. The risk of adolescent pregnancy in the first months of intercourse. *Fam Plan Perspect* 1991;23:108-17.
28. Rosenthal DA, Feldman S. The importance of importance: adolescents' perceptions of parental communication about sexuality. *J Adolesc* 1999;22:835-51.
29. Gurrin LC. Adolescent pregnancy: psychopathology missed. *Aust N Z J Psychiatry* 1999;33(6):864-8.
30. McGrath JW, Strasburger VL. Preventing AIDS in teenagers in the 1990s. *Clin Pediatr* 1995;34:46-7.