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The silent truth of teenage pregnancies – Birth to Twenty cohort's next generation

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To the Editor: By the 1970s teenage pregnancies were recognised as a problem worldwide. Initially the major concern focused on the potential biological risks of obstetric complications in adolescents. Subsequent studies indicated that teen pregnancies do not present any problems unanticipated among primipara generally.1 Studies on the possible social and psychological problems associated with adolescent childbearing confirmed that lack of social support was a risk factor for the adjustment and development of both young mothers and their children.2 Recent concerns about teen pregnancies have centred on the disruption that childbearing causes to the educational and occupational trajectories of young women, consequently maintaining and exacerbating poverty.3

While teen pregnancy rates have fallen in most European countries except the UK, they remain an enormous challenge in the USA, where 1 in 3 women conceives her first child before the age of 20. South African newspapers have again recently reported escalating pregnancy rates among schoolgoing girls.4 Speculation that child support grants could be acting as an incentive for young girls to fall pregnant prompted the Department of Social Development to undertake a formal investigation into this possibility.5 However, available data suggest that there is no connection between the two. There has been no systematic enquiry into the characteristics of the men who impregnate teenage girls. It is frequently claimed, although less often substantiated, that adolescent girls are often involved sexually with older men in relationships where gifts of money, clothes, school fees and other goods are exchanged for sexual favours. There is a barely disguised moral opprobrium towards teen sexuality, especially among young women, and a deep ambivalence about teenage pregnancies, how they should be recognised and managed, and how they might be prevented and/or serviced to reduce negative effects on young parents and their children.

In 1990 the Department of Health estimated the teenage pregnancy rate to be 330/1 000 women under the age of 19 years (52/1 000 in the USA in 2000). Among blacks, the proportion of births resulting from teenage pregnancies is reported to have risen from 12.4% in 1984 to 15.5% in 1991. In 1994, the rate in KwaZulu-Natal was estimated at 15.3%. The 1998 South African Demographic and Health Survey revealed that approximately 2.4% of the adolescent girls surveyed had fallen pregnant by the age of 15, with 35% of the sample

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reporting a pregnancy by the age of 19. The LoveLife survey conducted by the Reproductive Health Research Unit in 2003 indicated that the rate of teenage pregnancies in South Africa had not diminished despite initiatives to improve reproductive health counselling and related services. These included sexuality education in the lifeskills curriculum in schools, access to contraception and termination of pregnancy without parental consent through public health services, widespread communication campaigns, access to condoms through HIV prevention efforts, and national campaigns to challenge men's coercive sex domination of women.

The Birth to Twenty longitudinal study of child health and development conducted at the University of the Witwatersrand provides insight into some issues around teenage pregnancy. In 1989/1990, 3 273 pregnant women were enrolled into the study. At the time of delivery, 29 women (approximately 1% of the sample) were aged 15 years or younger and 12% of the sample were 19 years of age or younger. This study is currently moving into the next generation and children who formed part of the original birth cohort have begun to fall pregnant. To date, there have been 6 pregnancies reported within the second-generation cohort, with all the girls under the age of 14 years when they fell pregnant. Three of these young mothers were themselves children of teen mothers.

A preliminary investigation demonstrated that young women, the fathers (18 - 22 years old), and their parents are locked into a silence of fear and shame preventing them from providing mutual support and from accessing available services. Sexual and reproductive health and educational services for young people are also subject to moral paralysis, rendering them equivocal in their dealings with teenage mothers and fathers, and leading young parents to experience these services as distant and inaccessible. In the case of Birth to Twenty's first reported pregnancy, the young mother was 14 years old when she delivered her baby. At the time of her pregnancy, at just over 13 years of age, she was living with her mother and attending school. Despite having been exposed to school life skills programmes and having the benefit of family support, she was not using any form of contraception and had not accessed any counselling or health care services. She had not disclosed the pregnancy to her mother until the birth was imminent, and her mother did not say anything even though she could see that her daughter was pregnant. Johannesburg-Soweto is the most urbanised and one of the best-resourced areas of the country. Yet we were unable to offer sufficient help to this young mother with regard to the choice to be pregnant or not, enjoyment of a normal pregnancy, preparations for the baby with family support, and having her mother meet the boy and his family.

One of the greatest barriers to assisting young people is their fear and shame about talking to the people who could potentially help them, viz. family, educators and health professionals. To date none of the young women we have seen told such people that they were pregnant until it was too late. They and their partners – at least those men who knew about the pregnancy – were depressed and anxious and did not know what to do about the situation. Other studies suggest that young people who become pregnant feel confused about their options and are ashamed and worried about the response of their families, teachers and others.6

Open and accepting communication among people who can help is necessary to deal with the personal and social problems of unwanted early pregnancies. Family members, teachers and professional nurses say that they wish teens in trouble would speak to them, so that they can assist them in making the best choices. However, studies of sexuality communication indicate that even when parents and schools think that they are talking to teens about sex, adolescents feel that they have not communicated enough.7

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If we are serious about reducing teen pregnancy rates, when it comes to teen sexuality and protection, repeated talking and listening are required. Young people must be reassured that when they get into difficulty they can turn to us, and our behaviour must demonstrate that we will assist them rather than harangue and harass them. Access to services that enable adolescent boys and girls to make sexual and reproductive choices with the assistance of caring adults requires change to a mindset that is genuinely helpful.

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