Primigravida Experience of Childbirth and and Parenthood - Part II: Follow-up Six months after Birth

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Summary

There has been a steady increase in the number of unwed mothers in the community, but a decrease in the number of children being placed for adoption. A comparative study was undertaken at two Johannesburg hospitals of a selected sample of matched married mothers and unwed mothers, keeping their babies. A third group was identified ie those married after conception. Significant differences were found in age, education and occupational status, as well as family background between the single and married mothers. Fathers too differed significantly. Reactions to the pregnancy, incidence of contraceptive usage, smoking, alcohol and drug taking also differed significantly between the three as well as some differences in the self perceptions of the mothers. It was concluded that those mothers that married after conception were a neglected group who required much counselling and support. Single mothers were a more "at risk" group than married mothers. Six months after the birth of the baby, 40% of the sample of single and married mothers could not be traced. These women were younger, of lower educational standard and less likely to be staying with husbands. The different groups were compared on various aspects of their social, emotional, financial and personal lives, and it was concluded that the "at risk" mothers were probably those who could not be traced and better follow up of these was recommended. The well-baby clinics were well attended and they could extend their services and play a major role in assisting the mothers.

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KEYWORDS:
Mothers; Mother-child relations; Parent-child Relations; Child care; Child Health Services

Introduction

The adjustment to motherhood is a period of transition which involves changes in relationships, lifestyle and responsibility. There appears to be a dearth of information concerning the adjustment of single mothers who keep their babies in South Africa.

A study of unmarried and married mothers who delivered their babies at JG Strijdom and Johannesburg Hospitals during the period November 1986 - March 1987 were interviewed during their post-partum stay in hospital. (The results of this study were reported previously). This paper deals with the follow-up of these mothers six months later.

Methods

At the time of the initial interview in the hospital the mothers agreed to a follow-up visit six months later at home. All single mothers were keeping their babies. The mothers were then again interviewed in their homes and a second questionnaire and the Beck Inventory for Depression (BDI) was administered. The BDI has been viewed as one of the better self report measures of screening for depression in clinical research.[1]

Initially the sample consisted of 98 mothers in each group. There were 25 who lived in areas which could

not be visited because of distance and inaccessibility and therefore questionnaires had to be posted. Despite having the name of a contact person with a telephone, 35% of women could not be traced and 5% refused or cancelled the home visit. Those that refused, considered it as an intrusion on their privacy. Thus, 118 mothers completed the second questionnaire and 104 completed the Beck Inventory. The drop out rate was thus 40% of the total sample.

Results

The profile of the mothers who dropped out of the study and those who completed it, were examined. There was no difference in the distribution of mothers who married (M) prior to or after conception (S $\rightarrow$ M) or single mothers (S) or between their family backgrounds. The women who dropped out of the study were significantly younger, ($p=0,0024$) their education status lower ($p=0,0084$) and there were less that stayed with their husbands ($p=0,0389$) (44% vs 57%).

At the time of the home visit 68,9% of S mothers, 51,0% M and 61,9% S $\rightarrow$ M mothers had returned to work. Of these, 87,5% S mothers returned to work full time, as compared to 50% M women and 61,5% of S $\rightarrow$ M mothers. Significantly more S mothers than M mothers returned to work on a full time basis ($p=0,0032$). There were no other differences between these two groups and the S $\rightarrow$ M mothers. Although there was a difference in the nature of support networks of mothers, the majority of subjects irrespective of status, had good support systems. Looking at the support systems of mothers, 91% of the S mothers were supported by their parents, friends and distant relatives, whereas 70% of the M mothers were supported by their husbands and maids and relatives. Only 31,7% of the mothers left their babies in a creche or with a child minder. Four percent (4%) of S mothers received no financial help whatsoever.

Adjustment to motherhood involves changes in relationships, lifestyle and responsbility

94% of all mothers attended the well-baby clinics

Mothers were asked if their husbands helped with the baby and if so, what sort of help they were giving. There was a significant difference between the three groups ($p<0,0001$). In the M group 92% of husbands did give practical help with such tasks as bathing, feeding and changing nappies. On the other hand 59% of the S women received practical help from the putative father. All the S $\rightarrow$ M mothers were helped by their husbands.

Ninety-four percent (94%) of all mothers attended the well baby clinics. Forty percent (40%) attended weekly and only 5% attended occasionally. There was total compliance in terms of up to date immunisation.

During their postpartum stay in hospital 80% were breastfeeding. Fifty-one percent (51,7%) of the mothers who were breastfeeding when they left hospital, stopped doing so within the first six months. Forty-one percent (41,5%) of these stopped within the first three months. Therefore 40% still breastfed at 6 months.

Since birth 72% of the babies have been ill. Most of the complaints were upper respiratory and urinary tract infections, diarrhoea, thrush, and other ailments common in babies. Most mothers sought their primary care from GP (31,9%), hospital (26,4%) paediatrician (16,5%) and clinics (5,5%).

Mothers were asked if they found that the baby restricted them in any way. Twenty six percent (26%) found that they were tied down. Fifty-two percent (52%) of mothers either had not known what to expect or found it different to what was expected. When asked in what way it was different, the most common reaction to the baby was that it was more time consuming, exhausting and restricting than they had anticipated. There was no significant difference between the three groups.

Most mothers found it more time-consuming, restricting and exhausting than expected

Mothers were asked to describe their babies' crying in the first three months. There was no difference between the three groups of mothers. Altogether 69,2% of them claimed

that the babies were crying occasionally, 21,4% frequently and 9,4% continuously. Irrespective of how often the baby cried, the mothers described their feelings to this as upset, frustrated, panic stricken, distressed, insecure, worried, nervous, anxious and angry.

At six months 57,3% of babies were still waking at least once at night. Surprisingly, 31,4% of all mothers were not using contraception at the time of the home visit. Of these, 54% were S mothers.

S mothers did not appear to be more isolated than the M mothers. (No significant difference between the groups). However, 22,4% of women had contact with family or friends only on a fortnightly or monthly basis.

The mothers' level of depression during the post natal period six months after the birth of their baby, as measured by the BDI, revealed no significant difference between the groups. The results reflected very little depression among the mothers, 73% were not depressed, 20% were

No significant difference in level of depression between the groups

mildly depressed, 4% were mildly to moderately depressed, and 3% were moderately to severely depressed.

These results were supported by the findings obtained from the question which explored their coping ability. No significant differences were found between the groups. Eighty nine percent (89%) felt that they were coping well, and 11% felt they were coping satisfactorily.

Discussion

Forty percent (40%) of the sample dropped out of the study. They were of lower educational standard and younger. It is likely that those who dropped out were the most unstable and at risk for neglecting or abusing their children. They were possibly the most mobile and least established of the sample population.

Within 6 months, more than 50% of the mothers had gone back to work

Within six months after the birth more than half the total sample of mothers had returned to work. The majority of married women were part-time workers whereas the single mothers went back full time. These were mothers who kept their babies and thus needed financial support and left their baby in the care of relatives and friends whilst at work. If children are left with grandparents, the latter tend to take over the major part of the responsibility which often leads to conflict and role confusion. However, without this support, many single women would not be able to resume work or easily be able to cope on their own. Those not living with boyfriends or family were struggling to cope financially. There are no special facilities available for unmarried mothers and their babies in Johannesburg.

Fathers play a significant role in the physical, social, emotional and cognitive development of their children, both directly and through the relationship with the mother.[2,3] Positive paternal involvement with teenage mothers has been found to have significant effects on the health of the infant and reduce stress in the mother.[4,5] The babies of single mothers in this study are likely to have little contact with their fathers as few of the fathers played an active role in the child's upbringing at 6 months. Only 8% of unmarried mothers were supported by their boyfriends at 6 months. Other studies have shown that two years after birth less than a quarter of unmarried mothers had regular contact with the father.[6,7]

The most trying aspects of adaptation to motherhood are the responsibilities of continuous coverage and loss of free time.[8,9,10,11] Coupled with this is the crying of the infant, which the mothers found most stressful, even if it was only occasional. Many mothers had little support and a considerable number had infrequent contact with significant others. Loneliness,

Most of the babies of single mothers had alsmot no contact with their fathers at 6 months

isolation, and a crying infant are some of the risk factors which contribute to child abuse and neglect.[12,13,14,15]

In view of the excellent attendance at the well baby clinics, it seems that the clinics' potential in playing a vital role in assisting and supporting mothers

could be expanded, especially as many mothers appear isolated and feel restricted by the baby. Crisis intervention services, support groups, short-term creche facilities to allow mothers some free time, are just some of the services that could be incorporated.

Non-use of contraception, especially by single mothers after the birth of the baby is surprising. Other studies have shown the same pattern

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The mothers who disappeared are probably the most needy and their children most "at risk"

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especially among teens.[16,17] They are the group most likely not to use a method in the year following the birth of their first child,[18] and is probably one of the most important factors in more than one out of wedlock pregnancy.[19]

Primigravida women are at greater risk for post-partum depression than multiparous women.[20,21] This could partly be explained by the fact that first time mothers have greater changes to negotiate.[22] After six months, depression was not a major feature. This could be attributed to early employment, social support received by most mothers and the absence of any seriously ill infants. The perceptions of the majority of the mothers were that they were coping well six months after the birth. The unmarried mothers may have felt the need to say they were coping well so as to create a better impression, and also many had handed over responsibility for the infant to their parents.

Conclusions and Recommendations

Mothers who were contacted appeared to be coping relatively well with their babies. It is probable that those who had disappeared were most needy and their children most "at risk". Support systems play a major role in helping single mothers to cope, as they return to work full time much earlier than their married counterparts. Married women are provided with support from their husbands. Women who married after conception approximated the single women more than married women. The single women are younger, of lower educational and occupational status, emanate from disturbed family backgrounds; are more likely to smoke during pregnancy, are less likely to have a planned pregnancy and less likely to use contraceptives after the birth of their baby; more likely to return to work full time before the baby is six months old.

Well baby clinics are in a strategic position to provide a host of

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In view of the excellent attendance at the well-baby clinic, these services could be expanded to play a vital role in supporting and encouraging the frustrated mothers and prevent child abuse

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supportive services to mothers. The existing services should be extended to include family planning, counselling and support groups. General practitioners are also key persons who come into contact with young mothers and should provide them with support and encouragement with contraceptive usage and refer for counselling. Social work services in hospitals could perhaps be utilised to a greater extent to ensure more adequate follow up of unmarried mothers "at risk" in the community.

Well-baby clinics are the strategic places for all kinds of supportive and preventive services

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Components:

Flunitrazepam

Indications:

Tablets: sleep disturbances, whether occurring as an isolated functional disturbance or as a symptom of an underlying chronic disease.
Ampoules: pre-anaesthetic medication; induction of anaesthesia; maintenance of anaesthesia.

Dosage/Administration:

Treatment of insomnia. Adults: 1 – 2 mg; elderly patients: 0,5 – 1 mg, immediately before going to bed.

Anaesthesia:

Adults:
Premedication: 1 – 2 mg i.m.
Induction of anaesthesia: 1 – 2 mg by slow i.v. injection.
Maintenance of anaesthesia: if the amount used for inducing anaesthesia is inadequate, further small doses may be injected slowly.
Children:
For premedication and induction of anaesthesia: 0,015 – 0,030 mg per kg by i.m. or slow i.v. injection.

Contra-indications:

Severe chronic hypercapnia.
Hypersensitivity to benzodiazepines.

Precautions:

General: elderly patients with organic cerebral changes. Avoid alcohol during treatment.
Pregnancy.
Discontinue breast feeding.

Packs:

Tablets 2 mg: 30's, 100's.
Ampoule pack containing:
5 ampoules with 2 mg of active ingredient in 1 ml solution;
5 ampoules with 1 ml of sterile water for injections as diluent, to be added prior to i.v. or i.m. injection.

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