ORIGINAL ARTICLE

"She was just a girl": insights into early motherhood in recent decades

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Abstract

Objectives: Brazilian Law 12.015 classifies libidinous acts with minors under 14 years of age as statutory rape. Despite this, the number of pregnant girls in this age group still constitutes a public health concern. Thus, understanding the context and perceptions of girls who became mothers before the age of 14 can contribute to the development of public policies.

Methods: individual interviews were conducted with ten women over 18 years of age who had become mothers before the age of 14. The discussion was divided into three categories, related to the periods in which these experiences occurred.

Results: the understanding of the circumstances surrounding these pregnancies and the strategies adopted to cope with them varied according to the specific period. The expansion of rights and public policies has broadened access to care; however, despite advances in equity policies, social markers such as gender and race continue to render girls vulnerable over time. While recognizing gender-based violence as a public health issue has improved assistance, challenges remain – particularly regarding the guarantee of legal abortion.

Conclusions: these insights are urgently needed to challenge the normalization of early pregnancy and to improve access to comprehensive, equitable care for children and adolescents.

Key words *Mothers, Comprehensive health care, Sex offenses, Gender-based violence*

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Introduction

Brazilian Law No. 12.015[1] classifies as statutory rape the practice of libidinous acts with children under 14 years of age, regardless of any potential consent from the victim, as it is understood that due to their particular developmental stage, they lack the capacity to permit or agree to sexual intercourse.

Girls under 14 years of age are the most frequent victims of such crimes. Of the total cases reported in 2017 and 2018, over 50% were committed against female minors aged 14 years or younger.[2] One of the potential consequences of these acts is early pregnancy, a problem that raises significant public health concerns. The frequency of unplanned pregnancy after rape is imprecise, yet studies estimate it to be between 5% and 17% per episode, a value that can increase among adolescents due to their higher probability of becoming pregnant.[3]

Data on live births among child-mothers, in turn, are alarming: between 2010 and 2019, over 250,000 girls between 10 and 14 years of age had children in Brazil.[4] In 2020, 17,579 girls became mothers, that is, 48 per day, which means two cases of statutory rape per hour. Of these, 75% were Black, which reinforces the understanding that racism aggravates the vulnerability of these girls.[4]

Pregnancy before 14 years of age increases the risk of maternal mortality, infant prematurity, low birth weight, and perinatal mortality. Additionally, it may lead to psychological, social, and economic impacts, such as limited access to education and employment opportunities.[5]

The Brazilian Penal Code provides that, if they so wish, girls and women may undergo an abortion when pregnancy results from rape or if there is a risk to life, with no gestational age or fetal weight limits. However, access to this right remains a challenge. In 2019, only 290 facilities were equipped to offer the service, and about one-third performed no procedures that year. In addition, there are geographical barriers, lack of knowledge about the legislation, fear of criminalization, shame due to the stigma of the procedure, and physicians' refusal. Such failures can lead to clandestine and potentially unsafe abortions, which are cited as the third direct cause of maternal death in Brazil.[7,8]

Girls who do not want or are unable to undergo pregnancy termination have the right to specialized prenatal care, with early enrollment in the program, follow-up with a multidisciplinary team, adoption of risk protocols, and prevention to avoid a new pregnancy. However, timely and quality access for these girls to adequate care for the situation they have experienced remains a challenge.[8]

Despite having become subjects of rights and the transformations that have occurred in recent decades, difficulties in discussing autonomy and sexual and reproductive rights in adolescence still exist. This is evident in the dilemma faced by health professionals who, while required to handle situations involving pregnant girls under 14 years of age as cases of violence, encounter girls who believe they did consent to their sexual relations—including with family approval. There is a gap between what Brazilian legislation provides, the sociocultural understanding of age parameters for sexual initiation, and the perception of adolescents and their families on the subject.[9]

Due to historical-cultural shifts, experiences and perceptions regarding early pregnancy in different decades differ, since the problem is understood according to the context in which girls are embedded. Thus, using a chronological and historical approach, the aim of this study was to understand the context and perception of girls, who had children before 14 years of age regarding the process.

Methods

The COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines were followed to report the methodological aspects.[10]

This was a qualitative study, conducted through individual interviews with women aged 18 years or older who had one or more pregnancies and had at least one child before 14 years of age. It is an exploratory-retrospective study, since the interviewees were invited to recall past experiences, which may lead to recall bias due to the memory alterations and narrative reconstructions, as well as limitations regarding potential inferences.

Invitations to participate were published through posts on the social media accounts of the principal researcher and interviewer: a 28-year-old White, married, childless female psychologist who graduated three years ago, completed a multidisciplinary residency in public health, and is currently a master's student in psychology. Her interest in this research stemmed from her previous experience during undergraduate school and residency at a care service for victims of sexual violence assisting children and adult women, which sensitized her to the consequences of such experiences on the lives of those involved.

Although she was embedded in a health service, the researchers chose to recruit participants through posts that were reposted and shared by other individuals and profiles. This enabled women from different contexts, unknown to the researchers and interested in participating, to contact them via direct message on social media. During the data production period, 21 women sent messages expressing interest in participating. All of them received a response, but over the course of time, some explained that they would

not be able to talk about the topic, while others scheduled an interview but either failed to sign the consent form or did not show up on the scheduled day. This behavior led the researchers to reflect on the difficulty of talking about the experience and the affections surrounding pregnancy and motherhood before the age of 14.

Furthermore, it is important to emphasize that digital recruitment via a page featuring mental health content limited the profile of the participants, who necessarily had digital access, a prior interest in psychological topics, and higher educational capital—which may influence their perceptions of the experiences they underwent. Because they do not represent the diversity of experiences associated with early pregnancy, especially in contexts of greater social exclusion, there are limitations regarding the generalizability of the findings.

Due to difficulties in finding volunteers and the time constraints for completing the research, a total of ten women were interviewed. While this sample size limitation precludes generalizations, as this is an exploratory study on a complex and under-researched topic, its objective was to deepen the understanding of the issue.

None of the interviewees had a prior relationship with the researchers. The interviews took place between March and December 2023 and were scheduled individually via text message or phone. According to the participants' preferences, they were conducted mostly online, with only one taking place in person. The interviews lasted an average of 60 minutes each and were conducted without the presence of third parties. No interview needed to be repeated, and all of them were audio-recorded and transcribed in full.

A semi-structured guide built specifically for this study was used, based on the literature on the subject,[2-5,7-9,11,12] and containing sociodemographic information and questions regarding the circumstances of the pregnancy, the existing support network, health care received, the choice to continue the pregnancy, and the experiences of childbirth and the puerperium. The guide was tested in the first two interviews and remained unchanged.

The data were analyzed using thematic content analysis.[13] From an intersectionality perspective, which considers the intersections of gender and race in these experiences, the study sought to encompass debates on how social markers impact mothering and caregiving relations. The principal researcher self-identifies as a White woman and understands how the privileges of whiteness can interfere with the way research knowledge is produced and data are interpreted—including the choice of readings for the analysis. To prevent the erasure of structural racism, she sought to maintain an attentive, ethically committed listening process and to present interpretations that considered the meanings attributed by the participants and the impact of racism on the lives of girls and women.

Due to the participation of women of various ages who experienced motherhood in different decades, a temporal organization of the data was chosen for analysis and discussion. This is because, in each period, the context appears to have influenced perceptions of the experiences lived, social responses to the pregnancy, and the assistance received. The chronological organization of the data sought to highlight the similarities and differences among the participants against the backdrop of the social context in which they underwent the reported experiences, as well as the changes incorporated into maternal and child health and the conjuncture of violence against girls over time. This approach has no intention of generalizing or universalizing these experiences, focusing instead on deepening the understanding of the singular and historical impacts surrounding the phenomenon of pregnancy before the age of 14, while respecting memory reconstructions and the historical context in which the experience positioned the interviewees.

Thus, the data presentation and discussion were divided into three categories: 1960s and 1970s: "*as if I were a woman*"; 1980s and 1990s: "*I made it, so I have to raise it*"; and the 2000s: "*children shouldn't get pregnant*." The data were not returned to the participants for validation of the analysis and discussion conducted.

This research was approved by the Research Ethics Committee involving Human Beings of the Federal University of Uberlândia (Opinion Nº. 5.679.264). To ensure the participants' anonymity, they were identified by the names of other women who also represent struggles in our society.

Results and Discussion

The participants in this study were women aged 28 to 72 years (mean age of 46 years old). The study adopts a racial/color perspective, since only two interviewees self-declared as White, while all others did so as Black women. All women had at least nine years of educational attainment (completed elementary school), with two having completed higher education and one holding a graduate degree (Table 1).

The 1960s and 1970s: "*As if I were a woman*"

The participants who became mothers in the 1960s and 70s narrate similar contexts in which the pregnancy occurred: a secret relationship with an older boyfriend kept that turned into a marriage after the discovery of pregnancy.

Table 1

Characterization of participants.

Participants	Race/color	Age (years)	Educational attainment	Year and age at childbirth
Laudelina	Parda	72	Completed high school	1964 – 13 years old
Penha	Black	59	Completed elementary school	1976 – 12 years old
Joana	Parda	59	Completed high school	1977 – 13 years old
Dandara	Black	50	Incomplete high school	1987 – 14 years old
Maria	White	45	Completed higher education	1992 – 14 years old
Elza	Parda	43	Completed higher education	1994 – 14 years old
Eva	Black	38	Graduate degree	1995 – 11 years old
Ermelinda	Black	37	Completed high school	2000 – 14 years old
Nísia	White	30	Incomplete higher education	2006 – 13 years old
Rita	Parda	28	Incomplete higher education	2007 – 13 years old

The interviewees' age at the time of delivery were self-reported during the interview.

The Civil (1916) and Penal (1940) Codes established that, with parental authorization, minors under the age of 16 could marry.[14] The families of the interviewees influenced both the obligation to marry and the understanding of the pregnancy. Joana recounts that on the day of her marriage at the age of 13, the judge asked her to enter before the groom to see "whether she was big enough to marry, since she was of a child's age" (59 years old, *Parda* [mixed-race] woman).

At the time, marriage in cases of pregnancy guaranteed the restoration of a woman's honor and, when it involved the seduction of minors (current statutory rape), it extinguished the perpetrator's criminal liability. This premise was only revoked in 2005 (Law 11.106), which highlights how Brazilian legislation was extremely harmful to children and adolescents by adopting minimal age thresholds for granting or preventing child marriage—leaving girls prematurely fit for matrimony at all times.[14]

Biological aspects such as the capacity to gestate, give birth, and breastfeed support social issues involving girls and women, and naturalize motherhood and the sexual division of labor.[15] The adjustment of women to these roles and functions is the result of a discursive production that determines what each girl must be to be "truly" a woman and, thus, places marriage and motherhood not in the realm of desire, but of destiny. The interviewees recognize this process: "I was going to be a mother at some point anyway" (Penha, 59 years old, Black woman).

The destiny sealed for the interviewees was the same as that of other girls and women of that generation: marriage as a consequence of sexual relations and compulsory motherhood. In this process, assuming responsibilities for the home, the baby, and an adult life would repair the guilt for allowing themselves to be seduced by irresponsible boys/men and for not having prevented the pregnancy.[14]

In Brazil, before the Statute of the Child and Adolescent (ECA),[16] Decree 17.943 was consolidated, which presented assistance to "minors"—a term used to refer to people under 18 years of age. The concept of legal majority related age classification with rights, and therefore, only people over 18 years of age had rights and duties.[17] In this scenario, early pregnancy was not necessarily considered a problem[12]: "*It was a routine thing for a 13-year-old girl to be married. So much so that, at the time (1964), I even won an award for the youngest mother in town*" (Laudelina, 72 years old, *Parda* woman).

Upon becoming pregnant, girls came to be understood as mothers and motherhood as a destiny.[18] Women's health programs of the era had a maternal-child focus with care practices based on biological specificity and women's social role as mothers and homemakers. This resulted in interventions on the bodies of the girl-mothers aimed at ensuring that their children's health met social needs.[19]

In this context, there was little dialogue about the universe of reproduction and sexuality—even more so with children and adolescents. Furthermore, until 1979, the Law on Criminal Misdemeanors[20] banned advertisements for procedures, substances, or objects intended to induce abortion or prevent pregnancy, which hindered knowledge on the subject: "*I didn't know what a sexual relation was, I knew nothing, I was a child expecting another*" (Joana, 59 years old, *Parda* woman); "*I found out I was pregnant when I got very nauseous and I thought it was a worm problem*" (Penha, 59 years old, Black woman).

Still in the 1970s, by questioning—among other things—situations such as these, the second wave of the feminist movement proposed important debates on gender inequalities and the female overload. This wave introduced cultural and social questions regarding the premises that determined what it means to be a woman and concerning the prevailing family project that influenced the following decades.[21]

The 1980s and 1990s: "*I made it, so I have to raise it*"

In the historical-cultural context of the 1980s and 1990s, there were shifts resulting from feminist movements,

which substantially contributed to the implementation of the first public policies with a gender perspective in Brazil. Some of these policies focused on gender violence, which was then beginning to be understood as a problem subject to accountability.[22]

In this context, one of the four women interviewed who became pregnant during this period named what she experienced as violence: "*I ended up being violated by an acquaintance of my father when I was 13 years old*" (Maria, 45 years old, White woman). Because she was threatened by the assailant, she hid the pregnancy, which was discovered after six months. Maria's parents, even while recognizing the gravity of the situation, rather than seeking the police and health services to protect and care for their daughter, resorted to the recourse of previous decades: the obligation of marriage (which even freed the assailant from answering for the crime) and compulsory motherhood.

In contrast, the other interviewees report that they became pregnant in brief relationships with adult young men. Despite their families' disappointment, they were not forced to marry, but the interruption of the pregnancy also did not appear as a possibility at that moment.

The maternalist logic and the social construction of female subordination delegated responsibility for the pregnancy and motherhood to the girls, who found themselves forced to mature prematurely.[15] Meanwhile, the fathers chose not to participate in emotional care and shared only financial responsibilities.

Women who choose not to raise their children, terminate a pregnancy, or legally surrender a baby were—and still are—socially condemned. Female reproductive labor, besides being compulsory, is naturalized and remains invisible because it does not establish cycles of accumulation, wage relations, or a price for the product of its labor force.[15]

The interviewees report finding support, especially from their families: "I would stay awake all night and then sleep while my father looked after the baby" (Maria, 45 years old, White woman); "*I received help to give him a bath, with breastfeeding*" (Elza, 43 years old, Parda woman). Social support is one of the protective factors in the pregnancy and mothering process, especially among girl and adolescent mothers.[23] Having this support network helped the participants continue their studies, despite the impact and discrimination suffered at school.

The 1980s and 1990s were marked by important achievements such as the new Federal Constitution and the Unified Health System (SUS), which guaranteed rights to the population and favored the creation of health policies.[24] Another major milestone of this era, resulting from the process of transformation in the conception of childhood and adolescence that took place throughout the 1980s, was the enactment of the ECA in 1990. It regulated the rights that guarantee the comprehensive protection of this segment of the population and enable their physical, psychological, social, and moral development.[16,17] Among these rights are sexual and reproductive rights, which presuppose access to information and sexuality education actions aimed at greater autonomy, expression of sexual orientation, access to forms of reproductive prevention, and respect for one's own body.[25,26]

The structuring of such rights favored a greater guarantee of rights for children and adolescents. Amid these achievements, despite difficulties, the interviewees who had their children during this period had access to care during prenatal, delivery, and postpartum periods: "*I did my prenatal care in two hospitals, the municipal and the state one*" (Eva, 38 years old, Black woman). Elza and Maria also received prenatal care, even though they arrived later at the health service—one because she did not know she was pregnant and the other because she hid the pregnancy. This is not uncommon among adolescents.[5] Research even indicates that the timely initiation of prenatal care is lower among Black and Parda adolescents than among white girls across all ages, reflecting the pattern of racial inequities and discrimination present in the provision of care.[8,27]

Pregnancy among girls requires monitoring that addresses the high physical and psychosocial risk involved in such a situation and timely access, including to guarantee the legally provided right to abortion when desired/necessary. However, due to factors such as lack of knowledge about the pregnancy, fear of family reactions, attempts to delay the disclosure of a situation of violence, inefficiency of services, and lack of attention to the specific needs of girls, this rarely happens, which reinforces the importance of the possibility of terminating a pregnancy at any time.[5,8]

Three interviewees from this period had a C-section, a delivery described as "calm and fast" by Elza (43 years old, Parda woman). The discussion on the route of delivery and maternal age still involves prejudices, such as the notion that an adolescent would not be physically and emotionally fit to give birth via vaginal delivery. However, data show that the obstetric performance of adolescents is equal to or better than that of adult women.[8] Despite this, 38.4% of girl-mothers undergo a C-section.[5]

Regarding the puerperium, we highlight the issue of breastfeeding, as research indicates that adolescent mothers have a higher chance of early weaning due to the complexity involved in this context.[27] Dandara and Eva breastfed for two and three months respectively—the former due to severe anemia and the latter to return to studying. Both report that they did not wish to breastfeed, as they preferred to experience other things at that moment,

such as returning to school. As for Maria, her breast milk was the only way to guarantee food for her daughter: "*I starved, I even weighed 40 kg because I didn't eat. But she [her daughter] didn't go hungry because she breastfed from me*" (Maria, 45 years old, White woman).

These experiences reaffirm the importance of comprehensive care for each girl-mother, so that breastfeeding guidelines are viable and adequate for their well-being as well, without reinforcing processes of isolation and blame.[27] It is important to emphasize that, despite more than 10,000 girls under the age of 14 giving birth per year,[5] studies on breastfeeding and the specificities of these cases are still scarce.

The context in which these interviewees became mothers favored the availability of family members, particularly women, to act as a support network and provide the maintenance of a part of these girl-mothers' childhoods. But even so, the logic of "*I made it, so I have to raise it*" (Eva, 38 years old, Black woman) prevailed, and motherhood manifested in their lives prematurely.

However, the notion that they should be satisfied with raising children, providing biological support, and offering emotional investment[28] does not resonate among the interviewees. They affirm regretting having become mothers at that time and recognize that their childhoods were not protected. The repercussions of pregnancy and motherhood occurring before the age of 14 haunt the lives of these women, and despite their diverse experiences, persistent impacts remain – particularly on the mental health – resulting from the responsibilities assumed, the imposition of the caregiver role, and the naturalization of motherhood.

The 2000s: "children shouldn't get pregnant"

In the late 1990s, the World Health Organization (WHO) recognized that gender violence against girls and women is a severe public health concern due to its high prevalence and harmful consequences to health.[29] Since then, several studies and public policies have been developed, with a significant increase in both the knowledge about the subject and the visibility of the problem. In this context, the three interviewees who became mothers from the 2000s onwards recognized that they became pregnant in contexts of violence.

Nísia was 12 years old when she started dating an adult man who was always violent toward her, believing that "*if I had a child, he could change*" (30 years old, White woman). Thus, after five months of dating, she became pregnant. However, the violence did not stop: "*I thought the father of my daughter would be my safe haven, but he threatened to take the lives of my mother and my siblings if I left him*." At age 14, she managed to escape when her daughter was one year and eight months old.

Rita was raped for two years by her stepmother's brother until she became pregnant: "*It happened under the same roof and no one noticed. He was 27 and I was 10 when it started*" (28 years old, *Parda* woman). Even though she was only 13 when she became pregnant, instead of protecting her, the adults labeled her as shameless and a tramp: "*It's never the abuser, it's always the victim. And I was just a girl*." Ermelinda worked in a family's home, feeling welcomed and respected until the day her boss drugged and raped her. The assailant's wife and Ermelinda's own mother blamed her for what happened and brought her to court "*as if she were stealing another woman's husband*" (37 years old, Black woman). The police station professionals had to point out to the two women that she was a child and shared that they had already sheltered other victims of the same assailant.

Despite Law 12.0151 having been enacted only in 2009, when these girls went through such situations, the ECA[16] had already existed for over 10 years. Even so, family members had difficulty protecting them, which reinforces the mismatch that persists between legal provisions and social understandings regarding issues such as gender, sexuality, and violence. Bridging such gaps to ensure the enforcement of rights more swiftly requires that political-educational measures be implemented consistently, and not just with children and adolescents.

Autonomy for the safe exercise of sexuality depends, among other aspects, on access to qualified information. In the 2000s, actions regarding sexuality education, violence prevention, and discussions on gender equality were already/still being carried out among children and adolescents, especially in schools.[9,23] Furthermore, it is essential—even more so in a scenario of setbacks—to involve the community as a whole so that it can truly act as a protection network.[11]

The process of caring for individuals in situations of violence involves complex emotions and requires the activation of mechanisms such as networking and expanded clinical care, which are not always available in professionals' toolkits. This ends up pushing these cases into a marginal position and, not by chance, many end up in a game of buck-passing between services and sectors.[29]

However, it is from the support found in the different elements that make up a network that situations of violence—and other processes of vulnerability—can begin to be overcome. Ermelinda's encounter with the police officer, who recognized her as a child and named her situation as sexual violence, was fundamental for her to find some support—including the possibility of obtaining a legally permitted abortion, which she refused.

The other two interviewees did not even have information about this right, and one of them attempted to terminate the pregnancy on her own. It is estimated

that more than 700,000 unsafe abortions occur annually in Brazil.[7] A lack of awareness regarding the right to abortion in cases of rape and the difficulty of accessing services that perform legally authorized abortions often lead girls and women to resort to clandestine attempts. Because they are generally poorer, low-income Black girls tend to face greater insecurity and run a higher risk of criminalization.[2,7]

In Brazil, non-white women suffer the most from gender-based violence, including obstetric violence, which is characterized by the violation of a woman's sexual and reproductive health—through action or omission—during prenatal care, labor, and the postpartum period. The devaluation and dehumanization linked to Black women, a result of our colonial heritage, are still legitimized within biopower relations, expressed through inadequate care and violent practices.[30]

The three interviewees recognize violent situations during childbirth, such as disqualification due to young age, lack of explanation regarding procedures performed, and the use of unnecessary interventions, such as the Kristeller maneuver: *"([...] he threw his whole body on top of my belly twice so my son would come out*" (Rita, 28 years old, Parda woman). Ermelinda went to the hospital in pain, but the doctor said: "*You are not going to deliver today, you can go home, it's only two weeks from now. [...] Oh, when I was leaving the hospital, thank goodness I was wearing a dress, my water broke, I just squatted down and out he came*" (37 years old, Black woman). At age 14, she gave birth at the entrance of the institution, without proper assistance.

Among these interviewees, there were also no adapted and/or appropriate guidelines on breastfeeding. Rita and Ermelinda breastfed for a short time. Meanwhile, Nísia found in breastfeeding a way to protect herself and her daughter from the domestic violence she suffered: "*I was very terrified that she would cry and he (the biological father) would fight with me. She lived on my breast because I was really scared*" (30 years old, White woman).

Social and cultural shifts, as well as the presence of public policies focused on addressing gender violence may have enabled the participants who had children in the 2000s to have a different perception of the violence they experienced. However, the care they received still had shortcomings that had consequences for them and their children.

Final considerations

The crime of statutory rape and early pregnancy—one of its possible consequences—are long-standing problems that still lack recognition and problematization. Among our interviewees, the violence experienced was more clearly recognized from the 2000s onwards, but early marriage and, especially, compulsory motherhood remained naturalized over the years.

Despite the progress made in recent decades, including the enactment of Law 12.015/2009, the invisibility and naturalization of the sexual violation of girls still persist. The participants reported situations that signal a lack of adequate care, negligence, and the trivialization of the violence they experienced, perpetrated both by family members and by professionals who should have protected them as developing individuals.

In this regard, the way gender, sexuality, and human rights are understood affects how girls are supported—or not—when going through such situations. These understandings also interfere with ensuring access to legally permitted abortion, which should not be subject to questioning when linked to statutory rape. Therefore, there is an urgent need for further research on the reality of girl-mothers and on the perceptions and practices of professionals—especially, but not exclusively, in healthcare—regarding the care provided.

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Author's contribution

Dias MA and Hasse M: conceptualization, methodology, formal analysis, writing – original draft and writing – review and editing.

Both authors approved the final version of the manuscript and declare no conflicts of interest.

Data availability

All datasets supporting the results of this study are included in the article.

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