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## Adolescent Pregnancies: The case of Pakistan

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### Abstract

Early motherhood not only causes poor health outcomes, but often also deprives adolescent girls of educational, social, and economic development opportunities for the rest of their lives. Evidence suggests that although the burden of adolescent pregnancies is less in Pakistan than in Bangladesh, Afghanistan and Nepal, the pregnancy outcomes continue to be devastating in this country. This paper discusses the social barriers in addressing this issue in Pakistan and proposes recommendations for targeted interventions to reduce the high birth rate amongst adolescents in the country. The role of midwives as frontline gatekeepers can be pivotal for prevention of teenaged pregnancies in Pakistan. Unfortunately, the existing midwifery workforce is not very well prepared to deal with adolescents' Sexual and Reproductive Health (SRH) issues.

**Key Words:** *reproductive health, childbirth, teenage pregnancy, South Asia*

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### Introduction

According to the World Health Organization, adolescents are people between 10-19 years of age.<sup>1</sup> Complications during pregnancy and childbirth are the second leading cause of death among adolescent girls and their children, globally, and the risk of dying decreases with increasing age.<sup>2</sup> Despite a remarkable decline in the prevalence of adolescent pregnancies, worldwide, during the last two decades, recent statistics reveal that each year 11% (13 million) of all births are given by girls aged 15 to 19 years; 95% of these occur in low and middle income countries.<sup>2</sup>

A population-based systematic analysis of adolescent maternal mortality rates around the world<sup>3</sup> identified that every year 10% of the pregnant girls, between 15 and 19 years of age, die due to pregnancy related causes; 82% of these deaths occur in 20 countries of Sub-Saharan Africa

and Asia. A study<sup>4</sup> of 344,626 adolescent mothers in Latin America found that the greatest fatality rate was among girls under 15 years of age. They were also at a 50% higher risk of having Low Birth Weight neonates (LBW), Small for Gestational Age (SGA), and early neonatal deaths, and were 40 times more likely to be anemic than women between 20 and 24 years. The study also revealed that adolescent girls in this age group had a higher risk of developing preeclampsia, eclampsia, puerperal sepsis, postpartum hemorrhage and preterm births than older women.

Although the burden of adolescent pregnancy has overall declined, it is a pervasive problem in low resource countries, where around 2.5 million births are given by girls under 16 years of age annually. One in every five girls becomes pregnant in these countries, out of which a majority of the pregnancies are aborted and, hence, are often under reported.<sup>5</sup> The findings from African countries estimate the highest birth rate among adolescents, especially in Niger, Mali, and Guinea, with 122, 172, and 146 per 1000 live births respectively.<sup>6</sup> The world's second highest rate of adolescent pregnancies occurs in South Asia with the highest birth rate in Bangladesh (113), followed by Nepal (71), Afghanistan (51.9), Pakistan (44)<sup>11</sup>, Bhutan (28.4), and Sri Lanka (20.3); the lowest rate is in the Maldives: 13.7 per 1000 live births.<sup>6</sup> The root cause of such high adolescent birth rates, as reported in various studies, is 'Girl Child Marriages.' Although the prevalence of girl child marriages under 14 years has significantly decreased in India, Bhutan, and Pakistan during 1991-2007, marriages of girls who are 17 to 18 years old is still a major problem in these countries.<sup>7</sup>

### **The Case of Pakistan**

Pakistan has a very high number of adolescents, nearly 40 million, that makes up 22.3%<sup>8</sup> of the total population, as compared to only 16% in the USA and Japan.<sup>9</sup> It has always been difficult to estimate the death rate associated with adolescent pregnancies because of the under-reporting of criminal abortions and the legal restrictions that prohibit abortions.<sup>5</sup> The minimum legal age for marriage in Pakistan is 18 years for males and 16 years for females, except in the Sindh province, which has increased the legal age of females to 18 years.<sup>10</sup> Thirty five percent of the females are married by the age of 18 years and eight percent of the girls deliver their first child before the age 15.<sup>11</sup> The proportion of adolescent births differs across the provinces; the highest proportion of adolescent births is in Khyber Pukhtoon Khuan (10.3%) and the lowest rate is in Gilgit Baltistan (6.5%).<sup>11</sup>

A study was conducted on a sub-set of 1526 ever married women, between 20 and 24 years of age, who were a part of a larger study of 10,023 women, were asked about their ages at marriage.<sup>12</sup> The study revealed that the mean age of marriage was  $17.52 \pm 2.68$  years; 5% got married when under 14 years of age; around 18.5% between the age of 14-16 years, and 26.4% got married at around 18 years of age. Of those who got married earlier, most (57.6 %) had had no formal education and resided in rural areas (70%). However, even after adjusting for social equity indicators, a history of early marriage was significantly associated with poor fertility outcomes.<sup>12</sup> These findings are alarming for Pakistan because, despite the lower prevalence of adolescent pregnancies than Bangladesh and Nepal, Pakistan's fertility indicators that is higher fertility rate and lower contraceptive prevalence rate, are less favorable as compared to these countries.<sup>7</sup>

### **Outcomes of Adolescent Pregnancies in Pakistan**

Many studies have found that the outcomes of pregnancy are worse for Pakistani adolescent girls as compared to older mothers. A case control study found that 50% of the Pakistani adolescent mothers were primigravidas, >32% were having their second baby, and around 17% were delivering their third or more babies.<sup>13</sup> The frequency of anemia among adolescent mothers was three times higher as compared to the non-adolescent mothers. Moreover, the adolescent mothers had significantly lower pre-pregnancy Body Mass Index (BMI), were twice as likely to have instrumental births, and three times more likely to acquire chorioamnionitis.<sup>13</sup> Besides these outcomes, other studies also reported higher incidences of eclampsia, pregnancy induced hypertension, prolonged and obstructed labor, obstetric fistulas, spontaneous and unsafe abortions, and increased rates of cesarean sections among adolescent mothers. Also, their babies were at a higher risk of having low Apgar scores, being born preterm, experiencing intrauterine growth restriction (IUGR), meconium aspiration, and neonatal death.<sup>14,15,16</sup>

### **Factors Associated with Adolescent Pregnancies in Pakistan**

There are several factors associated with adolescent pregnancies in Pakistan, and most of them are common in the South Asian region. Besides poverty and illiteracy, the prevailing social norms in the rural areas are a major challenge. A study from Bangladesh<sup>17</sup> reported several socio-cultural norms that could be found in Pakistan also. These customs include beliefs that wives should be several years younger than their husbands; a demand of young men for marriage due to

their sexual desires; the mother-in-law's dominance, and the desire for a daughter-in-law who can be shaped by her husband and his family members from a young age; parents' perceptions that marrying their girls earlier saves them from sexual exploitation; and misconceptions that family planning causes infertility.<sup>17</sup> In addition, the majority of adolescents lack information regarding sexual and reproductive health issues and rights, because discussion of these issues is a social and religious taboo. Even parents show discomfort in guiding their children.<sup>18</sup> Hence, misconceptions regarding sexuality and contraception prevail. Furthermore, women have a low status; a male child is preferred over a female due to the dowry traditions. Girls are considered an economic liability, and men are considered breadwinners; education for males is preferred and a woman is not allowed to use contraception when her husband wishes for more children.<sup>12</sup>

## **Discussion**

Unlike Pakistan, India increased the legal age of girl's marriage to 18 years in 1978.<sup>19</sup> Despite this change in the law, a study showed there was only a 5% reduction, overall, in adolescent pregnancies.<sup>19</sup> The same study also revealed that one in every eight women who had been married as a child was now sterilized. Of those who were not sterilized, the majority (77%) did not use contraception and were significantly more likely to have had three or more births, including a repeat childbirth in less than 24 months, multiple unwanted pregnancies, and pregnancy terminations. These outcomes were significantly associated with women who lacked education, resided in rural areas, practised Hindu, Muslim, or Buddhist religion, and whose husbands lacked education. These poor outcomes suggest that besides increasing the legal age of girls for marriage, it is also important to address the social vulnerabilities of young women and ensure legal protection of their rights.

Learning from the experiences of other countries, there are lessons for Pakistan when initiating targeted interventions to reduce adolescent pregnancies. Bangladesh was just second to Niger in adolescent births in the 1990's,<sup>17</sup> which prompted the government to seek foreign aid from United Nations Population Funds (UNFPA) and United Nations Children's Fund (UNICEF) for this issue. Amongst the greatest barriers to reducing high adolescent fertility were the strong socio-cultural norms that promoted early marriages in rural populations. Strategies that were initiated in Bangladesh to control the adolescent birth rate were: providing secondary school scholarships to young girls, improving communication across Non-Governmental Organizations

(NGOs), and utilizing the mass media channels to educate the population regarding the hazards of early marriages. Despite the slow transition attributed to these interventions, a behavioral change was reported amongst the Bangladeshi rural population.<sup>17</sup> These findings were also associated with an advanced role for midwives in community settings, which included creating awareness amongst families and young women about the benefits of delaying marriage, including an increased ability to earn income and avoidance of poor health outcomes resulting from early pregnancies. These interventions from midwives are crucial for women's empowerment and for providing insights to men that early pregnancy is associated with maternal morbidity and mortality.

Industrialized countries have sustained comparatively lower rates of adolescent pregnancy because of a continuing focus on the issue. These strategies include better access to and completion of formal education; increased availability of high quality sex education in schools; and an obligation to acquire job skills before starting a family. In England, for example, a 41% reduction in the adolescent birth rate occurred from 1998-2012; this has been maintained as the all-time lowest fertility rate in the developed world.<sup>20</sup> The success story involved efforts for prevention at the primary level by involving the local government, health organizations, health services, and frontline practitioners. Reducing adolescent pregnancies is one of the 66 indicators in the public health outcome framework of the National Health Service (NHS),<sup>21</sup> and it is a priority in the Framework of Sexual Health Improvement (FSHI).<sup>22</sup> This framework includes provision of high quality Sex and Relationship Education (SRE), promotion of friendly discussions with parents, and provision of youth friendly contraceptive services through a strong school health program, which is run by school health nurses. Moreover, England has also strengthened the role of midwives and nurses, with the Family Nurse Partnership (FNP) program for young adolescent mothers and fathers, from 28 weeks of pregnancy to 2 years after birth, to support their physiological and psychological transition to parenthood.<sup>20</sup>

Pakistan still observes many of the socio-cultural norms that contribute to adolescent pregnancy, however, illiteracy is a major barrier among both boys and girls. Only 51% of the Pakistani girls are enrolled in primary education, as compared to 60% of the boys, and of those who are enrolled, two thirds of the girls and half of the boys do not complete primary education.<sup>11</sup> Religious restrictions do not permit the promotion of SRE through the mass media. The small number of NGO's and health practitioners who are involved in Sexual and Reproductive Health (SRH) promotion activities have limited outreach and, therefore, limited effectiveness.<sup>23</sup> The role

of certain NGO's is critical in promoting SRH and contraceptive services to adolescents in the country; yet, the contraceptive prevalence rate among married adolescents (15-19 years) is only 13%.<sup>11</sup> This illustrates the slow pace of SRH interventions and signifies the need for interventions on a larger scale. Banning early marriage until the age of 18 has only been legally reinforced in the Sindh province so far, and its impact on reducing adolescent pregnancies has not yet been explored.<sup>24</sup> The greatest concern is that if adolescent pregnancies are not reduced there could be a population boom over the next few years because there is such a large number of adolescents in the country. Until now, whatever has been done appears inadequate to address this issue. There is a dire need to re-strategize and plan interventions that can have an impact on this growing problem.

### **Conclusion & Recommendations**

Adolescent pregnancies can be a major threat for the growth and development of the upcoming generation. It can have devastating health, economic, and social implications for individuals, families, and the entire country. Pakistan needs to strengthen female child education to support their empowerment, and to limit their exposure to early marriages. School and community health programs must target adolescents and their parents, regarding awareness about SRH and the disadvantages of early marriages. Education at the rural community level should be promoted. It is important to promote an understanding that menarche does not signify readiness for marriage, and that this can have fatal outcomes for women later in their lives. Simultaneously, laws also need revision to provide legal and financial protection for women if they want to refuse marriage. Social and health services need to identify the population that are vulnerable to early marriage; the role of nurses and midwives is crucial in identifying these cases and generating referrals according to their needs. Furthermore, the involvement of males should not be ignored at any level. Their education about these issues should also be prioritized, and frontline providers need to consider their involvement to sensitize them to these issues. Finally, all these competencies must be included in the midwifery curricula to enhance the role of midwives in preventing adolescent pregnancies and in supporting adolescent parents in their healthy transition to parenthood. These efforts are very important for improving maternal and child health. They can also contribute to reducing poverty, promoting gender equality, and the empowerment of women because they can improve the ability of girls to remain in school and become economically independent members of society.

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