

# Teen pregnancy and infant mortality research paper example

[Sociology](#), [Community](#)



Teenage pregnancy is associated with a myriad of risk factors. Amongst them are the physical risks for mother and child, as well as psychological and sociological factors that should not be underestimated. Some 11% of the births worldwide occur in women 15-19 years old and the problem is particularly acute in lower income countries such as sub-Saharan Africa, Bangladesh and India. (Gibbs, Wendt, Peters, Hogue 2012; Conde-Agudelo, Belizan, Lammers, 2005) Adolescent childbirth has been linked to poor maternal and child health outcomes even though this may be linked to poor education levels and economic status that these families usually have. Large numbers of young girls giving birth are illiterate, school dropouts, and lacking basic health insurance (Keskinoglu, et al., 2007).

Teenage pregnancy has been linked to a variety of diseases, including pregnancy-induced hypertension, inadequate maternal weight gain during pregnancy, anemia, placenta previa, abruption placentae, operative vaginal delivery, caesarian delivery, abortion, stillbirth, preterm delivery, and low birth weight (Keskinoglu et al., 2007). The ramifications of these diseases are enormous on a personal and social level. Obviously, the mother and child are greatly affected by these diseases - but they also have an enormous economic cost associated with them. Thus, it is not only the immediate family that is affected, but society at large that must bear the burden of these illnesses in lost productivity and actual dollars spent.

According to a large retrospective study conducted by Keskinoglu (2007), adolescent mothers had much higher rates of preterm deliveries (18. 2% vs 2. 1%), however the rates of caesarean births were lower (27. 7% vs 37. 4%). The birth weights of babies born to adolescents (aged 12-17 years old) were

not statistically different than the birth weights of older mothers. Ultimately, their study found no real differences in the levels of neonatal complications in the adolescent mother category vs. the older mother category – finding that the main difference was in fact one of economics (i. e. the lack of insurance, education, marital status, etc.)

Another trend of note is that adolescent mothers are more likely to have a 2nd birth than 1st births among adolescents in general and approximately 25% of births in this age group are not first births (Ventura, Ventura-Laveriano, Nazario-Redondo, 2012). In the retrospective study conducted by Ventura, et al. (2012) it was found that BMI was a little higher in multiparous adolescents than in nulliparous adolescents (23 vs 22). Furthermore, the multiparous adolescent group in the study was significantly more likely to have received inadequate prenatal care than either nulliparous adolescents or multiparous adults (47% vs 29. 3% and 33. 5%, respectively). Caesarian birth was less likely in the adolescent group (as was the case in Keskinoglu's study). No significant difference was detected in the rates of early births in the multiparous or nulliparous adolescents – but both adolescent groups tended to have a higher rate of births prior to 37 weeks (6. 8% and 6. 2% vs 5. 1%). Similarly low birth weight was similar in both adolescent groups, and again higher than in the adult group. Perinatal death or 5 minute Apgar score did not have any statistical difference between any of the groups (Ventura, 2012).

In a large cohort study of more than two million pregnancies encompassing most of Latin America conducted by Conde-Agudelo, et al., (2005) showed that the adolescent group was more likely to be nulliparous, without

permanent partner, and to have lower pre-pregnancy BMI than the older groups. Similarly to the other studies reviewed, the adolescents tended to have less adequate prenatal care. They found lower numbers of low birth weight infant (Contrary to the Ventura, et al. study), perinatal deaths, and chronic hypertension in adolescents as a whole (<15-18 years old). However, they did find higher levels of preeclampsia, eclampsia, anemia, hemorrhage, and puerperal endometritis in the younger women. Furthermore, the youngest adolescents had the highest rate of maternal fatality. The youngest age groups (<15 years old) had the highest rates of low birth weight, preterm delivery, and small for gestational age babies. The risk of anemia in this group was 40% higher than woman aged 20-24 years old. Adolescents considered as a whole did not have higher rates of complications, but this hides the fact that the group that was <16 years old were 4x as likely to die than mothers aged 20-24. Adolescents were at decreased risk for gestational diabetes, third-trimester bleeding, and caesarian delivery compared to the older mother group. Gibbs, et al., (2012) conducted a large meta-analysis looking at many individual indices of disease. Among their findings from the many studies they reviewed were that anemia during pregnancy was more common in adolescents 12-16 years old than in women > 19 years old. They examiners could find no significant differences in changes to maternal body composition in the age groups. BMI was slightly lower for pregnant women <16 years old than among adults aged 18-29 years old. No difference in premature ruptures of membranes was found between the two groups, however pre-eclampsia was more common in the younger age group. Findings relating to the newborn suggested a moderate association between

decreased maternal age and low birth weight babies. They also found an association between mothers <15 years old and preterm births and that the association may be stronger in developing countries. Neonatal mortality seemed to be unrelated to mother's age, and no studies regarding perinatal mortality met their inclusion criteria. The studies regarding maternal age and stillbirth were conflicting and the authors reached no conclusion regarding the risk posed. Gibbs, et al., state several hypotheses regarding the risk factors - seeming to prefer the theory of feto-maternal competition for nutrients and red-blood cells to account for the risks.. As can be seen, while sometimes the reports are conflicting, there are many risks to having a child at an early age. Low birth weight babies, maternal anemia, maternal death during childbirth are all very real risks even though some of the literature might be conflicting. The matter is of grave public concern due to the fact of the heavy burden that maternal death, poor maternal education, and unhealthy newborns puts on society at large. These groups will consume a large amount of health care spending and have questionable outcomes. The primary task of a Community Health Nurse must be educating the populations at risk for adolescent pregnancy. It is clearly not enough to educate teenagers who have already gotten pregnant, even though they must be educated regarding proper maternal nutrition, prenatal vitamins, and the importance of the prenatal medical checkups. It is also very important to educate teenagers about safe sexual practices and proper birth-control methods. There are many institutions, agencies, non-profits, and even corporations that are stakeholders in this issue. They all must be involved in augmenting this education. Obviously, schools must be involved

too and should encourage consultation and should encourage discrete counseling of students. Furthermore, hospitals, physicians, and nurses must also be involved with counseling and education and have an open-door policy, ready to answer questions and promote safe-sex practices in a non-discriminatory, non-judgmental, discrete, and confidential manner. For the girls at highest risk for negative outcomes, there must be complete education and disclosure of all the risks and the potential options regarding their pregnancy. The problem of adolescent pregnancy seems to be of particular concern to low-income groups and also developing countries. Considering these two at risk groups, it is also necessary to consider the help that multi-governmental groups such as various United Nations entities could offer. Clearly, individual autonomy must be maintained and appreciation of cultural norms must inform the practitioners approach to how to handle this delicate issue. Aside from the immediate potential health risks to mother and child though, the lack of education that is apparent in many of the reviewed studies must also be addressed. The lack of education has many more knock-off consequences too, such as the inability of the mother to adequately support herself and the newborn. These are delicate issues and there is no easy answer or quick fix. In sum, adolescent pregnancy and childbirth is a dangerous experience. Whereas there is no direct evidence of an increase in child mortality related to lower maternal age, there is certainly evidence of negative consequences to the health of the child and the four-fold increase in maternal death associated with pregnancy at <15 years old. The job of the community health nurse will be in educating young women about the health risks associated with promiscuous activity, and proper birth

control methods to avoid the direst of consequences of teenage pregnancy. It is incumbent on society at large to help these women because otherwise it is societies burden to look after these women and their children who often times have many more problems than just the immediate health risks associated with the state of pregnancy.

## References

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