Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module H

Care of adolescent pregnancy and childbirth

This handout presents background information to complement the material in module H entitled *Care of adolescent pregnancy and childbirth*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

This handout provides information on the following:

1. The scope of adolescent pregnancy, childbirth and maternal mortality

It is estimated that 15 million births occur every year to adolescents. This represents about 11% of all births each year (*1*). The global average rate of births per 1000 females aged 15-19 years is 65. There are however wide regional variations – see Table 1.

TABLE 1

Rate of births per 1000 females aged 15-19 years

Africa	143/1000	Range: from 45 in Mauritius to 229 in Guinea
Middle East	56/1000	Range: from 18 in Tunisia to 122 in Oman
South-East Asia	56/1000	Range: from 4 in Japan to 115 in Bangladesh
Latin America	78/1000	Range: from 56 in Chile to 149 in Nicaragua
Europe	25/1000	Range: from 4 in Switzerland to 57 in Bulgaria
North America	42/1000	Range: from 24 in Canada to 60 in USA

Source: References (2,3,4).

Declines in adolescent pregnancy and birth rates have occurred in most developed countries and also in a wide range of developing ones (*5*). Significant delays in the age of first marriage and accompanying declines in early childbearing have occurred in North Africa and Asia. However, the proportion of women who give birth as adolescents is still very high in Sub-Saharan Africa. Further, the proportion of adolescent births to unmarried women is increasing in some countries, and can be expected to continue to do so if contraceptive use among unmarried, sexually active young women does not increase rapidly (*6*).

For those adolescents who do give birth every effort is required to make motherhood safe. The statistics show that this is not currently the case. Pregnancy-related complications are the main cause of deaths for 15-19-year old girls worldwide (*7*). In some developing countries, maternal mortality among adolescent girls under 18 years is 2-5 times higher than in those aged 18-25 years (*8*).

Children born to adolescent mothers often experience higher risks of death during the first five years of life. A comparative study of Demographic and Health Surveys data from 20 countries showed that the risk of death by age five was 28% higher for children born to adolescent mothers than those born to women aged 20-29 years. (*9*)

An important contributory factor to maternal morbidity and mortality among adolescents is their higher recourse to unsafe abortion. In countries with reliable statistics, 40-60% of adolescent pregnancies end in induced abortion (*10*). Another contributory factor of growing importance, both to maternal mortality and to childhood mortality, is HIV/AIDS (*11*).

2. Factors that influence adolescent pregnancy and childbirth

A range of social, cultural, biological and service delivery factors contribute to the high levels of adolescent pregnancy and childbirth. These factors are shown in Box 1.

BOX 1

Factors contributing to adolescent pregnancy and childbirth

Declining age of menarche – The age of menarche has declined in developed countries and in the urban areas of many developing countries from +/- 15 years to +/- 12.5 years.

Longer periods of education and delayed marriage for some adolescents, and early marriage and pressure to have children for others – A growing number of adolescent girls stay on in school for longer periods and marry late as a result. For many other adolescent girls, female status is equated with marriage and motherhood. They are required to marry early, and face immediate pressure to prove that they are fertile.

Initiation of sexual activity during adolescence – In many parts of the world, adolescents become sexually active whether or not they are married. Sexual activity among unmarried adolescents is increasing in many parts of the world. However, it must be noted that the age of first sexual debut has increased or remained unchanged in a number of countries, notably in Asia and Latin America.

Sexual coercion and rape – Adolescent girls may be coerced into having sex, often by adults and peers in their social circle. Pregnancies can result from such assaults. Girls who are subject to sexual abuse and rape can suffer serious, life-long physical and psychological consequences.

Education levels – This strongly influences adolescent childbearing as seen in many countries in which women with no education give birth before the age of 20 years, whereas women with even some secondary schooling, are less likely to do so.

Socio-economic factors – Economic hardships can force young girls to leave home and seek a living elsewhere. Sexual exploitation and prostitution are sometimes the consequences of this. Through ignorance of contraception, inability to access contraceptive services, and inability to insist on condom use, the young girl may soon find herself pregnant.

Other risk behaviours – The use of alcohol and other substances may be associated with unprotected sexual activity, leading to unwanted pregnancies.

Lack of knowledge – Sexual and reproductive health information and education programmes are underway in many places. This has contributed to increases in knowledge and understanding. However, adolescents in many places continue to have significant knowledge gaps and misconceptions about sexuality and reproduction.

Lack of access to services – In many places, a range of barriers hinder the abilities of adolescents to obtain the contraceptive services they need[1]. Further, termination of pregnancy is illegal in many parts of the world. Even where it is legal, it is often inaccessible to adolescents.

Source: References (12,13,14,15,16).

[1] Adolescent pregnancies tend to be highest in regions with the lowest contraceptive prevalence. Moreover in many developing countries recent gains in contraceptive prevalence have been almost exclusively among older, married women and not adolescents.

3. Risks associated with pregnancy and childbirth in adolescence, and how they differ from those in adults

Pregnancy and childbirth in adolescence carry a greater risk to the health of both mother and baby, than in adult women. This is attributable to both biology and the social environment. A young maternal age, when combined with low social status and inadequate access to health care, contribute to the high maternal mortality in adolescents reported in many developing countries. The risks are high during the antenatal period, during labour and in the postpartum period (Box 2). Babies born to adolescent mothers also have a higher risk of being of low birthweight, and of higher rates of mortality and morbidity.

BOX 2

Pregnancy complications occurring more commonly in adolescents than in adults

- Pregnancy-induced hypertension
- Anaemia during antenatal period
- STIs/HIV
- Higher severity of malaria
- Pre-term birth
- Obstructed labour
- Anaemia during postpartum period
- Pre-eclampsia
- Postpartum depression
- Too early repeat pregnancies
- Low birthweight
- Perinatal and neonatal mortality
- Inadequate child care and breastfeeding practices

Problems in the antenatal period *(17)*

Pregnancy-induced hypertension

There are conflicting reports on the incidence of hypertensive diseases of pregnancy in adolescents. However, studies report an increased incidence of the condition in young adolescents, when compared with women aged 30-34 years.

Anaemia

Results from a meta-analysis of studies show an increased risk of anaemia in adolescents from developing countries, compared with women over 20 years of age. Anaemia in pregnancy is often caused by nutritional deficiencies, especially of iron and folic acid, and by malaria and intestinal parasites. Vitamin A deficiency and HIV infection may also play a role in its causation.

STIs/HIV

Sexually active adolescents are at an increased risk of contracting STIs, including HIV infection, owing to their biological and social vulnerability. There is also the increased risk of mother-to-child transmission of HIV in adolescents, because the HIV infection is more likely to be recent, and therefore associated with higher viral loads. The presence of other STIs (syphilis, gonorrhoea and chlamydia) with local inflammation may increase viral shedding, thereby increasing the risk of transmission during labour.

Higher severity of malaria

Malaria is one of the most important causes of anaemia during pregnancy. First-time pregnant women (which includes many adolescents) are more likely to be infected with malaria than women who have been pregnant before. They are also more likely to suffer its more severe forms. This puts them at risk. It also puts their foetuses at risk of intra-uterine death or low birthweight.

Problems during labour and delivery

Pre-term birth[1]

A meta-analysis using data from developed and developing countries showed that, compared to women over twenty years of age, adolescents are at increased risk for pre-term delivery. A likely cause of this is the immaturity of the genital organs of young women. However, social factors such as poverty, behavioural factors such as psycho-active substance abuse, and lack of optimal antenatal care also have a negative influence on pregnancy outcome.

Obstructed labour

In young girls (below 15 years of age), cephalo-pelvic disproportion is more likely to occur than in older adolescents, and in adult women. This is due to the immaturity of the pelvic bones, and the small size of the birth canal. In such circumstances, lack of access to medical – and surgical – care can result in obstructed labour with all the attendant implications. Prolonged obstructed labour can result in vesico-vaginal and recto-vaginal fistulae, which if left untreated can have serious social repercussions for the young woman.

Problems in the postpartum period

Anaemia

Adolescents are more at risk of anaemia in the postpartum period due to pre-existing anaemia during pregnancy. This may be further aggravated by blood loss during labour and delivery and may increase the risk of puerperal infection.

Pre-eclampsia

Several studies report that pre-eclampsia occurs more often in young adolescents. The symptoms may become worse during the first postpartum days, and occasionally the first symptoms are recognized postpartum.

Postpartum depression

Adolescent women are also more likely to suffer from postpartum depression, or other mental health problems.

Too early repeat pregnancies

In many countries unmarried adolescents face considerable barriers in obtaining reliable contraception, because of barriers to the provision of services to them. Unprotected intercourse and repeat pregnancy have been found to occur in as many as 50% of these young women, within 24 months of delivery.

[1] Gynaecological age is defined as the chronological age less the age at menarche. A value of less than two years is associated with a higher risk of pre-term labour, and possibly cephalo-pelvic disproportion and consequent obstructed labour.

Problems affecting the baby

Low birthweight

A number of clinical studies in developing countries, and some from developed countries, have showed a higher incidence of low birthweight (weight <2500 grams) among infants of adolescent mothers.

Perinatal and neonatal mortality

Clinical studies in both developing and developed countries have found increased perinatal and neonatal mortality rates in infants of adolescent mothers, compared with infants of older mothers.

Inadequate child care and breastfeeding practices

Young mothers, especially those who are single and in difficult socio-economic situations, may find it hard to provide their children with the care they need. This is reflected in their poor child-feeding, including breastfeeding, practices.

Why are these complications worse in adolescents than in adults?

The complications described above are by no means limited to adolescents. Older women also suffer from similar complications. Also, the situation of adolescents varies depending on their marital status and the support available for them during pregnancy and childbirth. Social and cultural norms may hinder the ability of adolescents (married and unmarried) to obtain information and access antenatal, delivery, and post natal services. There are, however, several reasons why the complications have a worse outcome in adolescents.

1. Biologically, young adolescents are not mature enough for the strain imposed on them by pregnancy. Firstly, in physical terms, their pelvic bones are not fully mature, and as a result, cephalo-pelvic disproportion could potentially occur. Secondly, young adolescents may continue to grow during pregnancy. What this means is that there is a potential for competition between the mother and the foetus for the nutrients required for growth and development. If the adolescent's growth and development have been hindered by under-nutrition during childhood, she would then be entering pregnancy with nutritional deficiencies as well as impaired growth and development, further increasing the risk of negative outcomes. Thirdly, young adolescents may also not be psychologically prepared for motherhood. This could result in mental health problems such as depression.

2. Compared to older women, adolescents are less empowered to make decisions about matters affecting their health (as well as other matters). If married, the husband is likely to be older, better educated and the principal family wage-earner. In some cultures, the husband's mother and sister (s) are likely to have a greater say in decision-making in matters concerning the household than his young wife. If single, the shame of the pre-marital pregnancy may leave her voiceless and even as a family outcast. In some cultures, single pregnant adolescents are sent away to distant relatives until after delivery. In such circumstances, the adolescent is unlikely to get the psychological and practical support that she needs.

3. Adolescents are more likely to enrol later and to make fewer health-facility visits for antenatal care. Clearly, socio-economic factors have a major influence on antenatal care utilization. The stigma associated with premarital pregnancy is another critical factor contributing to this. In many places, unmarried adolescents hide their pregnancies for as long as they can. On the other hand, married adolescents may not even know of the value of antenatal care, and even if they do, may be unable to obtain it. What this means is that adolescents are deprived of a service that has been shown to contribute to positive pregnancy outcomes.

4. In many places, adolescents deliver at home. They come to - or are brought to - hospital only as a last resort, often with serious complications. The factors that contribute to this include:

   - Social and cultural norms may dictate that they deliver at home;
   - They may be afraid of hospitals;
   - They may have heard discouraging stories about mistreatment by hospital staff (and especially labour room staff);
   - They may be unable to bear the hospital charges, or even for the cost of private transport to get there.

   What this means is that a problem that could be prevented or promptly managed in a hospital could potentially get out of hand during delivery at home.

5. In many places, pregnant adolescents – especially unmarried ones – are treated with scant respect by medical and nursing staff, as well as clerical and other staff. Further, many health-care workers are not conversant with the issues that need to be borne in mind when providing care during pregnancy to adolescents. As a result, antenatal visits and the delivery experience can be unpleasant for the young person, and in addition inadequate in terms of technical quality.

4. Care of adolescents during pregnancy, childbirth and the postnatal period

There is much that can be done to reduce the occurrence of problems, and to improve the health of the mother and the (unborn) baby. This includes early diagnosis of pregnancy, effective antenatal care, effective care in labour and delivery, and effective postpartum care.

Early diagnosis of pregnancy

The early diagnosis of pregnancy is an important first step in drawing the adolescent into antenatal care. Health-care providers and other adults in more regular contact with the adolescent, including family members, have the shared responsibility of creating a supportive environment in which she feels able to share information about her situation. Health-care providers need to be aware that a young adolescent may not know that she is pregnant. This may be because she may not remember the dates of her last menstrual period, or because her periods are not regular. Another issue to be aware of is that if the adolescent is unmarried, she may want to hide her pregnancy or even to terminate it. Being aware of these issues, and being on the lookout for telltale signs of early pregnancy (such as nausea) will help ensure that an early diagnosis of pregnancy is made and that the adolescent receives the care and support she needs.

Antenatal care

Repeated contacts with the health-care system provide a useful opportunity for the detection and treatment of problems that commonly affect pregnant adolescents. Pregnancy-induced hypertension can easily be detected. Uncomplicated hypertension can be managed on an outpatient basis. In case of complications (such as pre-eclampsia, eclampsia, and abruption placentae), referral to a hospital is indicated. Anaemia and malaria too can be detected and treated during routine antenatal care. Antenatal visits also provide a valuable opportunity to screen for STIs such as syphilis and to provide the required treatment, when needed. They also provide an opportunity for the provision of food supplements, in case under-nutrition is detected. It is worth noting that there is only limited evidence of the value of food supplementation on increasing birthweight. Finally, antenatal visits could help identify those adolescents – especially very young adolescents – at risk of pre-term labour, though interventions to address this are limited *(17)*.

Antenatal care should go much further than the detection and treatment of problems. It provides a valuable opportunity for the provision of information and counselling support that adolescents need. WHO recommends a minimum of four antenatal visits for all pregnant women *(18)*. This is especially important in the case of adolescents – especially unmarried ones – because of their greater need for support.

Antenatal care also provides an entry-point for the identification and provision of social support services. The waiver of user-fees, and the provision of medicines such as anti-malarials, and food supplements free-of-charge will help ensure that they do in fact benefit from antenatal care.

Counselling during pregnancy

As indicated above, health-care providers should seek to understand the situation that their adolescent patients are in, and to provide them with the information and counselling support that meet their needs (listed below). In addition, pregnant adolescents may have questions and concerns of their own. They must be given an opportunity to raise and discuss these issues.

- The life situation of the adolescent including her marital status and socio-economic situation, and the support available to her from her husband/partner, family members, friends and others;
- The options available to her in terms of the pregnancy (e.g. in some places discreet arrangements are available for handing the child over for adoption soon after birth);
- The support that she needs, and the social support services for which she is eligible;
- Her access to health services for routine antenatal care and in case of emergency;
- Her plans for the delivery;
- Her plans for the care of the baby;
- Her plans for continuing with her education or work after the delivery.

Counselling should also include health issues that are relevant to the person. These include good nutrition, malaria prevention and smoking (and other psychoactive substance use) cessation. Another important issue is HIV/AIDS. As indicated above, adolescents are at an increased risk of contracting HIV infection, and of transmitting the infection to their infants. In a growing number of countries, voluntary counselling and testing services, as well as anti-retroviral therapies to prevent mother-to-child transmission, and to safeguard the health of the mother, are becoming available. Adolescents should be encouraged to obtain HIV counselling and testing. In addition to opening the door to anti-retroviral therapy to prevent mother-to-child transmission, and to prevent/reduce viral multiplication in her body, the knowledge of her HIV status will enable the HIV-infected adolescent to take the necessary steps to prevent transmission to others. For those who test HIV-negative, this provides an opportunity to reinforce the message of STI/HIV prevention.

Management of labour and delivery

If the pregnancy in an adolescent is uneventful, complications such as anaemia are treated adequately, labour starts at term, and the infant is in cephalic presentation, labour is not at increased risk. However, if the adolescent is severely anaemic, postpartum haemorrhage can be dangerous. In very young adolescents, pre-term labour as well as obstructed labour are more likely to occur. What this means is that although in general, labour is not necessarily more risky in adolescents than it is in adults, some adolescents clearly are a high risk for specific reasons.

As a general rule, if the labour is a potentially high-risk one, it is advisable to encourage hospital delivery. In some places, "waiting mothers" shelters have been established to help ensure that women who are likely to require institutional delivery do not find themselves stranded at home because there is no one around to accompany them to the hospital, or because transportation is not available/affordable.

Guidelines for the provision of care during normal labour have been developed by WHO *(19)*. Besides observing and monitoring, supporting the woman and her partner (or companion) is very important, especially in adolescents. Studies have shown that continuous empathetic support during labour, provided by a nurse or midwife results in many benefits both to the mother and the baby *(17)*.

Postpartum care

Postpartum care includes the prevention, early diagnosis and treatment of postnatal complications in the mother and the infant. It also includes the provision of information and counselling on breastfeeding, nutrition, contraception and care of the baby *(20)*. The adolescent mother will require support on how to care for herself and her baby. Since many adolescents – especially those in difficult social situations - do not receive adequate antenatal care, or the support of their partners/families, postpartum care is even more important for them.

Contraception

Many too-early repeat pregnancies are unplanned and as a result of absent or inadequate contraceptive efforts *(17)*. The postpartum period presents a good opportunity for taking concrete steps towards pregnancy prevention and for promoting dual protection by using condoms.

Nutrition of the mother

The lactating adolescent needs adequate nutrition to meet her own bodily needs as well as the extra needs required for breast-milk production.

Breastfeeding

WHO has made recommendations concerning breastfeeding *(20)*. A young adolescent – especially one who is single – would require extra support in achieving breastfeeding successfully.

Between 5-20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding depending on a range of factors. Every HIV-infected mother should receive counselling, which includes information about the risks and benefits of different infant feeding options, and specific guidance in selecting the option most suitable for her situation. The final decision should be the woman's, and she should be supported in her choice. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life, and should be discontinued when an alternative form of feeding becomes feasible (*21*).

The first weeks and months as a young mother

Many adolescents return with their babies to the love and support of their families. Many others are less fortunate. Their social circumstances are often distressing. If the adolescent mother is unmarried or without a partner, she may face problems with her family and community because they disapprove of her behaviour. In such circumstances, her health and well-being and that of the baby are at risk. Maintaining ongoing contact through home visits has been shown to be helpful in reducing rates of child abuse and maltreatment. In addition to support with baby-care, the adolescent will benefit from support for planning her future. Responding to this can be both rewarding and challenging.

SUMMARY

- Pregnancy in adolescents is not uncommon.
- Many factors contribute to adolescent pregnancy.
- Adolescents have higher maternal mortality than adults.
- Babies born to adolescents have a higher mortality too.
- Many of the complications arising during pregnancy and delivery have worse outcomes in adolescents.
- There are important issues for health-care providers to be aware of, in caring for adolescents through pregnancy, labour, delivery and the postpartum period.
- Promoting safe pregnancy and childbearing in adolescence requires concerted actions beyond the health sector. Three key actions in relation to this are increasing girls' access to education and job opportunities, enhancing their status of women and girls in society, and improving their nutritional status.

5. References

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Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

In developing countries, how does the rate of maternal mortality of pregnant girls under 18 years old compare with adults?

please mark your answer with a spot anywhere along the line

The rates are about the same	About twice as much as for adults	About three times as much	About four times as much	About five times as much

SPOT CHECK 2

Which factors could contribute to antenatal complications in pregnant young adolescents?

please write down one example each for married and unmarried adolescents

MARRIED

UNMARRIED

SPOT CHECK 3

What are the most common antenatal complications in young adolescents?

SPOT CHECK 4

In your opinion, what are the most important issues to raise in counselling sessions with pregnant adolescents?

please write down your answers

SPOT CHECK 5

What are the critical aspects in caring for the pregnant adolescent in the postpartum period?

please write down your answers

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Annex 2

Case study

Session 6: ACTIVITY 6-1

CASE STUDY

Safina, a 15-year old adolescent girl was brought to the casualty department of a government hospital located in the a sprawling district of an East African country. The accompanying relatives told the doctor on duty that she had been in labour for three days, and was being cared for at home by a Traditional Birth Attendant (TBA).

This was Safina's first pregnancy. She had not attended any antenatal clinic for the entire duration of her pregnancy (which was at term). According to her relatives, labour had started three days earlier. The TBA who had been attending to her, gave her herbal potions to speed up the labour, to no avail.

Safina had complained of unbearable abdominal pain, had started bleeding from her vagina and had grown progressively weaker. That is why her relatives decided to bring her to hospital. Further enquiry revealed that Safina had been married a year ago to a man in his late fifties. She was his fourth wife.

Examination revealed a young woman with pregnancy at term. She was pale and dehydrated. Her abdomen was tender and firm. Foetal heart sounds could not be heard. There was moderate vaginal bleeding. Vaginal examination revealed a fully dilated cervix with marked caput. The foetal head was 3/5 and fixed.

A diagnosis of obstructed labour with intrauterine foetal death was made. Arrangements were made for emergency caesarean section.

At caesarean section, the foetus was found lodged in the abdominal cavity. It was evident that the uterus had ruptured at the fundus, extending to the left lateral side. There had been severe bleeding. The doctors considered uterine repair but decided against it. A sub-total hysterectomy was performed and the abdomen closed.

Safina had a stormy post-operation period. Her temperature remained high despite antibiotics and on day 5 she started to have urinary incontinence although a Foleys catheter had been left in place. Her fever settled after 10 days but the urinary incontinence continued. At the examination under anaesthesia three weeks later, the presence of a Vesico-Vaginal Fistula was confirmed. She was discharged and advised to return after three months for surgical repair of the fistula.

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Annex 3

Role plays

Session 6: ACTIVITY 6-2

ROLE PLAY 1

A doctor, the nurse in-charge and two other nurses are conducting a ward round in the maternity ward of a government hospital. There are around 25 patients in the ward. About a third of them are adolescents. The team arrive at the bedside of a 14-year old girl who has been admitted with severe anaemia (complicating her pregnancy). Her haemoglobin is 7gm%.

As they reach the bed the nurse in-charge, starts berating the girl loudly. "You had no business to have sex before getting married, and no business getting pregnant. You play around and we all have to work to take care of you." The girl starts weeping silently. Her mother hangs her head in shame. The doctor is clearly embarrassed by this outburst. He gently tries to intervene…

Roles: Doctor, nurse-in-charge, 14-year old girl, mother.

ROLE PLAY 2

A woman in her mid-fifties has come in to the weekly antenatal clinic in a municipal health centre with her 15-year old daughter-in-law, who is pregnant (about 24 weeks). The doctor elicits information and carries out an examination. Her conjunctivae and nail beds are very pale, but apart from that, she appears to be well. He sends her for a quick check of the haemoglobin level. According to the report, it is 9 gm%. He sets about explaining the diagnosis and its implications for the health of the mother and her unborn baby, and what remedial action needs to be taken…

Roles: Doctor, 15-year old pregnant girl (24 weeks), mother-in-law.

ROLE PLAY 3

A teacher at a boarding school comes in to the casualty unit of a district hospital with a 16-year old school-girl (who is in school uniform). The teacher says that the girl has been complaining of severe lower abdominal pains, and wonders whether she has menstrual cramps.

On examination, the clinical officer on duty confirms a full-term pregnancy. The girl has concealed her pregnancy from her family and from teachers at school by binding her abdomen tightly.

The girl is in labour. Her cervix is 4 cms dilated. After sending the girl to the labour ward, the clinical officer sends for the doctor on call, to help explain matters to the teacher.

Roles: Doctor, clinical officer, teacher.

ROLE PLAY 4

A 15-year old girl who delivered a baby boy three days ago at a maternity hospital in a city, is now ready to go home. The nurse responsible for this is filling in the discharge slip and then turns to speak with her about follow-up care.

Roles: 15-year old girl, 3-day old baby (doll), nurse.