Too much too young? Teenage pregnancy is a public health, not a clinical, problem

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The argument as to whether teenage pregnancy is a public health problem or not entirely depends on the definition of a ‘public health problem’. In the absence of any working definition, Lawlor and Shaw concentrate on the biological outcomes of full-term pregnancies amongst teenagers. There is some legitimacy in their proposition that the adverse maternal outcomes, from a narrow medical perspective, do not constitute a major public health problem. They do not, however, deal with the much more important issues of the educational and social effects of early motherhood. It is surely a palpably good thing for it to be socially, culturally and economically unacceptable that so many teenagers disrupt their lives through the consequences of pregnancy whether it is wanted or not. That the health sector has an important role in this must surely be undeniable. There is not only the complexity of providing sexual health services for young people but also the organization of maternity services for teenagers who decide to continue with a pregnancy and the provision of termination services for those who do not. The strategy laid out in the Social Exclusion Unit’s report goes far beyond issues of health service provision and sets out to tackle issues including education, housing, social security benefits and self esteem.

The reason why teenage pregnancy is regarded alongside cardiovascular disease, cancer and mental health is precisely because similarly broad-based action is needed in all of these areas. The problems of obesity, smoking, poor diet, and social isolation cannot be considered solely as medical issues if we want to prevent disease rather than treat the consequences of it. That is not to say that there are not potential difficulties in singling out teenage pregnancy as a key issue in the sexual health field. The most serious issue is the way in which the setting of targets for teenage pregnancy can distort priorities within the sexual health field. The establishment of a target for the reduction in the rate of pregnancies to under 16s in the ‘Health of the Nation’ strategy encouraged some Health Authorities to reduce sexual health services for older groups despite the highest rate of unwanted pregnancy, judged by the termination rate, occurring amongst women in their twenties.
Lawlor and Shaw are incorrect to say that health risks arising from pregnancies to older women are disregarded. The growth of assisted, and particularly multiple, conception is seen as an important issue. The rise in age at first pregnancy has magnified widespread concern about the ineffective operation of antenatal screening and has led to a major initiative to improve the system in the UK.

The effort to medicalize public health goes back a long way. John Ryle was one of the most prominent advocates of substituting disease based social medicine for public health. He sought to substitute ‘inspiration more from the field of clinical experience’ for what he perceived to be an over-emphasis on the environment. Lawlor and Shaw have followed the same tempting, but flawed logic. This leads them to conclude that because the consequences of unwanted teenage pregnancy cannot be quantified as being substantial in terms of disease then it cannot be a public health issue.

Perhaps the most disturbing element of Lawlor and Shaw’s paper is the misconstruing of what Tony Blair wrote in his Foreword to the Social Exclusion Unit’s Teenage Pregnancy report. He did not write that teenage pregnancy was shameful, what he wrote was that the UK’s record in respect of the rate of teenage pregnancy was shameful. These are completely different things. The idea of teenage pregnancy being shameful is surely a concept that’s time has long passed, whereas a recognition that we as a society have a shameful record in the poverty, educational failure and social exclusion of teenage mothers is an important step in doing something to rectify that situation. Unless of course you care only for perinatal mortality rates and not about disrupted young lives.

References


Teen pregnancy is not a public health crisis in the United States. It is time we made it one

Janet Rich-Edwards

Strictly speaking, Lawlor and Shaw are correct. After adjusting for family background, race/ethnicity, socioeconomic position, educational success, and future prospects, many US studies show that teen mothers are as likely as older mothers to bear and raise healthy, successful children. After adjusting for being born to Texas oil barons and educated at Andover and Yale (throw in effect modification by paternal occupation), might you or I be the leader of the free world? Sure. The sanitary appeal of our modelling exercises can blind us to the sheer common sense of crude numbers. Teen parenthood is still associated with infant mortality, childhood illness, welfare dependence, academic failure, juvenile crime, and teen parenthood in generations to follow. This is not to deny the importance of research into the causes and effects of teen pregnancy. Indeed, it is testimony to the increasing strength of epidemiological methods that maternal age can be stripped from its tight association with economic and social risks, yielding the conclusion that teen pregnancy (at least for the 98% of teen pregnancies that occur after age 14 in the US) poses little, if any, inherent biological risk in the developed world. Such studies implicate poverty, not maternal age, as the real threat to maternal and infant welfare. It is not just the disadvantaged, but the ‘discouraged among the disadvantaged’ who become teen mothers. Poverty causes teen pregnancy. Simply put, girls with prospects do not have babies.

But does premature parenthood cause future poverty? Remarkably, with appropriate control for economic background and educational attainment prior to pregnancy, it appears that the life trajectories of teen mothers are little altered by becoming mothers in their teens. Circumstances were not about to improve for these young women, even if they had postponed pregnancy into their twenties. In the words of one Boston teen, ‘Why should you wait? Who’s coming?’ Under these circumstances, it would make little, if any, difference to US public health if teen mothers were to wait a few years. Indeed, where cumulative exposure to poverty and stress degrades maternal health capital, risks of poor pregnancy outcome may actually rise with maternal age. Arline Geronimus has argued that in the face of such powerful weathering forces, it makes sense for disadvantaged women to bear their children in their teens.

These data indict a society in which many youth face prospects so bleak that the conventional credentials of adulthood, a high school degree and a job, are rendered nearly worthless.