Too much too young? In Nepal more a case of too little, too young

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It is critical that as public health specialists we identify carefully and more exactly where the problem lies with teenage pregnancy. Is the age of the mother the critical factor determining the subsequent health of mother and baby? Or are the ‘other confounding factors’ referred to in some of the research studies in fact the real problems?

Lawlor and Shaw refer to studies that make more serious efforts to control for these confounding factors, concluding that increased risks are predominantly caused by ‘social, economic and behavioural factors that predispose some young women to pregnancy’. They indicate that cultural factors may also play a part. To what extent do the poor outcomes of teenage pregnancy reflect the attitude of a society towards teenage pregnancy? And what public health impact would we achieve if we could successfully intervene and change a woman’s age at first birth and nothing else about her up to that point?

To look at these questions in the light of 16 years of reproductive health work in Nepal is not just fascinating but vital; for many young women they represent life and death issues over which they have no control.

A simple place to start is to state that 43% of girls in the hill areas of Nepal marry in their teens (between 15 and 19 years of age). There is strong cultural and family pressure to produce a son within a year; the status of the young woman within her new family is dictated predominantly by this one factor. From the Nepalese perspective early pregnancy is a highly successful outcome; an extended family network cares for the baby, thus mitigating some of the problems associated with immaturity of the young mother.

Pregnancy outside of marriage, however, is a catastrophe. The girl becomes unmarriageable unless a hasty marriage can be arranged (which is not always culturally acceptable), her future is destroyed and she becomes a social outcast. The baby may be aborted (often at considerable risk to the life of the mother) adopted (rarely) or die. An unmarried teenage girl would not normally have the option to keep her baby and remain supported by her family. Some of these girls, in desperation, commit suicide or run away to avoid shame, in which case the baby may be born in the open and abandoned by the mother.

The simple answer to the question ‘is teenage pregnancy a public health problem?’ in Nepal, would initially seem to be: No. It is, as elsewhere, unwanted and socially unacceptable pregnancy, which is the problem.

On deeper examination however the situation may not be as simple as that. When one looks at the maternal and infant mortality rates for Nepal compared to England and Wales they are hugely different. The maternal mortality rate per 100,000 live births was 539 in Nepal in 1996, whereas in England and Wales it was 6.4; the infant mortality rate per 1000 live births was 78.5 in the period 1992–1996 in Nepal, whereas in England and Wales it was 6.2 in 1994. One may be drawn to conclude that age at first pregnancy in Nepal, even in the ‘socially acceptable’ group of married teenagers, may actually be a factor in high maternal and infant mortality rates. Let us ask the question again: ‘To what extent would delaying the age of marriage, and the age of first birth, have an impact on the outcomes of pregnancy and the health of both mothers and babies in Nepal?’

Some of the factors to consider are:

**Nutrition**

In the hills of Nepal the diet may be extremely limited (50% of the population receive less than adequate calorific intake). Young girls are usually last in line for food; they receive less food, of lower nutritional value, than their brothers. Once married, the daughter-in-law is the least important member of the family and certainly receives least food. The incidence of anaemia in pregnancy (63%), low birthweight (25.4% births less than 2500 g) and cephalopelvic disproportion are significant. Delaying age of marriage and first birth would have an effect on the nutritional and maturational problems faced by very young mothers, simply giving her longer to develop and grow, even if all other factors remained the same.

**Education**

Increasing numbers of Nepali girls are attending school and having the opportunity to receive high school education (female enrolment in high school as per cent of male enrolment is 28%). In the cities more females are attending college and have the chance to enter paid employment. Women who have a secondary schooling are less likely to give birth during adolescence, and the survival rate of children increases with years of high schooling received by the mother. On average women with seven more years of education marry four years later and have 2.2 fewer children than those with no education. In countries where women are subjected to multiple pregnancies over many years her later years of childbearing may also be high risk. To decrease her overall number of reproductive years, and the overall number of children, increases the survival and health of the smaller number she does have, as well as the health of the mother herself.

**Increased income-earning skills**

If young women are given the opportunity to gain skills with which they can earn an income, then they provide increased...
family income for food and medicines. Since poverty is almost certainly a key factor in health and child survival—and it is well known that mothers will use their own income to pay for food and medicines that their children need—then to delay marriage and childbearing until the woman has income-earning skills will increase her overall health and that of her children.

A direct spin-off from education, income-generating power, and literacy, are the increased levels of ‘empowerment’ experienced by women. Women with literacy, education and even small amounts of their own money have a confidence and bargaining power unknown to those without it. A woman’s reproductive health decisions are often controlled by her male partner—to empower a young woman may in itself be one of the most powerful factors in improving reproductive health. A woman able to: avail herself of family planning services, understand the messages and make informed choices about their use, limit her family size, negotiate safe sex and condom use to prevent infection with sexually transmitted diseases, and decide to take her child to the health centre and have her immunized, is in a powerful position to influence her health, and that of her children. Literacy, education and income do not guarantee a woman any of these freedoms, but they increase her chances of gaining them.

In conclusion therefore I would say that in Nepal it is not so much a case of ‘too much too young’, but the opposite, ‘too little too young’: too little food, too little education, too little finance and too little choice. This is what makes teenage pregnancy a problem. Active efforts to delay marriage and age of first pregnancy alone would make significant differences to the health of mothers and babies in Nepal. When active attempts are made to address the ‘too littles’ then we will begin to see real improvements in the health status of mothers and their children.

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References


What a difference a year makes?
Too little too late

Debbie A Lawlor and Mary Shaw

‘... if we could successfully intervene and change a woman’s age at first birth and nothing else about her up to that point?’

Scally argues that we do not deal with the much more important issues of the educational and social effects of early motherhood and focus on a narrow medical definition of public health. We would argue that we deal primarily with the detrimental effects, for mother and child, of social deprivation. However, we do not feel that these problems are the preserve of one particular age group. We agree with Scally, Rich-Edwards and Smith that some teenage mothers in the UK, US and Nepal have blighted lives, but we do not believe that labelling a woman who chooses to have a baby under the age of twenty as a public health problem actually helps the mother or her child. We believe that the underlying problem lies in society’s attitudes towards young people and specifically in attitudes towards women’s reproductive lives.

It seems that we are all agreed that there are no inherent health or medical problems associated with becoming pregnant and having a child before the age of twenty. Therefore, if society were such that a 16-year-old could begin her family at that age, and then say in her mid-twenties, return to education or a chosen career path, without prejudice and undue uphill struggle, there would be no problem. Referring to very different contexts Rich-Edwards and Smith suggest that if young women are provided with education, income-earning potential and empowerment then an additional benefit will be that early motherhood will be delayed. But we would argue that opportunities, support and services should be available to women regardless of their age and regardless of whether or not they have children. Provision should suit and support the reality of women’s lives, rather than limit their opportunities and choices unless they organize their reproduction in a socially acceptable way. Changing society’s attitude towards young women and their reproductive choices may facilitate better opportunities and support, labelling them as a public health problem is unlikely to. Understanding that an unwanted pregnancy is NOT the same as an unwanted child or a child automatically doomed to fail in society is also