



## Commentary

## WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries

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## A B S T R A C T

Adolescent pregnancy and its consequences represent a major public health concern in many low-middle income countries of the world. The World Health Organization has recently developed evidence-based guidelines addressing six areas: preventing early marriage; preventing early pregnancy through sexuality education, increasing education opportunities and economic and social support programs; increasing the use of contraception; reducing coerced sex; preventing unsafe abortion; and increasing the use of prenatal care childbirth and postpartum care. In each of these areas, World Health Organization recommends directions for future research. The summary concludes with a brief look at global and regional initiatives that provide a window of opportunity for stepping up action in this important area.

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The World Health Organization (WHO) recently published its guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries [1]. Adolescent pregnancy and its consequences represent a major public health issue with enormous social implications, in many countries of the world. In 2008, there were an estimated 16 million births to mothers aged 15–19 years worldwide. About 95% of these births occurred in low- and middle-income countries (LMICs) [2]. Births to younger adolescents were relatively less common, but according to recent estimates, 1 million births occur to girls aged 12–15 years every year [3]. Although adolescent birth rates are declining, the absolute number of births has declined less because of the increase in the size of the adolescent population [4].

First pregnancy at an early age is risky for the health of the mother. Even though births to adolescents account for 11% of all births worldwide, they account for 23% of the overall burden of disease (in terms of disability-adjusted life years) from pregnancy and childbirth among women of all ages. In LMICs, complications of pregnancy and childbirth are the leading cause

of death in women aged 15–19 [5]. The social consequences of pregnancy to adolescents include school dropout (with subsequent lower educational attainment and decreased social opportunities, including reduced lifetime earnings) and, in some settings, violence, including suicide and homicide [6]. The adverse effects of adolescent childbearing extend to the health of their infants. In LMICs, stillbirths and deaths in the first week and first month of life are 50% higher among babies born to mothers younger than 20 years than those born to mothers aged 20–29 years, and the younger the mother, the greater the risk [5].

**The WHO Guidelines: Rationale and Methods**

The new guidelines were developed according to WHO's Grading of Recommendations, Assessment Development and Evaluation process that includes a systematic review of the evidence that informs the formulation of recommendations by an expert panel [7,8]. Earlier policy and programmatic guidelines on adolescent pregnancy exist, but they tend to focus on single issues (e.g., preventing early marriage or providing sexuality education) rather than all the major determinants of adolescent pregnancy and pregnancy-related mortality and morbidity.

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Several factors make the development and implementation of such guidelines difficult.

The scale of the problem is different from one place to another. For example, the estimated adolescent pregnancy rate per 1,000 women aged 15–19 years in Niger is 199. In Uzbekistan, it is 26 [9].

The circumstances in which it occurs in different places is different. For example, in Pakistan, the vast majority of early pregnancies occur in girls and young women who are married at an early age, whereas in Haiti early marriage is uncommon but early pregnancy outside a formal union is.

The consequences vary from one context to another. For example, although early pregnancy and childbearing is common in Chile, it hardly ever results in obstetric fistulae because emergency obstetric care services are widely available and accessible. The situation is different in rural Ethiopia or Nigeria, where fistulas represent a public health problem.

Human, organizational, and financial resources vary across countries. Emerging economies, such as Mexico, are able to put in place and sustain expensive programs, such as conditional cash transfers, but many sub-Saharan African countries have few indigenous resources and are heavily dependent on donors [10].

There is limited evidence of the effectiveness of interventions in many areas.

The guidelines are focused on LMICs, or “developing countries,” and feature six domains:

- preventing early marriage;
- preventing early pregnancy through sexuality education, increasing education opportunities, and economic and social support programs;
- increasing the use of contraception;
- reducing coerced sex;
- preventing unsafe abortion; and
- increasing the use and the safety of prenatal care, childbirth, and postpartum care programmes.

The guidelines address different levels of interventions: the individual, the family, the community, health systems, and laws and policies. Each section ends with suggestions for future research. Table 1 summarizes the state of each domain.

## The WHO Guidelines

### *Preventing early marriage*

WHO's recommendation in this field are informed by 21 ungraded studies conducted in several LMICs [11–31].

In some parts of world, girls are expected to marry and begin child-bearing in their early or middle teenage years. Parents feel pressured by prevailing norms, traditions, and economic constraints. The most important way of addressing this is keeping girls in school. Many studies show that girls in school are less likely to be married at an early age. Empowering girls alone is not enough. Empowered girls need supportive families and communities. Community leaders must work with all stakeholders to challenge and change norms of early marriage.

In many places, laws do not prohibit the marriage of girls before the age of 18. Even in places where they do, these laws are not enforced. Consequently, child marriage is the norm in many countries. Policy makers should be encouraged to establish laws

to prohibit and enforce the marriage of girls before the age of 18 years of age.

Future research should focus on establishing evidence to support the formulation and application of laws and policies that protect adolescents from early marriage. We need better methods for assessing the impact of education and school enrolment on the age of marriage. We need to better understand how economic incentives and livelihood programs can help to delay the age of marriage among adolescents. Existing interventions should be examined for feasibility and taken to scale.

### *Creating understanding and support for preventing early pregnancy*

WHO's recommendations in this area are informed by two graded systematic reviews and three ungraded studies [31–36].

Many adolescents become sexually active at an early age when they do not know how to avoid unwanted pregnancies and sexually transmitted infections. Contextual factors, such as the pressure to conform to media stereotypes and the norms of their peers, increase the likelihood of early and unprotected sexual activity. Curriculum-based sexuality education should be implemented. These programs will be more effective if they develop life skills, address contextual factors, and focus on the emerging feelings and experiences that accompany sexual and reproductive maturity. Sexuality education programs should be encouraged to link with reproductive health services, notably contraceptive services.

There is considerable variability among LMIC on whether premarital sexuality can be discussed in a meaningful way. This presents a major challenge for programs. Stakeholders need to be engaged to develop culturally acceptable mechanisms to reduce pregnancy and the associated negative health outcomes.

Future research in this area should focus on building evidence on the effect of interventions that increase employment, school retention, education availability, and social supports. Research should be conducted across sociocultural contexts to identify feasible, scalable interventions to reduce early pregnancy among adolescents.

### *Increasing the use of contraception*

The guidelines in this domain are informed by seven graded studies or systematic reviews and 26 ungraded studies conducted in 15 countries [32,33,36–67].

Adolescents in many places do not know how to obtain or use contraceptives. They also have many misconceptions about contraception. Further, community norms hinder the provision of contraceptives to unmarried adolescents. Efforts to provide adolescents with accurate information about contraceptives must be carried out in combination with sexuality education. Community members must be engaged to support adolescent use of contraception.

A widespread problem is that adolescents do not seek contraceptive information and services because they are afraid of social stigma and judgmental health workers. Health services must be made “youth-friendly” to enable adolescents to obtain contraceptive services. Further, repeat pregnancies may be prevented by offering contraceptives to adolescents after they have had a child or an abortion.

Policy makers must be encouraged to enact laws and policies that enable adolescents to obtain contraceptive information and

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