

## **Teenage Pregnancy – An Adolescent Health Issue in Australia**

Donna Bishop  
Bachelor of Nursing, Year 2  
School of Nursing and Midwifery

### **Abstract**

Teenage pregnancy and childbirth is an important adolescent health issue in Australia due to its association with detrimental physical consequences and long-term negative psychosocial outcomes for both mother and child. This essay will begin by reviewing some key statistical data relating to teenage pregnancy and will then explore its association with negative consequences to both family and the community at large. Additionally, it will examine environmental risk and protective factors that influence teenage pregnancy. Whilst numerous determinants are highlighted, the paper will look briefly at two; a child's home life and access to education. In conclusion, parenting support and home visits to vulnerable new mothers will be advocated in order to 'improve the environment into which they [teenage mothers] rear the next generation' (Quinlivan et al., 2004: 203).

### **Methodology**

In this paper the term adolescent or teenage pregnancy will refer broadly to the ages of 14 to 19 year old females.

### ***Related Statistics and Health Outcomes***

Registered births to teenage mothers in the less than 15 to 19 year age group totaled 10744 in 2005 (ABS 2005: 41) and accounted for 4% of all births - a birth rate of 16 per 1000 teenage girls. Due to the difficulty in obtaining accurate data, this figure does not include induced abortions of unwanted babies, extra-uterine pregnancies, stillbirths or spontaneous miscarriages. However, in 2003 data obtained from Medicare and the National Hospital Morbidity Database indicated that a further 13855 pregnancies were terminated within this same age group (WHQW 2006). In an interview with ABC Radio in 2003, Dr Henrietta Williams estimated Australia's abortion rate to be 22 terminations per 1000 teenage girls, a statistic which highlights teenage girls' reliance on

termination as a form of contraception. In contrast, the United States of America which has the highest rate of teenage pregnancy and birth in western industrialised countries reports 750000 births to teenage mothers at a rate of 75 pregnancies per 1000 teenage girls, 80% of which are unintended and 81% are to unmarried mothers. It is estimated that teenage pregnancy costs the United States \$9 billion annually (The National Campaign to Prevent Teen Pregnancy 2007: 1). Compared to the United States, Australia's rates may not be considered high but they are four times as high as the Netherlands, Japan, Spain and Italy where the rate is 10 pregnancies per 1000 teenage girls (Allison 2004: 1).

Pregnancy can be an overwhelming experience at any age but in a teenager it can create a developmental crisis as the young girl alternates between two stages simultaneously: adolescence and parenthood (Rodriquez & Moore 1996 cited in McMurray 2003: 154 & Quinlivan et al., 2004: 197). 'Parenting teenagers have not had time to resolve their own stages of role identity and intimacy' (Hanna 2001: 457) and their cognitive immaturity makes them more inclined to put their needs ahead of the developmental needs of their child. Choosing between proceeding with or terminating a pregnancy is a decision which will have long-lasting repercussions for the teenage mother (McMurray 2003: 155). Statistics indicate that pregnant teenagers are more likely to terminate the pregnancy than proceed with the birth (Skinner & Hickey 2003: 160). However, where childbirth is the outcome, long term negative implications of teenage pregnancy are considerable. Teenage births carry a higher risk of complicated pregnancies, low birth-weight, premature births and the need for neonatal intensive care (McMurray 2003: 155 & Skinner & Hickey 2003: 159). Additionally, infants born to young adolescent mothers are more prone to exhibit inferior cognitive development and lower educational attainment; they are more likely to demonstrate childhood behavioural problems and adolescent antisocial behaviour; and are at an increased risk of suffering from poor nutrition, abuse, neglect and abandonment (Hillis et al., 2004: 320 & Woodward et al., 2001: 1171). Infant mortality within this group is 60% higher than for babies of older women (Swann et al., 2003: 8).

There has been ongoing debate about whether these psychosocial and health disadvantages arise from pre-existing socio-economic environments or whether it is the young age of the teenage mother herself that exacerbates these inequalities (Hillis et al., 2004: 320; Williams & Davidson 2004: 96 & Quinlivan 2004: 203). But what cannot be argued is that the short and long-term

negative consequences come at considerable cost to both mother and child, their families and the wider community. For politicians and governmental agencies, supporting teenage mothers and their children has enormous social and economic impacts (Driessna 2006: 513 & Hanna 2001: 457) and ‘consumes funds [and resources] that could otherwise be deployed elsewhere in the health and social systems’ (McMurray 2003: 155). To the young teenage mother, life course outcomes tend to be characterised by negative public attitudes (Hanna 2001: 462); social isolation (Robson 2006: 309); poverty and prolonged welfare dependence; poor participation in education, training or employment; decreased marital opportunities and greater exposure to physical abuse (Hanna 2001: 457; Quinlivan et al., 2004: 197 & Woodward et al., 2001: 1170). Additionally, Swann et al. (2003: 14) comments on Botting’s (1998) observation that teenage mothers are up to three times more likely to suffer from postnatal depression than their older counterparts. The practical difficulties and psychological pressures of raising a child in an environment bereft of social support, information, stability and financial assistance may contribute to a young mother’s poor self-esteem leading to an increased risk of mental health problems (Leishman 2004: 34). ‘Adolescent depression is a strong predictor of depression in later adult life’ (Rowling et al., 2002: 172) and adolescent parenting has long been identified as a risk factor predisposing infants and children to mental health problems in both childhood and adulthood (Townley 2002 & Zeanah et al., 1997 cited in Elder et al., 2005: 122).

### ***Factors in the Environment Influencing Teenage Pregnancy***

Children born to teenagers are at increased risk of growing up in poverty, to misuse alcohol and drugs, to become involved in crime and to become teenage parents themselves (Williams & Davidson 2004: 96). This ongoing intergenerational cycle of social disadvantage, unemployment and poor social functioning suggests that family pathology may contribute to the aetiology of teenage pregnancy (Quinlivan et al., 2004: 197; Hillis et al., 2004: 320 & Woodward et al., 2001: 1182). A host of community, family, school and individual factors have been identified as placing young teenage women at increased risk of pregnancy. For instance, exposure to family violence, early parental divorce or separation, poor relationships with parents (Quinlivan et al., 2004: 198); physical or sexual abuse, alcohol and substance abuse, lower parental education (Hillis et al., 2004: 320); maternal role models of single parenthood (Woodward et al., 2001: 1182); poverty, unemployment and adolescents caught up in the public care system (Knight et al., 2006: 392) are all widely recognised as antecedents to teenage pregnancy.

The most significant risk factor associated with teenage motherhood is childhood exposure to parental separation or divorce and childhood exposure to family violence (Quinlivan 2004: 201; Knight et al., 2006: 398; Woodward 2001: 1180). Many theorists draw attention to a child's early years in laying down the foundation for all future development (Elder et al., 2005: 121 & Harms 2005: 46) and as a child's home life is a major determinant, exposure to a dysfunctional, violent or deficient family environment will undoubtedly influence a child's 'developmental pathway' and behavioural outcomes (McIntosh 2003: 230). 'Family connectedness and good parent-child communication are protective factors for adolescent pregnancy' (Williams & Davidson 2004: 100 & Hillis et al., 2004: 326). There is good evidence to suggest that a sizeable proportion of teenage pregnancies occur out of an idealised belief that a baby will provide unconditional love and reconnect family members (Quinlivan 2004: 202; Quinlivan & Condon 2005: 918; McMurray 2003: 154). Consequently, some of the vulnerability and risk can be mediated by interventions aimed at enhancing parenting skills, promoting supportive relationships and assisting families cope with difficult personal circumstances.

Another significant influence of early pregnancy are school factors relating to educational performance (Quinlivan 2004: 201 & Woodward 2001: 1172) and school attendance (Knight et al., 2006: 396 & Hanna 2001: 457). Lack of educational achievement is a risk factor not only because of limited career and educational opportunities but also because of its correlation with a lack of motivation and ambition (Quinlivan et al., 2003: 203). Young people uncertain of a purpose in life or a career objective identify parenting as a future role (Quinlivan 2004: 202). In contrast, engagement with education is viewed as a protective factor (Woodward et al., 2001: 1173 & Wellings et al., 2001: 1850). These children usually have a more positive sense of self and are less likely to be influenced by peer pressure. Apart from the academic benefits, schools provide an avenue for children to broaden their social network; to enjoy new experiences and to meet people from varied socio-economic and cultural backgrounds. By learning to understand and accept a more diverse group of their peers, children are less vulnerable to social exclusion (Ridge 2003: 7). Friendships formed in such settings thus have a protective effect.

### ***A Health Promotion Strategy – Home Visits by Nurses***

Interventions early in life have a positive impact on later development (Department of Health & Human Services 2002: 29), and childhood is largely influenced by a parent's competence and ability to create a harmonious and stable home environment. So by improving outcomes for teenage parents and their children, nurses can markedly improve the social and health inequalities of young parents and their children. Mothers play a pivotal role in rearing the next generation. The period immediately following the birth of a child is fraught with tension as young mums suddenly inherit new responsibilities, roles and expectations. Nursing interventions that target new mothers in this transition period should aim to provide practical assistance, information and parenting and social support – strategies which will greatly enhance a new mother's parenting skills and self-esteem and improve outcomes for her child. Bearing in mind the multitude of research which points to antecedent family and personal factors as determinates of intergenerational cycles of disadvantage, a child health nurse plays an important role in identifying and implementing a program which prevents or enhances child development before the problem becomes irreversible.

'There is evidence that postnatal support can ameliorate adverse environmental impacts in teenage parenting outcomes [and] the leading strategy for improving postnatal support is sustained home visitation by nurses' (Quinlivan 2004: 206). Studies have shown that the more effective home visiting programs are those that commence during pregnancy and visit frequently and for long enough so that a therapeutic relationship with the mother is established. Randomised evaluations of two USA and one Australian trial found that nurse home visitation programs were associated with improvements in knowledge and use of contraceptives leading to a reduction in the number of subsequent pregnancies and thus the tendency for lifelong reliance on welfare. Additionally, findings were positively correlated with better parenting skills and an overall reduction in child behavioural problems, child abuse, neglect and childhood injuries (Quinlivan 2004: 206 & Olds et al., 2002: 486). By supporting teenage parents and facilitating contact with other early family services in addition to educating vulnerable young parents of the importance of the early years, a teenage mother's child is provided with the opportunity to realise their true potential. South Australia is one state that has implemented initiatives to affirm its commitment to improving outcomes for children and families. In February 2006, the South Australian Government responded to the Australian Human Capital Reform Program of Early Childhood and Child Care by initiating a universal program which will see all families of newborns visited by a qualified child and maternal health nurse. The Family Home Visiting Program is not restricted to teenage parents and provides

additional support to families in need of extra help and up to 34 nurse home visits within the first two years of their baby's life (Government of South Australia 2006: 6). Whilst it is too early to accurately gauge the program's level of success, similar programs targeted specifically at teenagers and that are sensitive to the cognitive developmental level of young adolescents can only benefit teenage mothers and their offspring.

The transition to motherhood can be daunting and previously identified environmental, family and personal factors can make this transition even more challenging. Child health nurses who meet with teenage mothers and their children regularly and over a prolonged period of time, who support, educate and encourage young mothers in their parenthood can help prevent negative cumulative effects and enhance the well being and life chances of these vulnerable people.

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