Reducing teenage pregnancy

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Abstract
The human population is growing rapidly and the impact of these numbers is potentially devastating.1 With an estimated 12% of South African teenagers having been pregnant in their lives, teenagers engaging in sexual experimentation may add to the number of unplanned births.2 Sexuality is an important part of human development, and the World Health Organization has identified adolescent-friendly health services as a worldwide priority.3

Introduction
Adolescent sexuality and the potential for unplanned teenage pregnancies are issues to be considered not only in terms of the pregnancies but also with a view to the world population, and concerns for the pregnant girl’s welfare.

Sexuality, sexual behaviour and relationships are an important part of human development. Adolescents may engage in experimentation in order to understand their emerging sexualities. The challenge is for healthcare providers to assist teenagers in such a way as to maintain optimal health and to avoid the possible negative consequences of sexual behaviour.3

World population numbers – Our biggest threat?
The human population is over 6.8 billion people (6,800,000,000) and the figure is rising. The current birth rate is approximately 134 million per year, with an estimated 57 million people dying per year.1 It is anticipated that the world population will reach 7 billion in 2011, 12 years after reaching 6 billion in 1999.4 Even with the population explosion beginning to abate, the number of people on the earth is steadily increasing.4,5

In developed countries the average woman bears 2.1 children. In some African countries fertility exceeds seven live births. Worldwide, the average woman bears 2.6 live offspring.5 The projection for population growth in developing countries assumes that fertility in those countries will decrease to levels similar to those of more developed nations (around two children per woman). This assumption may be over optimistic as the highest fertility rate is Niger, 7.4 children per woman, while the lowest is Taiwan, one child per woman.4

Demographic transition
Excluding migration, the rate of change in population numbers is the difference between the birth rate and the death rate. The population explosion reflects the excess of births over deaths. This was due in part to advances in industrial and technical advances causing death rates to fall. Birth rates remained high and population growth rates increased. Further advances meant that families in those countries developed the inclination and had the means to limit the number of children born. Fertility rates (the number of live births per year per 1000 women of childbearing age6) dropped and population growth slowed.5

Geographic transition
During the 20th century almost 90% of the population growth occurred in countries classified as less developed (LDCs) by the United Nations.7 Due to the greater population growth rates in LDCs, the growth of the world’s youth population is shifting to the poorest of those countries. Almost 80% of today’s youth live in Africa and Asia. Developing countries have young populations due to high fertility and improvements in child survival.7 The current trend of moving from rural areas to cities in search of education, training and job opportunities means that in many more developed countries (MDCs), population growth will come from immigration from LDCs.4,7

Changes in birth rates
While children are loved and valued for themselves, in certain settings they are also economic assets, able to work and provide for the family. However, many families choose to limit the number of children in order to be able to provide better care for the family as a unit. Birth rates are lowered by celibacy, later marriages and increased availability of contraceptive choices. Celibacy and sexual abstinence prevent pregnancy and the risk of sexually transmitted disease. The increasing opportunities and empowerment of women has resulted in many women choosing a career over family and thus choosing to delay having babies. The increased choice of contraceptives available allows women to successfully prevent or delay pregnancies.5

Changes in death rates
Infectious disease is a major cause of human mortality. In LDCs infant mortality can amount to more than 10% of all live births. Immunisation, improved hygiene and sanitation, clean drinking water, improved nutrition, and medical developments have helped in lowering the death rate due to decreased infant mortality, more children surviving childhood and adults living longer. The transfer of technology and knowledge from MDCs reduces mortality rates in LDCs.5

Impact of world population
The problems associated with population growth are varied. A
major concern is food and resource availability. Millions of people are already starving due to drought, improper land use and war. Natural resources are rapidly declining as the population increases. Fresh water supplies are finite and pollution of natural water supplies is becoming a significant concern. The biodiversity of the planet is at risk, as humans encroach on habitats and deplete natural resources. Improvements in agriculture, hygiene, education, and changes in attitudes may provide some solutions. Population control, however, may help decrease the drain on resources.

**Teenage pregnancy**

In a survey in 2003, it was determined that 12% of South African teenagers (15–19 years) were or had been pregnant in their lives. The proportion of teenagers who had been pregnant rose rapidly with each year of age from 15 years (2%) to 19 years (27%).

Research in the United States indicated that approximately 19% of teenagers who had sexual intercourse became pregnant.

**Adolescent sexuality**

Relationships and sexual relationships are fundamental to human development. In the United States, the age of menarche has decreased to 12.5 years of age. Almost 50% of high school pupils reported that they had experimented with sexual intercourse.

Human sexuality involves interaction between anatomy, biology, psychology, interpersonal relationships and socio-cultural influences. A child’s gender identity begins early based on anatomy and how the parents interact and play with the child. Personal and cultural influences affect the way in which the child starts to identify him or herself as a ‘boy’ or ‘girl’. As children become adolescents their influences broaden as they are exposed to media, peer pressure and community opinions.

Adolescent development may be divided into three stages based loosely on age:

1. Early adolescence – early adolescence (10–14 years) coincides with the onset of puberty, and involves concrete thinking, preoccupation with and insecurities around physical changes in the body.
2. Middle adolescence – middle adolescents (15–18 years) have completed the physical changes of puberty and begin to have more romantic relationships. Middle teens may be able to imagine the consequences of their actions, but are typically not able to understand them fully. Thus they may be aware that unprotected sex may result in pregnancy or sexually transmitted diseases (STDs) but think, “it won’t happen to me.”
3. Late adolescence – late adolescents (18 years and older) have more mature social skills and a better understanding of risks and consequences. They have a mature understanding of their gender role, sexual orientations and sexuality, and can participate in more adult relationships with romantic partners, family and friends.

**Factors contributing to teenage pregnancy**

There are several factors that may contribute to teenage pregnancies. These include a lack of maturity, a lack of understanding of the risks and possible consequences, gender power imbalances, lack of access to contraceptives and a lack of information regarding sexual health. Teenagers who lack the maturity to recognise the risks and consequences of sexual intercourse are unlikely to use any form of protection. A lack of information or education in sexual health will also mean that teenagers will have a low understanding of possible outcomes.

In relationships where the male partner is significantly older than the female, gender power imbalances may mean that the sex is coerced or forced. A lack of access or awareness may limit the use of contraceptives in younger teenagers, but since the legalisation of abortion in 1996, and increased availability of contraceptives, the number of teenage pregnancies in South Africa has decreased. Fertility declined by 10% between 1996 and 2001, and by a further 10% by 2007.

**Impacts of teenage pregnancy**

Consequences of teenage pregnancy are several-fold. Pregnant adolescents are more likely to delay seeking prenatal care, and have higher rates of unfavourable outcomes, such as prematurity, infant mortality and poor health and developmental outcomes. Teen mothers are often exposed to stigma and are likely to drop out of school. In South Africa, only about one-third of teen mothers return to school. Adolescents who do not return to school tend to face unemployment, live in poverty and rely on public assistance more than their peers who completed their education. Socially some teen mothers may feel isolated from their peers, and others may be rejected due to cultural views.

The feelings of being stigmatised, or not being able to cope, may result in suicide ideation during pregnancy or the post-partum period. A prior history of suicide attempt may place a teenager diagnosed with pregnancy at risk for a further suicide attempt.

Pregnant adolescents are at risk for poor nutrition. Normal pubertal changes place increased nutritional needs on the body, as does pregnancy. Inadequate nutrition puts maternal, foetal and infant health at risk.

**Legal issues**

There are several legal issues pertaining to sexual intercourse and pregnancy with regard to teenagers.

- The first is the legal definition of a child and the age of consent for sexual intercourse. In South Africa the definition is as follows:

  "1(1) ... child means
  a) A person under the age of 18 years; or
  b) With references to sections 15 and 16, a person 12 years or older but under the age of 16 years."

Sections 15 and 16 refer to sexual intercourse with children, thus the legal age of consent to sexual intercourse in South Africa is 16 years. Any person entering into sexual intercourse with a person under the age of 16 years is com-
mitting a crime even if the child consents to this act.

- The second issue is the age at which a child can legally consent to medical treatment and surgical procedures. According to the Children’s Act No.38 of 2005: Ch.7 Part 3 “129 Consent to medical treatment and surgical operations.
  2) A child may consent to his or her own medical treatment or to the medical treatment of his or her child if –
  a) The child is over the age of 12 years; and
  b) The child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.”

With regards to consent to surgical procedures the conditions are the same as for consent to medical treatment with the additional proviso c) that the child is duly assisted by his or her parent or guardian. This is subject to section 5(2) of the Choice on Termination of Pregnancy Act 1996.

- The Choice on Termination of Pregnancy Act No 92 of 1996 states that “no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.” The act promotes counselling but if the woman refuses counselling, the termination cannot be refused. If the woman is a minor, she will be advised to consult her parents, guardians, family members or friends before the pregnancy is terminated. However, if she chooses not to consult them, the termination cannot be denied.

- The Children’s Act also determines the right to access to contraceptives. According to the Act, no person may refuse to sell condoms to a child over the age of 12 years, and may not refuse to provide condoms where they are distributed free of charge. Contraceptives other than condoms may be provided to a child on request, without the consent of a parent or guardian, if the child is over the age of 12 years, if proper medical advice is given to the child, and if a medical examination is carried out to determine whether there are any medical reasons why a specific contraceptive is not suitable.

In summary, these various laws mean that a 12 year old child may consent to medical treatment, may procure certain contraceptives and may undergo a legal abortion, but is too young to consent to sexual intercourse.

The role of the pharmacist

Education is of primary importance in promoting the sexual health of teenagers. Education should be provided within the home, in schools, medical and community settings. Studies have shown that comprehensive sex education programmes can help to delay intercourse, reduce frequency of intercourse, reduce number of sexual partners, and increase use of condoms and other contraceptives.

Pharmacists must ensure that when they dispense a prescription for a teenager that may potentially interfere with the action of an oral contraceptive, that this is known to the teen. Many parents may think that their children are not sexually active and it is important that the message is directed to the child concerned. When dispensing an oral contraceptive to a teenager, even if it is initially intended for acne therapy, it is essential that the teenager be fully informed as to taking the pill correctly.

Information should include oral contraceptive use, interactions such as antibiotics, laxatives and other medicines, and consequences of diarrhoea and vomiting.

Studies have shown that there are high levels of knowledge about contraception, but incorrect and inconsistent use persists. Most young women became pregnant because they were not using contraception or because they stopped using contraception. If one oral contraceptive is not well-tolerated, it is important to counsel the patient that there are several oral contraceptives available and a switch to another product is recommended over stopping oral contraception to a less effective method.

A pharmacist may be one of the most accessible healthcare practitioners to the average teenager. Teenagers who are dropped off at a shopping mall do not have to attempt to travel to a doctor or clinic if a pharmacy is available. Teenagers may feel able to discuss issues with a pharmacist if there is a suitable private area for consultation. While it may be unlikely that any child will ask for advice on condoms, they may enquire about other contraceptives, emergency contraceptives or pregnancy testing. It is important that the pharmacist normalise the consultation, treat the teenager with respect and provide information in a manner that they are able to understand.

Provision of emergency contraception may be a contentious issue depending on the age of the teenager. In accordance with the Medicine and Related Substances Control Act, scheduled medicines may not be sold to persons under the age of 14 years, except on a prescription, or a written order by an older person known to the seller. Emergency contraceptives are schedule 2.

If the teenager wishes to have a pregnancy test, it is important to ask what she would do if the test is positive. The teenager needs to have considered all the possible outcomes: abortion, adoption or parenthood. Post-test counselling should include a non-judgemental and non-directional discussion of all options, as well as how the teen wants to go about informing the father of the baby, and her parents.

Conclusion

Adolescence is an important time in the development of sexual identity and sexual behaviours. Teenage pregnancies are associated with several adverse socioeconomic outcomes for the mother, father and child. Pharmacists, regardless of their personal opinion on teenage sex and sexuality can play a role in educating teenagers in the appropriate use of contraceptives to prevent unwanted pregnancies.
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References:
12. Choice on Termination of Pregnancy Act No 92 of 1996