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Anthropological Perspective on Adolescent Pregnancy

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Abstract

This article has outlined anthropological perspective on adolescent pregnancy. Prevalence of adolescent pregnancy in the world and Bangladesh is given briefly. It was assumed that there is a link between early marriage and adolescent pregnancy. Has early marriage been institutionalizing adolescent pregnancy in the society. The article has raised this question. Reproductive physiology of adolescent pregnancy is the key to understand why relationship between adolescent and pregnancy is problematic. Pregnancy occurs within social and cultural context and so it deserved special attention. Finally, anthropological perspective would refer to a comprehensive grasp of interrelationship of physiological, medical, social and cultural aspects of adolescent pregnancy. This article is limited to outlining these aspects.

1. Introduction

Adolescent pregnancy prevails worldwide. Adolescent comprises at least 30% of world's population (UN demographic yearbook 1989:34), 40% is under 15 years old (UNESCO 1991). About 15 million babies are born to adolescent mothers each year (The center for population options, 1992). About 8 in every 10 of these babies are born in the developing countries of Asia, Africa and Latin America (McDevitt, et.al., 1996).

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As of January 1995, the estimated adolescent population constitutes 22.6 percent of total population of Bangladesh which accounts for 27 million populations. Of the total adolescent population, 13 million are girls (Health and Demographic Survey, 1995: 7). There are 18.4 marriages per 1000 adolescents (HDS, 1995, 8).

Adolescent fertility rate is one of the highest in Bangladesh with 171 birth per 1000 women aged 15-19 years (Barkat et al, 1997:45). 96% of the ever married women are married when they were teenagers (Islam and Islam 1998, 32-33).

Adolescent pregnancy is closely linked to early marriage which is common in Asia and Africa. In Bangladesh, Mali and Niger 75% of girls under 18 are married. It is also high in Nepal (40%), Ghana, Kenya and Zimbiwe (33%), North America and Middle East (30%) and relatively lower in Botswana, Namibia, Rwanda (15%), Philippines and in Srilanka (14%). This statistics indicate that adolescent pregnancy prevails widely.

The question is what is the relationship between adolescent and pregnancy? Anthropological perspective would provide a comprehensive and in-depth grasp of adolescent pregnancy in its social and cultural context. Otherwise separation of cultural construction and social production of pregnancy from adolescent physiology and pregnancy pathology would be too mechanical.

To have a comprehensive understanding, these aspects of adolescent pregnancy is discussed below:

2. Conceptualization of Adolescence

The concept of adolescences has been inconsistently used in literature, and its meanings often conflated. WHO, UNFPA and UNICEF) together have conceived that the term 'adolescence' is attached to those who are aged between 10 and 8, and 'Youth' between 15 and 24; the development that takes place in adolescence is generally uneven. Although the onset of adolescence is usually associated with the commencement of puberty and the appearance of secondary sexual characteristics, which vary between individuals.

It represents the development stages between childhood and adulthood and considered to be a period of uneven transition, characterized by a

biological development from the onset of puberty to full sexual and reproductive maturity and a psychological development from the cognitive & emotional pattern of childhood to adulthood.

The passage from childhood to adulthood is often turbulent with emotion, and risk behavior (Gardner, 1995).

3. Reproductive Physiology of Adolescents

There are two bodies of literature pertaining to the anthropology of reproduction that have enhanced the study of teenage female reproductive physiology and pregnancy related pathology and obstetric. Adolescence is associated with puberty. Puberty is fundamentally a biological definition, which encompasses the stage of development during which individual acquires the capacity for reproduction. Physical changes of puberty often begin around the age of 10 (Blum, 1991). Developmental issues related to sexuality and self identity can be complex and confusing to the early adolescent as the myriad of physical changes evolve through puberty. The cognitive ability to think abstractly is usually achieved by the age of 15-16 years (Strassberger, 1991). Maturation of the hypothalamus and pituitary gland in the brain result in adrenal and ovarian hormone production leading to pubertal changes and ultimately to menarche, the first menstrual cycle, (Kessel, 1995). At this time various adolescent menstrual disorders such as painful menses (dysmenorrhoea), absence of menstruation (amenorrhoea) and abnormal bleeding may be apparent. The hormonal changes during adolescence confirm the gender identify and prepare the person for reproduction and parenthood. Changes in mood during adolescence are related to the hormonal changes they usually experience. During childhood and the transition to adulthood the reproductive system of girls is particularly vulnerable to infection. The cells and secretions of the physiologically immature reproductive tract are much less able than in adults to resist invasion and damage by sexually transmitted microorganisms. The physiologic immaturity is characterized by particular cellular characteristic of columnar and metaplastic cells. These cells provide a poor barrie to invasion by a number of microorganisms, including those associated with pelvic inflammatory disease and cervical cancer, namely C. Trachomatis and human papilloma virus (HPV), two

of the most sexually transmitted disease globally. The risks of these infections is associated with the proportion of the surface the cetocervix covered by these cells (Besley, 1988).

4. Pathology of Adolescent Pregnancy

Adolescence pregnancy has been associated with the increase incidence of obstetric complications. There are increased risks of anemia; pregnancy induced hypertensive disorders, prenatal deaths, sexually transmitted diseases, human immuno-deficiency virus infection and premature delivery. There is an increased incidence of cephalo-pelvic disproportion in women younger that 15 years of age which is related to the relative immaturity of the skeleton of the pelvis, as uterine muscles are not well developed, neither the pelvis is sufficiently developed that can facilitate delivery of the baby, often cesarean section is employed.

Cesarean section requires general anesthesia that leads to iatrogenic problems, congenital limb defects following the administration of the tranquilizer thalidomide. They also experience more postpartum infection and hemorrhage. Adolescent pregnancies are more likely to be associated with low birth weight, birth injuries, still births and infant mortality. The baby is not only born too soon, but also too small as well. The low birth weight baby may have immature brain, heart, lunge or other organs, it can experience difficulty in controlling its body temperature and blood sugar levels, it may suffer mental retardation manifested in speech problems or slow learning due to poor nutrition and anaemia during pregnancy. There is also a risk of dying in early infancy.

Pathology of adolescent pregnancy imparts serious health hazards for the mother and child both in developed and developing regions (Clarke, 1992). Though it is true that teenage pregnancy is not a new occurrence in history and that many young women have survived early child bearing, but not all young mothers are this fortunate. Worldwide pregnancy related complications are the main cause of death among 15-19 year old females. A major problem of early adolescent pregnancy is that young women are not fully-grown at the age between 12 and 15. Their pelvises develop fully only when they have attained their full status. This means that there is a danger of obstructed labour, which

without appropriate health intervention, can be fatal. If intervention is delayed, other serious health problems arise, most notably obstetric fistulas.

Pregnancy adds an undue burden to an adolescent's maturing body. Although an adolescent is able to reproduce her uterus is still too young to withstand the biological demands of pregnancy. Her body is not yet ready for the nature and delivery of a baby. Pregnancy without nutritional supplements and before completion of the adolescent growth spurt will slow or stop further growth. Obstructed labour are more common because of immature skeletal development and smaller pelvic diameters, (Moerman, 1982). Teenage pregnancies are more likely to obstructed labour, reptures in the birth canal and associated death of mother, infant or both. Risks are greater if prenatal care is inadequate (Philpott, 1995). The obstetric causes of maternal deaths are similar in all countries of the developing world, although their proportions may vary. Hemorrhage is the leading cause followed by illicit abortion, hypertension (including eclampsia), sepsis, obstructed labour and ruptured uterus. The pregnant adolescent is likely to be anemic, she can suffer pre-eclampsia or eclampsia (a condition occurring in young people having their first pregnancy) and is characterized by high blood pressure, edema or swelling in the hands, feet and face. Severe fits, may occur during pregnancy, labour or after delivery, (Clarke 1992; Rahman et al. 1989). A majority of adolescent experience significant morbidity associated with pregnancy and delivery e.g. uterine prolapse, vesico-vaginal fistula (Rahman S. et. al., 19891.

Abortion related complications such as hemorrhage and sepsis can account of the majority of pregnancy related deaths, especially in developing countries where abortion are illegal or not medically supervised. The group most vulnerable to complication form pregnancy and child birth are the young adolescents and for them termination of pregnancy may be unobtainable or unaffordable, performed at more advanced gestational stage than for adults (Clarke, 1992). Medical experts believe that the ages of 20-24 are the safest for child bearing, while risk at 10-14 years is much greater than 15-19 years. Besley (1988) stressed that adolescent pregnancy has impact on the future child bearing. Lee et al. (1988) have thought that adolescent females are at

greater risk for giving birth to low and very low birth weight infants. Clarke (1992) has observed that adolescents tend to have premature babies. Pressures, personal worries and severe emotional stress also affect adolescent physical and mental well being placing their own health and that of their babies at stake (Camiwet et al. 1992).

5. Social and Cultural Context of Adolescent Pregnancy

Biomedical aspects have dominated the study on reproduction. particularly nature of normal and abnormal gestational processes. Gradually social, cultural and psychological aspects of human reproduction have received attention (Philipps Yonas, 1980; Jones et. al. 1980; Ooms 1981). Cultural context of pregnancy not only show the myriad of ways women are pressured to become mothers but also the broader contexts within which women perform the maternal role. Ann Oakley's extensive writings (1972, 1980) on the ways motherhood is socialy and culturally shaped have significantly contributed to understanding of human reproduction. An universal oppression is rooted in women`s maternal and child raring role (Ortner, 1974). This argument is best manifested in early marriage.

Early pregnancy is considered a credible proof of reproductive capacity that increase women's social acceptance in the community. Birth of the first child to a young married women's confers status (Camiwet et al, 1992 and Senanayake, 1992). Construction of motherhood is the highest ideal for women. Political systems promote this ideal to reinforce patriarchy that look at women's reproductive capacity as a function and responsibility. Adolescent pregnancy is often not seen as a problem.

According to Muslim family laws ordinance 1961, the minimum legal age of marriage for female in East Pakistan was 16. A Government order in 1984 has fixed the minimum legal age of marriage in Bangladesh at 18 for females.

Early marriage was practiced in Mediaeval Bengal. It is evident in records such as Bhavadeva, Jimutavahana and Kulluka that girls had to be married before they reached the age of puberty (Hussain, 1985). In the 18th century, the mean female age of marriage was less than 10,

marriageable age ranged from 5 to 11, 'Ballya-bibaha' or childhood marriage was commonly practiced (Begum, 2001). In 'East Java, it was considered a disgrace to have a daughter experience her first menstrual period before being betrothed'.

Many societies protect a girl from unsanctioned sexual activity. It was believed in India that early marriage could guard against the promisive resurgence in adolescent girl's playfull childhood sexuality (Kakar, 1978).

The anxiety of Greek parents regarding the early marriage of daughters is derived from the view that if a timely marriage is not contracted the girl may fall victim to the natural urges of her youthfull condition. Female sexuality preserved by father by ensuring the chastity of daughters.

Shoshtak in 'kung women' describes that 'young girls are not considered truly adult or expected to assume full responsibility for themselves until they reach their late teens, have menstruated, married, and are likely to become mother. Marriage is occurred with puberty. Early marriage is a common practice in polygynous societies such as Uganda, Cameron, Tango and Liberia.

However WHO, has defined that a child means every human being below the age of 18 years. In Latin America and Caribbean countries there is a history of 'unofficial' marriage, known as consensual or 'convenient'. Youth people live together and have children without being formally married. Consensual union among the Ghsii of western kenya and Malawi are widely prevail. In some societies, adolescent sexual activity has traditionally been tolerated or even encouraged.

6. Conclusion

The article has drawn a broad outline of the anthropological perspective on adolescent pregnancy. It has provided some understandings about its physiology, pathology and social-cultural context. However, from the outline the following conclusions could be drawn.

Adolescent pregnancy prevails widely, especially in Asia, Africa and Latin America. Prevalence rate in South Asia and in Bangladesh is

high. Early marriage among girls is also widely practiced in Asia and Africa. Maternal role is emphasized by the society and often adolescent girls are pressured to get married at an early age to become mother. Therefore, a close relationship between early marriage and adolescent pregnancy is apparent

Adolescent pregnancy has been associated with the increase incidence of obstetric complications. There are increased risks of anemia; pregnancy induced hypertensive disorders, prenatal deaths, sexually transmitted diseases, human immune-deficiency virus infection and premature delivery. Adolescent pregnancies are more likely to be associated with low birth weight, birth injuries, still births and infant mortality.

Characteristics of adolescent physiology and the pathology of adolescent pregnancy make it apparent that it is fatal for both the mother and the child. Hence, adolescent pregnancy deserves recognition as a key health problem of girls. In order to address this issue effectively an anthropological insight on adolescent pregnancy will be useful.

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