Reducing maternal mortality by improving care for pregnant adolescents

Adolescent pregnancy - a global phenomenon

About 16 million girls aged 15 to 19 give birth every year. Worldwide one in 10 babies is born to an adolescent mother. Those infants and their mothers need special protection, since they are at a higher risk of disease and death, as well as social exclusion.

Although there are adolescent mothers in all societies, there are huge regional differences. Almost 95% of adolescent mothers live in developing countries. The highest levels of adolescent pregnancy are in sub-Saharan Africa where every second woman gives birth to a child before the age of 20. There are also high rates in Asian countries like Bangladesh and India, as well as in Latin America and the Caribbean. The overall trends in childbearing are particularly driven by socio-cultural patterns in these countries, as for example by a tradition of child marriage.

Worldwide, the majority of adolescent mothers are married and most of their babies are wanted. In the developing world, about 90% of the births to adolescents occur in marriage. In addition, three out of four pregnancies in this age group, mostly those in marriage, are planned. However, this means that every year four million adolescents become pregnant unintentionally.

In general, early pregnancies mean an increased risk to the life of the mother and her baby. In many countries the risk to die in pregnancy or childbirth is twice as high for mothers aged 15 to 19 compared to mothers in their twenties, and even worse for girls under 15. The babies of adolescent mothers are also more likely to die. Continued on page 8.

Health and social risks in early pregnancy

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Globally, every year, around 16 million adolescent girls get pregnant and 95% of these happen in the developing world. Although accounting for about 11 percent of all births worldwide, maternal conditions in adolescents contribute to 13% of maternal deaths.

It is estimated that 70,000 adolescent girls die each year in developing countries from causes related to pregnancy and childbirth. The tragedy doesn’t end here - too-early childbearing also has a negative impact on the survival of newborns. Studies have shown rates of newborn death to average about 50% higher to adolescent mothers when compared to mothers in their 20s.

Adolescent pregnancy is a critical issue not only for Maternal and Newborn Health but also for social and economic development - Not only do adolescent mothers account for a large and disproportionate share of maternal deaths and disabilities but early motherhood can contribute to problems beyond health - missed education and gainful employment opportunities, low self-esteem and a vicious cycle of poverty, morbidity and poor socio-economic and health outcomes that can have inter-generational effects.

Addressing the problems of adolescent pregnancy requires a multi-pronged approach that incorporates both prevention of pregnancy and care for pregnant adolescents and their newborns.

Making pregnancy safer for the young mothers and their babies is a clear priority for countries as they strive to meet targets for improving basic health care. Maternal and newborn health programs have a clear role in better serving the needs of the youngest mothers.

The Department of Making Pregnancy Safer, therefore, strongly advocates a continuum of care for pregnant adolescents from self-care to care at health facilities. Families and communities need information and empowerment to support pregnant adolescent girls. We will only be able to reduce maternal mortality in adolescents if we involve families, communities and the young people themselves and if we ensure that health care systems are responsive to the needs of adolescents.

In January 2008, the Making Pregnancy Safer Department at WHO introduced the MPS Brown Bag Lunches, a new series of monthly seminars at Headquarters in Geneva. MPS is inviting WHO staff from all departments to discuss hot topics in the area of maternal and newborn health throughout the year. In general, the meetings take place every third Wednesday each month.

By launching this series of monthly events MPS aims to share research findings, lessons learned from the field and partner experiences with interested staff of all WHO departments. With the Brown Bag Lunches, MPS also hopes to create a forum for stimulating broad and open discussion on a variety of topical issues related to maternal and newborn health and survival.

The first MPS Brown Bag Lunches focused on adolescent pregnancy, nutrition, as well as maternal and newborn health in crisis settings. MPS Notes, a related publication summarizing the presentations and discussions during each seminar, is currently under preparation.

From 30 June to 4 July, the Department of Making Pregnancy Safer (MPS) held its 3rd Orientation Workshop in Geneva. 25 staff from governments, donor agencies, international organizations, research institutions, the private sector and NGOs participated in the workshop that is part of a series of capacity-building workshops organized on a regular basis. The one-week workshop familiarized participants with WHO guidance on interventions and related health system issues for maternal and newborn health and enhanced their skills to improve related programmes and to plan, implement and evaluate services in countries with high maternal and neonatal mortality.

Director’s Message

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In Mozambique, over 30% of the population is aged between 10 and 24 years. Like many countries of Southern and Eastern Africa, Mozambique is facing a serious HIV epidemic. Young people account for around 60% of all new infections, and within this young women between 15 and 19 are being infected at a rate that is triple that of men of the same age. About 40% of women in the 15-19 years age group were pregnant or already mothers. A national study of maternal deaths confirmed that unsafe abortion was one of the leading causes of death in 1998.

Following the International Conference on Population and Development in 1994, Mozambique started to address the situation and in 1999, the Ministry of Health launched a multisectoral national initiative, Geração Biz (GB initiative), focusing on the sexual and reproductive health of adolescents.

The initiative aims to improve adolescent sexual and reproductive health by reducing the number of early or unwanted pregnancies and the infection with HIV/AIDS and other sexually transmitted diseases through activities that equip young people with the knowledge, skills, and services needed for positive behaviour change.

The collaborative initiative involves the health, education and youth sectors. To facilitate collaboration, a strong coordination mechanism has been put in place at the national, provincial and local levels. Young people are part of the coordinating committees at all three levels and work closely with other partners, namely the Ministries of Health, Education, and Youth and Sports as well as UNFPA, the Danish Development Agency (DANIDA) and Pathfinder. Other sources of support have come on board over time.

The initiative started in two pilot sites and was then scaled up to cover all eleven provinces of the country. Activities were also expanded within provinces in order to reach a larger number of adolescents.

Geração Biz is one of the few nationwide multi-sectoral programs. While now all eleven provinces are part of the program, there is still room for increased coverage within the provinces. Continuous evaluations and research studies (knowledge, attitudes, practices and behavior and client satisfaction studies) show that Geração Biz is a success story. They reveal the progress that has been made in the past seven years to develop a network of YFHS facilities that offer high-quality sexual and reproductive health services. Utilization of youth-friendly services is quite high compared with many other programmes operating in sub-Saharan Africa - in large part because it is supported by complementary components that seek to change behavior, including care-seeking behavior. The vast majority of the young clients report that the services meet their needs, they are treated with respect, and privacy and confidentiality are ensured.
The GB initiative demonstrates the feasibility and the value of addressing the sexual and reproductive health problems and needs of adolescents as part of one initiative. It also demonstrates that by putting in place mechanisms the active involvement of sectors other than the health sector, civil society institutions and of adolescents can be encouraged, scaled up at the national level and sustained over time.

Ugandan women parliamentarians advocate for maternal health

Following up on the first Meeting of Women Parliamentarians organized by the WHO Department of Making Pregnancy Safer (MPS) in March 2007, 37 women members of the Ugandan parliament committed themselves to become active advocates for maternal health.

Under the leadership of MP Sylvia Ssinabulya, the women parliamentarians engaged in a series of activities and pushed a motion in Parliament making maternal health a priority issue on the national agenda. With support from the WHO Country office and the Ministry of Health, the lawmakers are discussing the next steps within the national Road Map aimed at reducing maternal mortality in Uganda and hope to convince the President of Uganda and the Cabinet to finance the Road Map for the coming four years.

Making Pregnancy Safer

lying down in a collective ward, routinely applies oxytocin for induction of labour without offering any form of pain relief, and encourages episiotomy for all vaginal deliveries. Women told of emotional shock upon arrival at the labour ward – ‘a madhouse’, said one girl - and subsequently of feelings of intense isolation; yet usually they complied with institutional practice, since the procedures made sense according to their cultural understandings. Safe, modern birth occurs only in hospitals, they said. They ‘knew’ that childbirth is extremely painful - that only rich women can avoid suffering, by “programmed caesareans”. Few were aware of the possibility of pain relief for normal birth. They expected mistreatment from the birth attendants, and were grateful when shown kindness, however little.

Adolescents were particularly vulnerable to callous treatment. Some providers expressed feelings that adolescent pregnancy is the result of selfish and irresponsible behaviour. We heard one doctor snap at a weeping fourteen-year-old “You should be at home playing with dolls, not here having a baby!”

Role of concepts of gender and class

Nonetheless, researchers found that deficiencies in hospital care are not primarily attributable to caregivers’ individual attitudes and practices. Rather, they derive in the first instance from the structuring of care and, importantly, the cultural logic that underpins its perpetuation, including, especially, concepts of gender and class. Mere ‘technical knowledge’ of correct procedure was not enough to inspire reform. For example, doctors were aware that standard care for labour and delivery contravenes many recommendations in the medical science literature. But, they said, babies had to be born fast and beds freed for new parturients. Provision of epidurals was too expensive, so women must make do without. As poor women, they were accustomed to pain – even expected it when giving birth.

A particularly salient example of the hidden effect of cultural understandings about gender in perpetuating poor practice concerns women treated for miscarriage and incomplete abortion (usually provoked with misoprostol acquired on the black market). The care system evoked specific negative meanings. On admission, such patients were sent to the labour ward to wait curettages at the end of the day. They thus spent hours observing birthing or newly delivered women, isolated in their feelings (of loss, pain or confusion), highly visible as women who were not to become mothers. Staff referred to them informally with negative expressions, such as ‘the curettage spoons’. Many were sent to a ward known as ‘the infected ones’. Thus, the care system itself, as put into effect by the ‘careers’, inadvertently created a symbolic category of ‘Anti-Mother’, further worsening the suffering of these women.

Brazilians Maternities - Lack of support for pregnant adolescents

Not only medical and technical but also social and psychological aspects contribute significantly to the quality of health facilities. An ethnographic study in a Brazilian public maternity and teaching hospital provides a good example of the vital contribution such research can make. Part of the WHO-funded ‘Social Science Research Initiative on Adolescent Sexual and Reproductive Health’, the project involved intensive observation and interviewing of the health professionals and hospital users over a period of one year between 2002 and 2003.

The study found that institutional practice makes birth unnecessarily harrowing for women and adolescents. The care system offers beds on a first-come first-serve basis. Women may be admitted after a veritable via crucis, seeking admission in other hospitals beforehand. Hospital practice strips them of their individual identity (staff usually address them as ‘Mother’, not by name), denies them social support, obliges them to labour and deliver
Other than efforts to ‘humanize’ care, by punishing or dismissing notoriously unkind staff, hospital administrators have yet to address the many problems exposed by the study. The evidence shows that they, as well as policymakers, must take seriously the symbolic logic at work in institutions, and consider the effect of the cultural understandings of health care professionals (as well as users) in erecting barriers to the improvement of maternal health care. Such findings apply not only to public hospitals in Brazil but—no doubt—in other countries as well.

Cecilia McCallum and Ana Paula dos Reis, Institute of Collective Health, Federal University of Bahia, Brazil

WHO Regional Office for the Eastern Mediterranean

This graph compares the prevalence of adolescent pregnancy in two countries from the Eastern Mediterranean Region: Jordan and Morocco. A cross-sectional survey carried out in 1985-1990 reported that 2.6% of women aged 15-19 in Morocco and 2.1% in Jordan were currently pregnant with their first child. By 2001-2005, both countries showed declining trends in the prevalence of adolescent pregnancy, while the survey carried out in 2001-2005 revealed that the numbers of adolescents who were pregnant remained stable in Morocco, while the same number further declined in Jordan. The prevalence of adolescent mothers in Jordan dropped by 42% in Jordan between 1985-1990 and 2001-2005.

WHO Regional Office for South-East Asia

India takes steps to prevent adolescent pregnancy and mortality in pregnant adolescents

A comprehensive programme to prevent maternal mortality in adolescents should work to (a) prevent too early pregnancies – within or outside marriage, (b) prevent unsafe abortions, and deaths due to abortions, and (c) prevent deaths during pregnancy and child birth. These activities need to be grounded in national reproductive health programmes and linked intimately to efforts to prevent HIV. India provides a good example of how this is being done.

In 2004, a national Adolescent Reproductive and Sexual Health strategy was formulated within the framework of the national Reproductive and Child Health Programme (RCH II) in India. In order to reduce the infant mortality rate, the maternal mortality rate and the total fertility rate, the RCH II strategy aims to prevent adolescent pregnancy, maternal mortality in pregnant adolescents as well as HIV and other sexually transmitted diseases in adolescents by taking the following three measures. 1. Reorienting existing health services to ensure that adolescents are able to obtain the health services they need; 2. Strengthening communication to generate adolescent demand for health services and community support for their provision; and 3. Strengthening the existing health management information system to ensure that indicators of adolescent sexual and reproductive health are gathered, reported and used to sharpen programming.

Indian national standards for quality health services to adolescents

1. Health facilities provide the specified package of services that adolescents need.
2. Health facilities deliver effective services to adolescents.
3. Adolescents find the environment at health facilities conducive to seek services.
4. Service providers are sensitive to adolescent needs and are motivated to work with them.
5. An enabling environment exists in the community for adolescents to seek the services.
6. Adolescents are well informed about the health services.
7. Management systems are in place to improve/sustain the quality of health services.

The WHO Department of Child and Adolescent Health and Development (CAH) worked with UNFPA to support the health ministry in developing national standards and guidelines for making health services adolescent friendly.
The standards and guidelines clearly specify what health services are to be provided, by which service provider and at which service delivery point.

Following the launch of the document in May 2006, it was introduced to programme managers in 28 out of 35 states and union territories in a phased manner through orientation workshops which provided them with an opportunity to discuss practical considerations in applying this in action.

Alongside this important ground work was done. Generic WHO materials to train health workers were adapted for use in India. Posters, leaflets and booklets to reach adolescents and community members were developed and efforts were made to improve the cooperation with different government departments.

Two rural districts were identified to pilot this approach - Ambala in Haryana state and Midnapur in West Bengal state in order to gain local experience and to check whether the new approach (a) increases the use of services and (b) improves the quality of services.

The following criteria were identified to designate a health facility as adolescent friendly:

- At least one provider is trained in Adolescent Friendly Health Services (AFHS)
- Training material and communication materials are available
- Display of information that AFHS norms are applied
- Regular operation of a special adolescent clinic at least once a week
- Sufficient supplies of medicines and appropriate distribution to adolescents when needed
- Maintenance of age and sex disaggregated records

Within a year both primary health centres and their sixteen sub-centres were designated as adolescent friendly and a growing number of adolescents started to use the services. So far no final evaluation of the data on these pilot projects has taken place but it is expected that they will show reduced numbers of unwanted pregnancies, unsafe abortion and maternal mortality.

WHO staff at country level supported the Indian Ministry of Health throughout the process and is now assisting in the documentation of this story.

India is one of a growing number of countries which aims to address all three objectives through actions by the health and other sectors and by civil society.

Youth Project of the City of Taguig, Philippines

If visitors come to places like the Taguig district “Bayview”, they will see huts being a patchwork of stones, corrugated iron, wood and plastic covers. Palms line the streets made of mud, basketball fields are flooded after rainfalls. Right here, in one of the urban poor communities in the suburbs of Manila in the Philippines, one of five local youth organizations was formed in the framework of the Youth Project of the City of Taguig. These youth organizations are exploring new ways to address adolescent sexual health. They do not only discuss sexual health and self-confidence with adolescents but also involve them into joint activities including for example the renovation of sports centres and learning rooms.

WHO, in partnership with UNFPA, the Philippine Department of Health and the local government supports the project since 2005. Having started with 30 to 40 people each, today more than 400 people aged between 10 and 24 are listed as members of a group 40 peer counsellors elected by the members are now contacting other young people and initiate discussions about their needs.

Main subjects of interests identified include sex education on early sexual encounters, adolescent pregnancies and safer sex. Besides, the members agreed to discuss life skills, parents-youth relationship and team building.

“As a milestone of the initiative, the youths themselves conduct their own sessions and discussions in their own communities,” says Dr Jean-Marc Olivé, the former WHO representative in the Philippines.

Regional Journalist Workshop on maternal and newborn health issues

Journalists from Bangladesh, Cambodia, Fiji, India, Japan, Laos, Nepal, Philippines and Viet Nam participated in a media workshop held in Hanoi, Viet Nam from 1 to 6 June 2008. The workshop resulted in the participants’ improved understanding of maternal and newborn health issues and the journalists returned to their countries with many ideas on how to better cover the issues discussed and where to look for additional information.
MPS web site relaunch

Please click on http://www.who.int/making_pregnancy_safer/en/. The address of the MPS web site remained the same but look and content have changed. And, more importantly, the WHO site focusing on maternal and newborn health has been equipped with a user-friendly navigation allowing its visitors to find the material they are looking for very easily. The new edition offers technical publications, presents the Department and its activities and provides general as well as technical information related to maternal and newborn health.

On the occasion of a public presentation of the revamped MPS web site on 16 June 2008, the Assistant Director-General for Family and Community Health, Daisy Mafubelu, stressed, “I am convinced that the new web site will broaden MPS’ outreach and increase WHO’s visibility in the field of maternal and newborn health.”

The relaunch was preceded by an analysis of the user statistics in 2007. With 500 visits per day, the MPS web site is an important communication tool. The analysis revealed a high demand for publications and a great interest in multimedia content like the BBC videos “Fight for Life”. In response to these results, MPS created a document centre with categories for and descriptions of the publications available. The centre also allows the visitors to easily identify different language versions of MPS publications as far as they exist. The multimedia centre includes videos, audio files, photo stories and learning games. To interest a broader audience in maternal and newborn health topics, the web site also provides general understandable information for journalists and lay people.

Basic versions of the MPS web site in all official WHO languages are expected to go live in September 2008.

Country Profiles CD

The WHO Department of Making Pregnancy Safer (MPS) took the initiative and conducted a comparative analysis and a trend analysis through a compilation of 17 indicators for 72 countries based on Demographic Health Survey data.

The aim of the analysis is to highlight country situations and to indicate health trends in countries over time. In addition, the analyses present descriptive information on geographical and socioeconomic disparity in access to maternal and newborn health services. The analyses may serve as a practical tool at country level to identify priorities for programme planning and resource allocation.

UNFPA report on adolescent pregnancies

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Pregnancy- and childbirth-related complications are the number-one killers of 15-19 year old girls worldwide. But if adolescent girls have opportunities to stay in school, postpone marriage, avoid pregnancy, and build their skills, they will be better equipped for adulthood. They and their future children can be educated and enjoy a higher quality of life.

This UNFPA report highlights the issue of adolescent pregnancy among married and unmarried adolescent girls (10-19 year olds), especially those living in poverty. It draws attention to current trends, as well as the social, economic, and health consequences of adolescent pregnancy not only for the girls themselves, but for their families and countries. The publication argues for strategic investment in the health, education, and livelihoods of adolescent girls to empower them to avoid the trap of becoming mothers while still children. It also examines how targeted investment will improve the prospects for pregnant girls and young mothers. These investment will pay twice: impacting on today’s girls and tomorrow’s women. This publication also outlines what can be done to better address adolescent pregnancy and the multi-faceted needs of adolescent girls worldwide.

<http://www.unfpa.org/publications/detail.cfm?ID=346&filterListType=1>
Reducing maternal mortality by improving care for pregnant adolescents

The higher mortality rates can only partly be attributed to risk factors of age. Adolescent girls are for instance particularly susceptible to obstructed labour, if their pelvises are not fully developed. Other age-related risk factors are anaemia, malnourishment and first pregnancy, but above all there are social factors like lack of access to health services and low social status.

Adolescent mothers and their children are more likely to live in poverty, to be socially excluded, and little educated. Though recent studies could not show clearly whether the adverse socio-economic situation is a cause or a consequence of early pregnancy, it is well-known that many adolescent mothers drop out of school. The girls quit their education because of social expectations, stigma, or because they are expelled from school as soon as their pregnancy becomes known. By excluding girls from education, early childbearing can entrench the vicious circle of poverty.

Making pregnancy safer

To make pregnancy safer for adolescents, special health care programmes are needed. While their clinical needs are not different from those of other mothers, adolescent mothers need extra support to access skilled care before, during and after childbirth.

There are manifold reasons why adolescents usually seek care later than other mothers. First, they may not be aware of their pregnancy. Furthermore, the decision whether to seek care or not may not be taken by the girl, but rather by her husband or mother-in-law. Finally, the cost involved may present another obstacle that restrains adolescents from using available health services.

It is important to overcome those barriers to provide adolescents with early antenatal care. To this end, skilled health workers who know about the demand for special information and the psychological needs of adolescent mothers play a key role. Besides, families and communities have to be involved. Community programmes can help the girls to increase their self-esteem, decision-making abilities and autonomy.

Preventing and delaying pregnancy

Besides the strategy of making pregnancy safer, there are initiatives to prevent unwanted pregnancy. Several interventions have been tested and proven effective, as for example sexual education, whereas only little is known about how to delay wanted pregnancy in marriage. However, with a higher age of first marriage, rising rates of contraceptive use and improving educational levels of girls, there is a global trend of decreasing numbers of adolescent pregnancies. This development is not only favourable for women’s health, but can also slow down population growth rates and generate broad economic and social benefits.

More and better research is needed to expand the evidence base for effective interventions for pregnant adolescents and to translate knowledge into action at country level. The WHO Department of Making Pregnancy Safer hopes to contribute to this effort by publishing a position paper on adolescent pregnancy later in 2008. Using the framework of the Making Pregnancy Safer approach to “improving maternal and newborn survival” (WHO 2006) the position paper will lay out an action plan for WHO and partners to address adolescent pregnancy through the Making Pregnancy Safer Initiative.

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