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*Smaranda DIACONESCU, Tudor CIUHODARU, Catalin CAZACU,
Laszlo-Zoltan SZTANKOVSKY, Cristina KANTOR, Magdalena IORGA*

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Teenage Mothers, an Increasing Social Phenomenon in Romania. Causes, Consequences and Solutions

Smaranda DIACONESCU¹, Tudor CIUHODARU², Catalin CAZACU³,
Laszlo-Zoltan SZTANKOVSKY⁴, Cristina KANTOR⁵, Magdalena IORGA⁶

Abstract

In 2014 Romania holds the second position in teenage pregnancies among EU with 8500 teen births average per year and a teen birth rate of 39.4 ‰. Maternal and child mortality, school dropping and child abandonment are the most serious consequences of this phenomenon. This paper presents an analysis of the mentioned situation in the last 10 years, in a North-Eastern Children's Hospital from Romania. A number of 1643 minor mothers (12-17 years old) were hospitalized in order to treat their own children for different diseases. Variables like: age, number of children, clinical data of minor mother and child, educational level or socio-economic status were taken into consideration. From all teenage mothers, 68.72 % were coming from the rural area and 31.28 % originated the urban area. Age distribution showed that 0.18 % were 12 years old, 0.73 % were 13 years old, 3.83 % were 14 years old, 11.14 % were 15 years old, 26.96 % were 16 years old and 57.15 % were 17 years old. The socioeconomic status and the living conditions were influencing the unwanted pregnancy or "the unknown pregnancy" identified during the hospitalization. A national programme focused on sexual education, medical access policy and family involvement is needed to prevent the higher medical, psychological and social risks of teenage mothers.

Keywords: teen pregnancy, minor mothers, rural, vulnerable population, family background

¹ University of Medicine and Pharmacy "Grigore T. Popa", Department of Pediatrics, Iasi, ROMANIA. E-mail: smaranda.diaconescu@umfiasi.ro

² University of Medicine "Apollonia", Iasi, ROMANIA. Email: tudorciuhodaru@yahoo.co.uk (corresponding author)

³ University of Medicine and Pharmacy "Grigore T. Popa", Iasi, ROMANIA. E-mail: cmcazacu@gmail.com,

⁴ University of Medicine and Pharmacy "Grigore T. Popa", Bioethics, Iasi, ROMANIA. E-mail: sztankovszky@yahoo.com

⁵ University of Medicine and Pharmacy "Grigore T. Popa", Department of Human Resources, Iasi, ROMANIA. E-mail: cristina.kantor@umfiasi.ro

⁶ University of Medicine and Pharmacy "Grigore T. Popa", Department of Behavioral Sciences, Iasi, ROMANIA. E-mail: magdalena.iorga@umfiasi.ro

Teenage mother phenomenon in the World

According to Segen's Medical Dictionary (2011) pregnant teenager refers to pregnancy by female, age 13 to 19, which is understood to occur in a girl who hasn't completed her core education - secondary school – has few or no marketable skills, is financially dependent upon her parents and/or continues to live at home and is mentally immature. Teenager mother refers to an adolescent female, meaning the age of the mother at the time the baby is born. Because a considerable difference exists between a 12- or 13-year-old girl and a young woman of 19, authors sometimes distinguish between adolescents aged 15–19 years, and younger adolescents aged 10–14 years. Birth rates and pregnancy rates are counted per 1000 of a specific population (WHO, 2014).

According to the WHO, about 16 million girls aged 15 to 19 and some 1 million girls under 15 give birth every year - most in low - and middle-income countries and every year, some 3 million girls aged 15 to 19 undergo unsafe abortions. The 2014 World Health Statistics indicate that the average global birth rate among 15 to 19 year olds is 49 per 1000 girls. Country rates range from 1 to 299 births per 1000 girls, with the highest rates in sub-Saharan Africa.

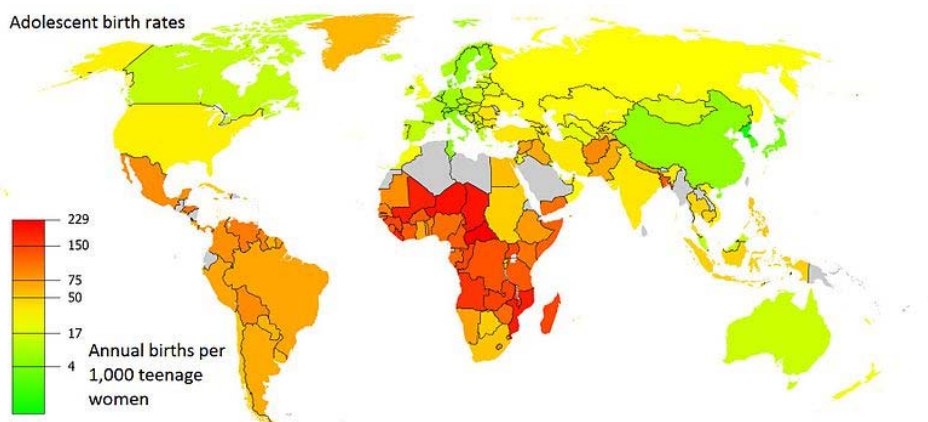


Figure 1. Source: United Nations, Department of Economic and Social Affairs, Population Division (2014)

This problem was intensely researched and discussed, due its important causes, consequences and needed solutions. The study of this problem of ‘children with children’ revealed, along the years, that a lot of variables are determining the development of this phenomenon (ethnicity, culture, education, type of family etc.) and many countries tried to develop national programs in order to diminish the worrying increasing the number of teenage mothers. The causes of this increasing phenomenon are various and most of them are depended variables for

studies. Geographical region, urban/rural area, religious or ethnic aspects, community's customs, family background, type of couple or educational level are most common factors that predict teen pregnancy.

Specific customs and traditions lead to early child marriage. The highest rates of child marriage are found in South Asia and Sub-Saharan Africa, almost half of all child brides worldwide live in South Asia; 1 in 3 is in India. Child marriage affects girls in far greater numbers than boys (UNICEF, 2014). Most of the cases are well-known in developing countries. The social-economical factor seems to be a very important one. Poverty, the lack of education, a poor school performance with low expectation and low self-esteem increase the risk of becoming mother at an earlier age.

Family background with different situations like: the teenage mother is coming from a family with a single or teen parents, with a lack of support from the community, family or friends goes to a so-called "second injury" to victims (Symonds, 1980), most of them prior victims of sexual, psychological or emotional abuse. Exposure to abuse is more frequent. 30% of the abused teenage mothers are reporting as being abused by a family member; generally, the victims knew the abuser and more than 60% of the subjects reported coercive sexual experience (Gershenson *et al.*, 1989), being more exposed to depression, anxiety and life stress. All of the perpetrators were males, the largest proportion of whom were boyfriends or ex-boyfriends (23.4%), followed by friends (17%), uncles (14.9%), stepfathers (12.8%), strangers, (12.8%), cousins (6.4%), teachers (6.4%), neighbors (4.3%), and brothers (2.1%) (Osborne, Rhodes, 2001).

Violence and family strife at home are also reported by researchers. (Ellis 2003, Tamkins 2004)

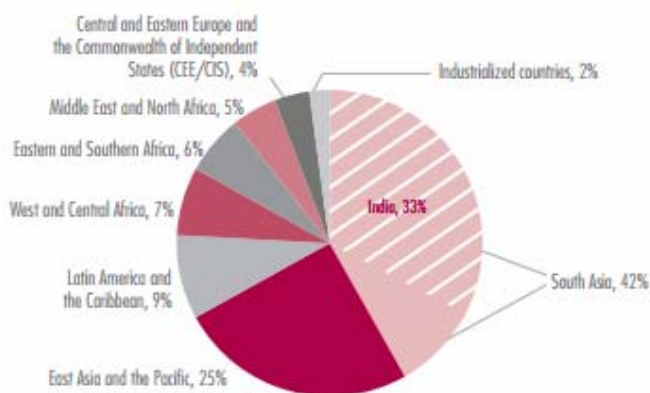


Figure 2. Source: UNICEF. Percentage distribution of women aged 18 years and older who were married or in union before age 18, by region (2014)

The psychological and behavioral aspects are also linked to risk of teenage pregnancy and motherhood: having an older male partner (being perceived as having more sexual experience, with ability to take care and avoid exposing the partner to a pregnancy or, on the other hand, being more determined to emotional abuse and control the girl); looking for gratification and satisfaction (which usually comes, at this age, from educational results or social activity), behavioral problems influenced by alcohol and drugs, lack of education and information about contraception (UNICEF, 2008)

A secular trend, with age at menarche declining at a rate of 2-3 months per decade and an overall decline of about 3 years; an initiation of the first sexual activity at younger ages is doubled by a decreasing age of starting sexual activity which expose an immature body at an immature affective level to immature behaviors and reactions in case of unwanted pregnancies (CDC, 2002; Lyu, 2014; Wyshack, 1982).

Among the most serious consequences of this phenomenon are complications during pregnancy and childbirth, an increase of infantile mortality, low-birth weight newborns, school dropping, child abandonment, a major contribution to the cycle of ill-health and poverty, serious psychological consequences that may lead to risky behaviors (Conde-Agudelo, 2005; Gilbert, 2004; Igwegbe, 2001).

Teenage mother phenomenon in Romania

In the EU the highest rates of poverty, superior to 20 %, are observed in eastern countries like Romania and Bulgaria. Romania has around 20.0 million inhabitants, a GNI/capita of 9370 USD and a population below poverty line of 22.4% (World Bank, 2015). Across the European Union, the poverty rate of women is higher than of men: 17.1 % against 15.7 % (data from 2010). The gaps of poverty levels to the detriment of women are highest in Romania, Sweden, Austria and Italy (about 3 percentage points). More than 20 % of children under the age of 16 are poor in Europe. The northern countries show a lower rate, from 10 % for Denmark to 12.4 % for Sweden. In return, the highest rates are observed in Romania (31.3 %) and in Bulgaria (26.4 %) or even in Spain (25.3 %). (Inequality Watch, 2010)

Poverty leads to insufficient medical surveillance with important consequences on mother and child's health; the lack of education (abandoning school, repeating the school year, a great number of school absences, illiteracy) and the impossibility to find a decent job are increasing risk factors. Across the EU28 in 2012, the birth rate among women aged 15-19 was lowest in Denmark (4.4), Slovenia (4.5) and the Netherlands (4.5). Figure 3 reveals that the highest birth rates were in Romania and Bulgaria at 39.4 and 42.6 (ONS, 2014)

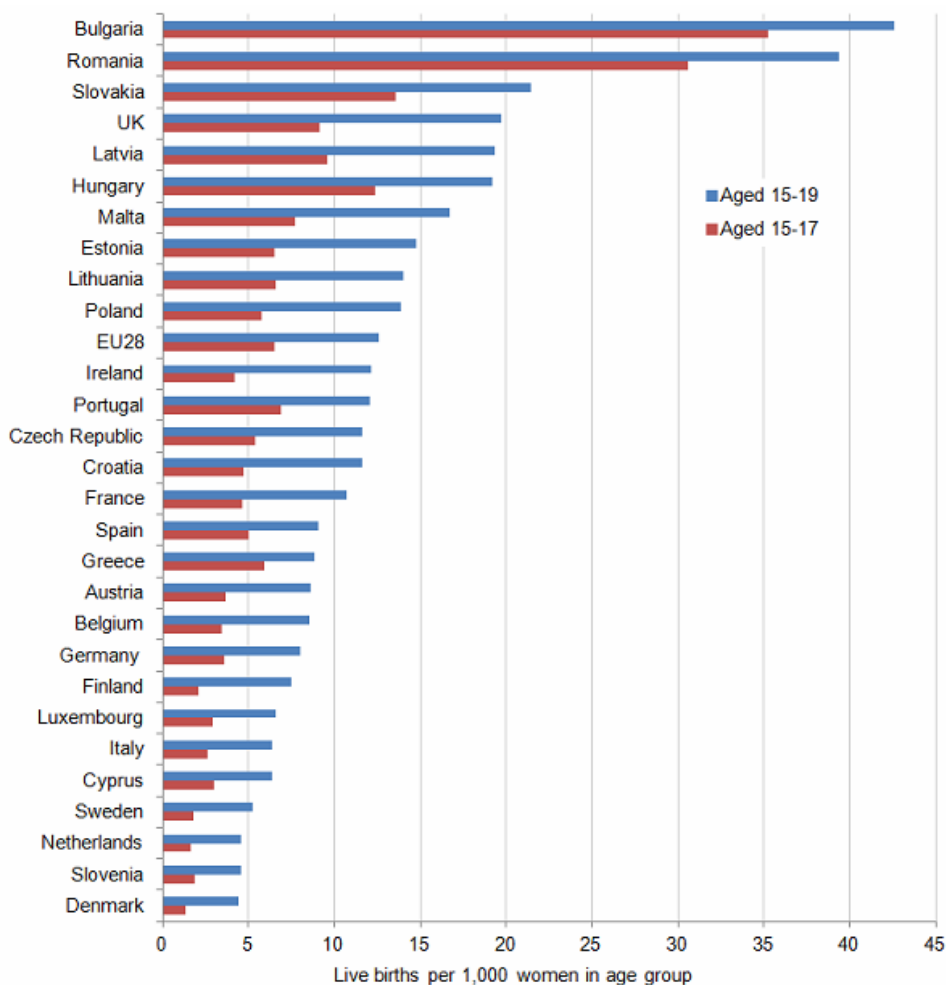


Figure 3. Source: Eurostat data, compiled by the Office for National Statistics (ONS), 2012

The 2014 World Health Statistics indicate that the average global birth rate among 15 to 19 year olds is 49 per 1000 girls. Country rates range from 1 to 299 births per 1000 girls, with the highest rates in sub-Saharan Africa (WHO, 2014). Compared to these rates, the situation in Romania is concerning; with a teen birth rate of 39.4 % Romania holds second position in the EU after Bulgaria and before Slovakia. Almost every of the above-described risk factors acts in Romania and there are particular aspects that lead to the existing situation.

The purpose of the study

In 2011 the WHO published guidelines on preventing early pregnancies and reducing poor reproductive outcomes with 6 main objectives: reducing marriage before the age of 18; creating understanding and support to reduce pregnancy before the age of 20; increasing the use of contraception by adolescents at risk of unintended pregnancy; reducing coerced sex among adolescents; reducing unsafe abortion among adolescents; increasing use of skilled antenatal, childbirth and postnatal care among adolescents (WHO, 2011).

Furthermore, in December 2014 the United Nations Committee on Economic, Social and Cultural Rights recommended Romania to adopt a national strategy on sexual and reproductive health and to intensify its efforts to prevent unwanted teenage pregnancies, to ensure that sexual and reproductive health services, including abortion and contraception services and information, are available, accessible and affordable without discrimination, including to adolescents and to ensure that all pregnant women and girls have access to specialized medical care, including measures to prevent mother-to-child HIV transmission. (UN, 2014)

Research methods

For ten years, a number of 1643 young girls were hospitalized in our tertiary center for various pathologies of their own children. Different variables were taken into consideration like: age, number of children, clinical data of teenage mother and child, educational level or socioeconomic status. The research presents an analysis of statistical data (2003-2013) regarding adolescent mothers. The limits of the study are due to the fact that data are obtained only from a children hospital records, thus identifying only the minor mothers that addressed for different health problem of their children. Further research should include national studies regarding contraceptive knowledge among teenagers and school dropping among teen mothers together with data from maternity wards and family doctors or data collected from the maternities or centers for abused mothers.

Results

We report a number of 1643 minor mothers admitted with their children. Rural provenience dominated the urban one (68.72 % vs. 31.28 %). The annual rate of admissions ranged between 157 and 170 minor mothers/year. The age distribution from total (10 years) is presented in *Table 1*.

Table 1. *Number of cases distribution, according to the age*

Age of the teenage mother	12 years	13 years	14 years	15 years	16 years	17 years	Total
Number of cases	3	12	63	183	443	939	1643

Age distribution was as following: 0,18 % - 12 years, 0,73 % - 13 years, 3,83 % - 14 years, 11,14 % -15 years, 26,96 % -16 years and 57,15 % -17 years. The average of the age is 16. 4. The age distribution related to the urban/rural variable is shown in *Figure 4*. It is obvious that it is registered an increasing number of cases of teenage mothers in the rural area and a constantly decrease of cases in the urban area.

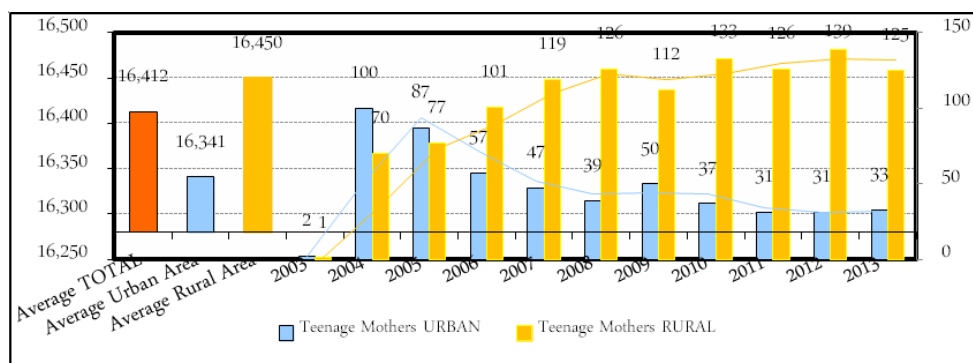


Figure 4. *Age distribution of teenage mothers during 10 years, according to the age and urban/rural area*

A number of 1447 children with ages between 0-1 years old (88%), 158 children aged 1-2 years old (10%) and 38 children with ages between 2-3 years old (2%) were admitted mainly for respiratory tract infections or digestive pathology. Age distribution of hospitalized children is shown in *Figure 5*. The following disorders were listed as first diagnostic, in various associations: acute rhinopharyngitis (259 cases), other specified interstitial pulmonary diseases (240 cases), interstitial pulmonary disease, unspecified (180 patients), acute bronchiolitis, unspecified (145 children), noninfectious gastroenteritis and colitis, unspecified (112 children), other gastroenteritis and colitis of infectious and unspecified origin (102 patients), otitis media unspecified (99 cases), pneumonia due to other specified infectious organisms (96 cases), mild protein-energy malnutrition (88 patients), other specified bacterial diseases (84 patients), congenital malformation of cardiac septum, unspecified (83 children), pneumonia,

unspecified (75 children), acute laryngotracheitis (73 patients), talus equinovarus (63 cases), other low birth weight (62 children), acute pharyngitis, unspecified (61 cases), acute tonsillitis, unspecified (60 cases), eating disorder, unspecified (57 children), tachycardia, unspecified (53 patients).

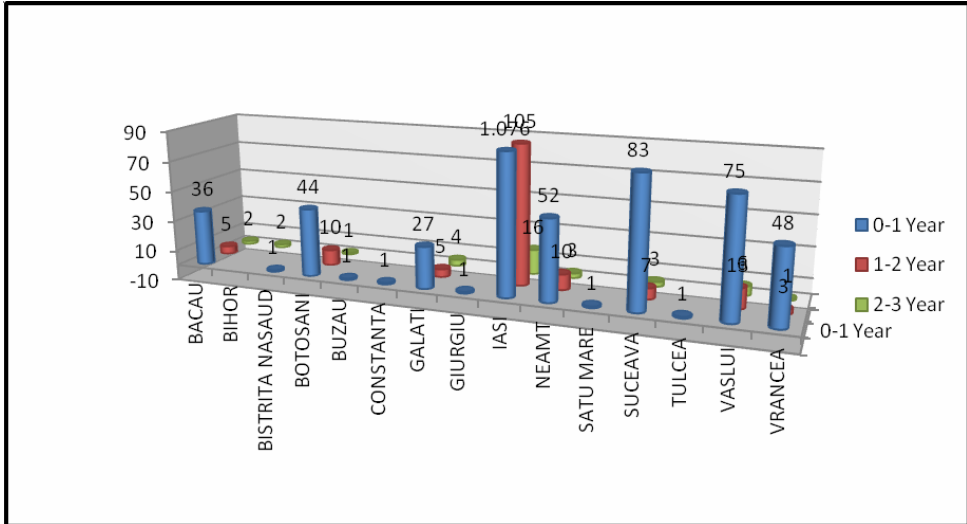


Figure 5. *Distribution of hospitalized children according to the age*

We report a number of 62 teen pregnancies that were unknown prior to hospital admission and were incidentally detected by routine abdominal ultrasound. We can observe that, among the 81 pregnant teenagers, the majority of pregnant girls aged 11-14 years old were living in the urban area. Starting with 15 years old, there is a significant increasing rate of pregnancies among teenagers from the rural area (the rate is 1: 5). The frequencies are presented in *Table 2*.

Table 2. *Age distribution for pregnant teenagers*

age	urban	rural	total
11	1	0	1
12	1	0	1
13	1	2	3
14	5	3	8
15	3	16	19
16	4	19	23
17	4	22	26
total	19	62	81

The results are showing an increasing rate of teenage pregnancy and motherhood. The average of 16 is coming from several causes: the age of first sexual experience decreased, being around 11-12 years old; becoming mother between educational cycles - finishing or abandoning school, due to economical reason (the family is not able to afford studies after the secondary school) or educational reason (the girls has not acceptable marks for having access to the next study level, like professional school or college); the girl has no parental support or parental education, due to several reasons (abnormal family, the parents are divorced or working abroad, living with relatives etc.). Other causes are a late identification of the pregnancy which leads to an impossible interruption; poor sexual education or the lack of accessing/applying contraceptives methods; ethnics, cultural, religious or regional rules (Viner *et al.*, 2012; Leppälahti *et al.*, 2012; Sagili *et al.*, 2012). Regarding the Roma family is the early unofficial marriage and the need to have many children: in the rural area is the desire to have a family; for religious reasons is the impossibility to abort; in case of regional reasons there are different customs like the lack of access to continue studies or having a job, so having a family is most common purpose of an adolescent (Pantea, 2013).

A teen mother is more exposed to different risks than an adult mother. She is more likely to drop out of school, have no or low qualifications, be unemployed or low-paid, live in poor housing conditions, suffer from depression which may result in suicide, live on welfare. On the other hand, the child is exposed to different risks like: live in poverty, grow up without a father, become a victim of neglect or abuse, do less well at school, become involved in crime, abuse drugs and alcohol, eventually become a teenage parent and begin the cycle all over again. (UNICEF, 2008).

Teenage mothers in Rural Area, One Parent Family or Roma Communities

It is important to identify the fact that a lot of adolescent mothers are coming from areas with a high rate of Roma families, well-known for the early age marriages, early sexual activity, the school abandoning and the numerous members in the family. According to the World Bank Romania has the highest proportion of rural population in the EU (45%), and the highest incidence of rural poverty (over 70%), and one of the largest gaps in living and social standards between rural and urban areas. (World Bank, 2011) A direct consequence of poverty is a high number of Romanians that leave the country for working abroad, 1,211.000 persons according to Romanian Census from 2011 and 3,000.000 persons as unofficial data reports (Romanian National Statistics Institute, 2011)

Symptoms like anxiety, depression and suicidal attempts are not rare; these children are more exposed to low school performance or school dropping, smoking, drinking, drug intake and, consecutively, to sexual activity at younger ages and unprotected sex. Strongly related to poverty and in the same time a cause and a consequence of teen birth, the rate of adult participation in lifelong learning is only 2% and Romania has currently a high proportion of early school leavers of 17.5%, higher than the EU average (13.5%) (Romanian National Statistics Institute, 2011; Katz *et al.*, 2012). A neglected child with a low economic status and bad life models is more supposed to become from a victim of her parents a victim of the society. With no adult near her, the teenage girl is more exposed to become a victim of abuse.

A particular situation occurs in Roma communities from Romania that counts 621.673 people according to 2011 Census, in opposition with European Commission data that suggest a more realistic number of 1.500.000. The community, predominantly rural is characterized by extreme poverty and has the highest rate of school dropping; only 17% are legally employed. In this community the early marriage practice is still widely spread; even if it's pretended to be rather a consensual union in order to prevent Child Protection intervention, in certain cases girls are getting married and begin their sexual life at the age of 10-12 years or even earlier. Another concerning fact is the age at first birth that ranges between 14 and 23 years with extreme cases of young mothers aged 12; hence, the children are at high risk for perinatal pathology. The birth rate in Roma women and the overall fertility rate is almost double than in Romanians (25‰ vs. 10.2‰) and 3.1 children/woman vs. 1.4 children/woman. About half of Roma women either have never seen a gynecologist (12.2%) or have only seen a gynecologist during pregnancy (34.1%); in the beginning of their sexual life they have no idea about contraception. 33.7 % of women aged 15 to 19 years old have already gotten married. The infant mortality among Roma is four times higher than in general population, 40 % of Roma children have severe malnutrition and about 50% have never been vaccinated (Ghetau, 2007; Rosicova *et al.*, 2011; Parekh et Rose, 2011; Cook *et al.*, 2013, Wamsiedel *et al.*, 2009).

Sexual Education in Schools. Between Yes and No

Another particular situation is that sexual education in Romania is an area of serious and urgent concern. Law No. 272/2004 regarding rights of the child explicitly mentions the obligation of schools to ensure access to age appropriate sexual education. However, according to the National School Curriculum, health education, including sexual education, is part of the optional rather than the mandatory school curriculum. Optional disciplines are chosen by each school, every semester, at the discretion of the school principal. Sexual education is still

provided only in a minority of schools due to a strong opposition from parents, NGO's, teachers and even church and siblings, internet or movies are the most common source of knowledge.

Hence, children and young people in Romania receive no or little sexual education in school, mostly in grades 11 or 12 so teenagers have no idea about contraception or prevention of sexually transmitted diseases. Family discussions about sexual activity seem to be considered taboos or "too early to be discussed". The gap between generations but, most common, the impossibility to communicate between generations are increasing the phenomenon. One of the most serious consequences of teen birth is the high rate of maternal and infantile mortality; according to the WHO pregnancy and childbirth complications are the second cause of death among 15 to 19 year olds globally (WHO, 2014).

With 9.2 deaths per 1,000 live births according to the Eurostat statistics database in 2013 Romania had the highest infant mortality rate in the European Union, the main cause being pre-term birth. In 2011, infant mortality was up to a high of over 10 deaths per 1 000 live births in Mexico, Romania and Turkey. Large population based studies showed that teenage pregnancy was associated with increased risks of very pre-term delivery, pre-term delivery, low birth weight, SGA (small for gestational age) and neonatal mortality with a general tendency of poorer outcomes in younger teenagers (Chen *et al.*, 2007). Due to the inappropriate conditions for intrauterine development, birth difficulties, difficult expulsion, low birth weight, anemia, prematurity, malformations have been described together with impaired psychosomatic development, behavior disabilities and impaired language latter in the child's life.

Some investigators believed that the adverse outcomes observed in teenage pregnancies might have been attributable to socio-demographic factors such as poverty, low education level, inadequate prenatal care and unmarried status (Chen *et al.*, 2007, Larson 2007). Adolescent pregnancy can also have negative social and economic effects on girls, their families and communities. Many girls who become pregnant have to drop out of school. (Gueorguieva *et al.*, 2001, Rosenthal *et al.*, 2009) Educational strategy and family environment are important keys for moral behavior in the society (Iorga, 2013).

A difficult relation with the family increases the risk to be excluded from the family. Many of these cases are media reported and showed that rejected teenage mothers are supposed to be abused, involved in illicit activities or prostitution. In our country, existing legislation guarantees the right of minor mothers to continue their education, but there are no studies regarding the proportion actually doing so. Data from various NGOs indicate that most teenage mothers never return to formal education, such cessation of education having negative consequences regarding personal and professional development, and employment. This can also have an economic cost with a country losing out on the annual income a young woman would have earned over her lifetime, if she had not had an early pregnancy.

Conclusions

Pregnant teenagers and minor mothers should be assisted by multidisciplinary teams including pediatricians, psychologists, obstetricians, neonatologists and family doctors together with child protection and educational authorities. NGOs are also welcomed due to the fact that entering in ethnic or religious communities is usually reserved to people from these backgrounds. A nationwide extended programme on reducing the teen birth focused on implementation of a comprehensive and mandatory programme on sexual and reproductive health in schools should be part of the National Strategy for Health 2014-2020, focusing on health policy, educational policy and family-centered policy.

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