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Young Mothers, Lasting Costs: Reframing Adolescent Pregnancy as a Public-Health Emergency

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Adolescent pregnancy remains a major global public health concern with well-documented risks to both young mothers and their infants. In low- and middle-income countries, adolescents (15–19 years) experience an estimated 21 million pregnancies annually, about half of which are unintended, resulting in roughly 12 million births[1]. Adolescent mothers face substantially higher risks of obstetric complications, notably eclampsia and infections, than women in their early twenties[1]. Their infants are likewise more vulnerable: babies born to adolescent mothers have significantly higher rates of low birth weight, preterm delivery, congenital anomalies and neonatal mortality[2]. These elevated risks are compounded by underlying social determinants. In South Asia, where adolescent pregnancy prevalence is among the world's highest[2], contributing factors include poverty, limited female education, lack of reproductive health knowledge and entrenched norms of early marriage[2,3]. These factors underscore that preventing adolescent pregnancy and its adverse outcomes is critical to achieving global maternal and child health goals.

South Asia bears a disproportionate share of the adolescent pregnancy burden. In fact, Bangladesh stands out within the region with one of the highest rates. UNICEF's analysis notes that Bangladesh, Nepal and India report prevalences of adolescent pregnancy as high as 35%, 21% and 21% respectively. Remarkably, the United Nations Population Fund (UNFPA) reports that *"Bangladesh has the highest adolescent pregnancy rate outside Sub-Saharan Africa"*, with about 113 of every 1,000 girls becoming pregnant before age 19[3]. This intense pressure of early childbearing in Bangladesh is driven almost entirely by child marriage: about half of women are married before 18 and adolescent marriage is the primary cause of teen pregnancy[3]. Indeed, according to the latest national survey (BDHS 2022)[4], 23.7% of girls become mothers during adolescence, largely because 50.1% were married as children. These sobering statistics reflect a cycle in which rural and low-income girls, often with minimal schooling, enter marriage and pregnancy at a very young age. Our own recent hospital data echo this pattern: over 90% of adolescent mothers were aged 18-19 (mean 17.8 years), and 62% came from rural areas while 68% were socioeconomically disadvantaged. This alignment with regional trends emphasizes that targeted efforts in Bangladesh must address the underlying social drivers such as poverty, child marriage, & gender norms, that put girls at risk.

WHO emphasizes that adolescent mothers have higher incidence of eclampsia and puerperal infection than older women. Even a few cases of eclampsia or post-partum haemorrhage among teenagers is cause for concern, given their smaller blood volume and limited physiological reserve. Globally, studies consistently report that hypertensive disorders of pregnancy and anemia are among the most frequent complications in adolescent pregnancies. Fetal and neonatal outc omes likewise reflect the vulnerability

of infants born to young mothers. Babies of adolescent mothers are more likely to be premature or low birth weight, with correspondingly higher rates of neonatal morbidity and mortality[1,2]. Poor intrauterine growth in adolescent pregnancies often reflects maternal malnutrition and anemia, conditions which are more common in younger mothers, and can have lifelong consequences for the child.

These findings carry important implications. Bangladesh's high burden of adolescent pregnancy contributes to maternal and infant morbidity and mortality, and also has far-reaching social effects. Girls who become pregnant often drop out of school, truncating their education and future opportunities. The UNICEF South Asia flagship report emphasizes that ensuring girls remain in secondary education is *"crucial"*: higher education levels not only improve health and economic prospects, but also provide a vital platform for health education and protection[5]. Schools can deliver comprehensive sexuality education, menstrual hygiene management, and information on contraception - interventions that directly discourage early marriage and childbearing[5]. Yet in Bangladesh many adolescent mothers leave schooling early due to social pressure. Strengthening education, especially sex and reproductive health education in schools and colleges, is therefore a key strategy to prevent teenage pregnancies.

National policies and international guidelines also underscore multi-sectoral solutions. The WHO's latest guidelines on adolescent health call for interventions that address the root causes of early pregnancy: preventing child marriage, expanding adolescent access to contraception, and ensuring youth-friendly maternal health services[6]. In Bangladesh, for instance, these measures would involve enforcing the legal minimum marriage age, increasing community outreach about the dangers of early childbearing, and making family planning more accessible to unmarried and married teens alike. Community-level awareness programs involving parents, local leaders and religious figures are crucial to changing norms that condone child marriage. Likewise, secondary schools and vocational institutes should integrate reproductive health into curricula and provide "life skills" training, as UN agencies are already piloting[3].

In summary, adolescent pregnancy in Bangladesh represents a persistent challenge at the intersection of health and social policy. We echo international calls for evidence-based policy: Bangladesh must bolster sex education and reproductive health services in schools and communities, and intensify efforts to end child marriage. By investing in girls' education and empowerment, and by promoting community awareness of the harms of early marriage and childbearing, Bangladesh can mitigate the personal and societal toll of adolescent pregnancy. The health and futures of mothers and children depend on it.

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