family income for food and medicines. Since poverty is almost certainly a key factor in health and child survival—and it is well known that mothers will use their own income to pay for food and medicines that their children need—then to delay marriage and childbearing until the woman has income-earning skills will increase her overall health and that of her children.

A direct spin-off from education, income-generating power, and literacy, are the increased levels of ‘empowerment’ experienced by women. Women with literacy, education and even small amounts of their own money have a confidence and bargaining power unknown to those without it. A woman’s reproductive health decisions are often controlled by her male partner—to empower a young woman may in itself be one of the most powerful factors in improving reproductive health. A woman able to: avail herself of family planning services, understand the messages and make informed choices about their use, limit her family size, negotiate safe sex and condom use to prevent infection with sexually transmitted diseases, and decide to take her child to the health centre and have her immunized, is in a powerful position to influence her health, and that of her children. Literacy, education and income do not guarantee a woman any of these freedoms, but they increase her chances of gaining them.

In conclusion therefore I would say that in Nepal it is not so much a case of ‘too much too young’, but the opposite, ‘too little too young’: too little food, too little education, too little finance and too little choice. This is what makes teenage pregnancy a problem. Active efforts to delay marriage and age of first pregnancy alone would make significant differences to the health of mothers and babies in Nepal. When active attempts are made to address the ‘too littles’ then we will begin to see real improvements in the health status of mothers and their children.

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References


What a difference a year makes?
Too little too late

Debbie A Lawlor and Mary Shaw

‘... if we could successfully intervene and change a woman’s age at first birth and nothing else about her up to that point’?

Scally argues that we do not deal with the much more important issues of the educational and social effects of early motherhood and focus on a narrow medical definition of public health. We would argue that we deal primarily with the detrimental effects, for mother and child, of social deprivation. However, we do not feel that these problems are the preserve of one particular age group. We agree with Scally, Rich-Edwards and Smith that some teenage mothers in the UK, US and Nepal have blighted lives, but we do not believe that labelling a woman who chooses to have a baby under the age of twenty as a public health problem actually helps the mother or her child. We believe that the underlying problem lies in society’s attitudes towards young people and specifically in attitudes towards women’s reproductive lives.

It seems that we are all agreed that there are no inherent health or medical problems associated with becoming pregnant and having a child before the age of twenty. Therefore, if society were such that a 16-year-old could begin her family at that age, and then say in her mid-twenties, return to education or a chosen career path, without prejudice and undue uphill struggle, there would be no problem. Referring to very different contexts Rich-Edwards and Smith suggest that if young women are provided with education, income-earning potential and empowerment then an additional benefit will be that early motherhood will be delayed. But we would argue that opportunities, support and services should be available to women regardless of their age and regardless of whether or not they have children. Provision should suit and support the reality of women’s lives, rather than limit their opportunities and choices unless they organize their reproduction in a socially acceptable way. Changing society’s attitude towards young women and their reproductive choices may facilitate better opportunities and support, labelling them as a public health problem is unlikely to. Understanding that an unwanted pregnancy is NOT the same as an unwanted child or a child automatically doomed to fail in society is also
important. Labelling any aspect of teenage pregnancy as shameful is unlikely to be beneficial. Concerted efforts to reduce poverty and inequalities—a clear public health threat—for women and men of all ages is clearly where public health policy should be focused.3

References
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