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Skip to main content Pregnant and postpartum women✻ are at increased risk of developing tuberculosis (TB) disease (1, 2). In addition, TB during pregnancy is associated with worse maternal outcomes, complications during birth and adverse perinatal outcomes; it contributes to 6–15% of all maternal mortality and puts neonates born to mothers with TB at higher risk of the disease (2–4).This featured topic:highlights current global initiatives and projects that include efforts to improve the prevention and treatment of TB during pregnancy and in the postpartum period;summarizes existing estimates of the burden and risk of TB during pregnancy and postpartum; anddiscusses what data are of particular relevance for collection, analysis and use by national maternal and child health (MCH) programmes and national TB programmes (NTPs) – either through routine surveillance, sentinel surveillance, periodic surveys or research projects. The World Health Organization (WHO) published a roadmap for childhood TB in 2013 (5). This was updated in 2018 as the Roadmap towards ending TB in children and adolescents (6), and again in 2023 in an edition that included attention to maternal TB for the first time (7). The roadmap recognizes that effectively addressing TB in infants and young children is inextricably linked to effectively addressing TB in pregnant and postpartum women, and it calls for action on a variety of fronts; for example:increasing funding, leadership and accountability;implementing social protection programmes;sustaining advocacy at all levels;building and sustaining local capacity for prevention and management of TB;scaling up TB prevention;increasing access to optimal care, and strengthening integrated people-, family- and community-centred strategies;improving data collection, reporting and use; andsupporting research and innovation.Together with the SMART4TB consortium (8), WHO is also leading a process to reach consensus on the earlier and optimal inclusion of pregnant and postpartum women in TB drug and vaccine trials. Pregnant women are excluded from most of these trials; hence, they may not benefit from the most optimal and safest options for prevention and treatment. WHO has established five expert working groups to develop discussion documents on the following topics: advocacy, maternal TB surveillance (programmatic and pharmacovigilance), preclinical trials, therapeutics and vaccine trials (5). A meeting that aims to reach final consensus is scheduled for February 2025. Estimates of the incidence of TB disease in pregnant and postpartum women are currently limited. In 2019, global estimates presented during an annual global conference on TB and lung diseases suggested that about 200 000 pregnant or postpartum women develop TB annually (151 000 during pregnancy and 49 000 in the postpartum period), mostly in the WHO African Region and South-East Asia Region (9).More recently, a systematic review has reported incidence risk ratios of 1.4 (95% C.I. 1.1–1.7) for TB disease during pregnancy and 1.9 (95% C.I. 1.5–2.5) in the postpartum period (1). It is possible that the former is an underestimate, because there are challenges with the screening and diagnosis of TB in pregnant women due to physiological and immunological changes. The increased risk in the postpartum period may reflect delays in detection during pregnancy and immune changes after delivery.Considering the severe implications of TB for both the mother and her infant, interventions are critical to improve the detection and treatment of TB during pregnancy and the postpartum period. Such interventions can be informed by better collection, analysis and use of data, including through research studies that involve pregnant and postpartum women. Of particular importance are data that allow assessment of the coverage of TB screening among pregnant women in high TB burden settings, the proportion of people notified with TB who are pregnant or postpartum, and the TB treatment outcomes of pregnant and postpartum women. WHO guidelines on TB recommend that all pregnant women living in high TB burden countries and all pregnant women living with HIV should be screened for TB, at every visit to a health care facility (10). WHO guidelines on antenatal care (ANC) recommend screening, diagnosis and treatment of TB disease in pregnant women in settings with a high TB burden; this includes TB screening at every ANC visit and contact with a health care worker (11). In addition, eligibility for TB preventive treatment (TPT) should be assessed for all pregnant women living with HIV as part of comprehensive HIV care and ANC.Despite these recommendations, many countries do not routinely record TB screening among pregnant women (2).One possible approach to ensure better availability of data related to the provision of TB screening during pregnancy is sentinel surveillance. Another option is to record and report data about TB screening through the routine surveillance system, in all health facilities throughout the country. Uganda is an example of a country in which this is being done.In Uganda, the Ministry of Health introduced a TB active case finding (ACF) strategy in 2019. This strategy prioritized provider-initiated TB screening at all primary health care (PHC) entry points, including ANC. The TB ACF strategy includes checking the TB status of all pregnant women presenting for ANC, with links to microbiological testing, TB treatment or TPT. Tools for the country's National Health Management Information System were updated in 2019, to align recording and reporting tools to the TB ACF strategy. The integrated ANC register includes a column on TB status for each ANC visit; also, all pregnant women identified with presumptive TB are recorded in a presumptive TB register, which is available at the ANC clinic. The data on TB screening in ANC are reported by each PHC facility on a weekly and monthly basis through the routine surveillance system (which uses DHIS2 software) and are used to guide decision-making related to TB ACF. The coverage of screening for TB among pregnant women presenting to ANC increased from 55% in the first quarter of 2020 to 90% in the first quarter of 2024 (Fig. 1). Two examples of countries in which data on TB screening among pregnant women are being collected, but not yet routinely reported, are Brazil and South Africa.In Brazil, pregnant women have access to TB diagnosis and treatment through primary care provided by the country's Unified Health System. The country's prenatal guidelines (12) include TB screening and inquiring about contact with people with TB; they also provide specific recommendations on TB diagnosis, treatment and follow-up. Information on TB screening is recorded in an individual medical record (maternal health booklet) but is not routinely reported as part of TB surveillance.In South Africa, pregnant women are routinely tested for TB (using the Xpert® MTB/RIF Ultra assay) during their first ANC visit. The results are recorded in a TB screening register, but are not routinely reported as part of TB surveillance. WHO's guidance on TB surveillance (13) includes a set of core indicators to report and use for all countries, irrespective of whether the surveillance system for TB is a case-based digital or paper-based aggregated system. These core indicators do not include those related to whether someone is pregnant or in the postpartum period. Five additional core indicators – focused on rapid testing, contact investigation and TPT – are recommended for all countries with case-based digital surveillance for TB. The guidance also provides examples of additional disaggregations of data for people notified as a TB case (e.g. by provider category, risk factor or source of referral) and additional indicators (e.g. treatment outcomes disaggregated by age and sex) that could be considered for use in countries with case-based digital TB surveillance, according to country context. To assess the proportion of people notified as a TB case who were pregnant or postpartum, and their TB treatment outcomes (including how these compare with other people treated for TB), one option could be to include a standard variable related to pregnancy or postpartum status in a case-based digital system.As highlighted in the WHO guidance (13), there are alternative (and complementary) approaches that can be used to answer specific questions of interest, but do not require the continuous collection of data for everyone diagnosed with TB. Two examples are as follows:Data collection for a random sample of medical records. This is expected to entail less overall effort in terms of data collection – for example, record reviews could be used to assess TB treatment outcomes among pregnant and postpartum women, compared with other people treated for TB.Record linkage between databases. For example, it might be possible to link records in case-based digital databases managed by MCH and TB programmes, and in turn to assess both TB treatment outcomes and TB-related pregnancy outcomes.Brazil and South Africa are two examples of countries in which NTPs are collecting data related to pregnancy, on a routine basis.In Brazil, information about pregnancy status has been incorporated into the TB notification form since 2007. This allows for monitoring of several indicators for pregnant women. Pregnant women with TB represented 0.46% (n=390) of the total number of new TB notifications in 2023. The aim is to use findings to inform implementation of interventions that will result in better maternal and neonatal outcomes.In South Africa, the NTP added "Pregnant during multidrug-resistant TB and rifampicin-resistant TB (MDR/RR-TB)" as a variable in the digital register for MDR/RR-TB in mid-2023, linked to the planned roll-out of a new regimen containing bedaquiline, pretomanid, linezolid and levofloxacin (BPaL-L). This is expected to help the NTP to monitor treatment outcomes of women treated for MDR/RR-TB while pregnant. National guidelines use the BEAT-Tuberculosis regimen (6 months of bedaquiline, delamanid, linezolid, levofloxacin and clofazimine) instead of BPaL-L for pregnant women with MDR/RR-TB (14). TB in pregnancy and the postpartum period can have serious implications for both mothers and their infants. However, current estimates of the burden of TB in pregnant and postpartum women are limited by the paucity and heterogeneity of available data. The consensus process on the optimal inclusion of pregnant and postpartum women in TB drug and vaccine trials has further highlighted the need for better data on TB, and associated data analysis and use, in these subpopulations. Options for generating the most relevant data include routine surveillance, sentinel surveillance, record linkage and periodic studies. Generating and using the relevant data will require strong collaboration and coordination between NTPs and MCH programmes at country level, supported by global stakeholders, as appropriate.✻Note: The terms 'women' and 'mothers' are used in this featured topic. These terms are intended to be inclusive of all people who experience pregnancy, regardless of their gender identity. In the context of this featured topic, post-partum is used to refer to the period up to 6 months after giving birth. ReferencesMorton AJ, Roddy Mitchell A, Melville RE, Hui L, Tong S, Dunstan SJ et al. 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Departamento de Atenção Básica; 2013 (C3%A7%C3%A3o-ao-Pr%C3%A9-natal-de-Baixo-Risco.pdf).Consolidated guidance on tuberculosis data generation and use. Module 1: tuberculosis surveillance. Geneva: World Health Organization; 2024 (.Clinical management of rifampicin-resistant tuberculosis. Updated clinical reference guide. Pretoria: Department of Health, Republic of South Africa; 2023 (. Skip to main content In a bid to tackle the leading cause of death globally among 15–19-year-old girls, the World Health Organization (WHO) today released a new guideline aimed at preventing adolescent pregnancy and its significant related health complications. Among other strategies, the guideline urges rapid action to end child marriage, extend girls' schooling, and improve access to sexual and reproductive health services and information – all critical factors for reducing early pregnancies among teenagers around the world."Early pregnancies can have serious physical and psychological consequences for girls and young women, and often reflect fundamental inequalities that affect their ability to shape their relationships and their lives," said Dr Pascale Allotey, Director of Sexual and Reproductive Health and Research at WHO and the United Nations' Special Programme in Human Reproduction (HRP). "Tackling this issue therefore means creating conditions where girls and young women can thrive – by ensuring they can stay in school, be protected from violence and coercion, access sexual and reproductive health services that uphold their rights, and have real choices about their futures."More than 21 million adolescent girls become pregnant each year in low and middle-income countries, around half of which are unintended. With impacts on girls' education, social connection and future employment prospects, early pregnancy can create cycles of intergenerational poverty that become difficult to break. It also brings serious health risks, including relatively higher rates of infections and preterm births as well as complications from unsafe abortions – linked to particular challenges in accessing safe and respectful care. Reasons for early pregnancy are varied and interrelated, including gender inequities, poverty, lack of opportunity and inability to access sexual and reproductive health services. There is a strong correlation with child marriage: in low- and middle-income countries, 9 in 10 adolescent births take place among girls who were married before the age of 18.The guideline recommends holistic efforts to provide viable alternatives to early marriage by strengthening girls' education, savings and employment prospects. If all girls finished their secondary schooling, it has been estimated that child marriages could be reduced by as much as two thirds. For girls at highest risk, the guideline recommends considering incentives to support secondary school completion, such as targeted financial stipends or scholarship programmes. The guideline also recommends laws to prohibit marriage below the age of 18, consistent with human rights standards, and community engagement to prevent the practice."Early marriage denies girls their childhood and has severe consequences for their health," said Dr Sheri Bastien, Scientist for Adolescent Sexual and Reproductive Health at WHO. "Education is critical to change the future for young girls, while empowering adolescents – both boys and girls – to understand consent, take charge of their health, and challenge the major gender inequalities that continue to drive high rates of child marriage and early pregnancy in many parts of the world."The recommendations highlight the need to ensure adolescents can access high quality, adolescent-responsive sexual and reproductive health services including contraceptive options. In some countries, consent from an adult is required to access services, which is a significant barrier to their use. Young girls who get pregnant also need to be able to access high quality and respectful healthcare during and after pregnancy and birth, free from stigma and discrimination, as well as safe abortion care.Finally, comprehensive sexuality education is essential for both boys and girls to ensure they know where to access such services and how to use different types of contraception. It has been shown to reduce early pregnancies, delay the onset of sexual activity, and improve adolescents' knowledge about their bodies and reproductive health. This guideline updates an earlier edition of the guideline on adolescent pregnancy prevention from 2011 and focuses particularly on preventing child marriage and improving adolescents' access to and use of contraception. It complements WHO's related guidance around health services for adolescents, comprehensive sexuality education and gender-based violence.Globally, there has been progress in reducing adolescent pregnancies and births. In 2021, an estimated 1 in 25 girls gave birth before the age of 20, compared to 1 in 15 two decades prior. There remain significant disparities. In some countries, close to 1 in 10 adolescent girls (15–19 years) give birth each year. Pregnancy is a period of up to 41 weeks in which a fetus develops inside a woman's womb. NICHD conducts and supports research and training to help promote healthy pregnancies, with a focus on the important events that occur before, during, and after pregnancy. Pregnancy is the period during which a fetus develops inside a woman's womb. Pregnancy usually lasts about 40 weeks, or just over 9 months, as measured from last menstrual period to delivery. More >> A primary sign of pregnancy is missing 1, 2, or more menstrual periods in a row, but many women experience other symptoms of pregnancy, such as fatigue or nausea, before they miss a period. More >> Home pregnancy tests are often the first way women learn they are pregnant. If a home test is positive, a woman should call a health care provider to make an appointment and confirm the test. More >> Early and regular prenatal care, health care during pregnancy, improves the chances of a healthy pregnancy and birth. More >> Common complications of pregnancy include high blood pressure, gestational diabetes, infections, preeclampsia, preterm labor, pregnancy loss, and stillbirth. More >> A high-risk pregnancy is one that threatens the health or life of the mother or her fetus. High-risk pregnancies often require specialized care from specially trained providers. More >> Infections that can affect the health of the pregnant woman, the pregnancy, and the baby after delivery can include chlamydia, gonorrhea, HIV/AIDS, human papillomavirus, syphilis, and Zika. More >> Labor and delivery are the processes by which the fetus and the placenta leave the uterus. Delivery can occur vaginally (through the vagina) or by a cesarean or surgical delivery. More >> A cesarean delivery is a surgical procedure in which a fetus is delivered from the womb through an incision in the mother's abdomen and uterus. More >> "Postpartum depression" is not just depression and is not just postpartum. Women can experience depression, anxiety, and other mental health issues during pregnancy and after the baby is born. More >> NICHD conducts and supports a variety of clinical research projects related to pregnancy and complications of pregnancy. More >> Find answers to other common questions about pregnancy, such as how much weight a woman should gain during pregnancy and what challenges pregnant women with disabilities face. More >> Links to websites of groups that study or provide information about pregnancy. More >> Pregnancy is the term used to describe the period in which a fetus develops inside a woman's womb or uterus.Pregnancy usually lasts about 40 weeks, or just over 9 months, as measured from the last menstrual period to delivery. Health care providers refer to three segments of pregnancy, called trimesters. The major events in each trimester are described below.1 The events that lead to pregnancy begin with conception, in which a sperm penetrates an egg. The fertilized egg (called a zygote) then travels through the woman's fallopian tube to the uterus, where it implants itself in the uterine wall. The zygote is made up of a cluster of cells that later form the fetus and the placenta. The placenta connects the mother to the fetus and provides nutrients and oxygen to the fetus.2 Between 18 and 20 weeks, the typical timing for ultrasound to look for congenital anomalies, you can often find out the sex of your baby.At 20 weeks, a woman may begin to feel movement.At 24 weeks, footprints and fingerprints have formed and the fetus sleeps and wakes regularly.According to research from the NICHD Neonatal Research Network, the survival rate for babies born at 28 weeks was 92%, although those born at this time will likely still experience serious health complications, including respiratory and neurologic problems.3 At 32 weeks, the bones are soft and yet almost fully formed, and the eyes can open and close.Infants born before 37 weeks are considered preterm. These children are at increased risk for problems such as developmental delays, vision and hearing problems, and cerebral palsy.4 Infants born between 34 and 36 weeks of pregnancy are considered to be "late preterm."4Infants born in the 37th and 38th weeks of pregnancy—previously considered term—are now considered "early term." These infants face more health risks than infants who are born at 39 weeks or later, which is now considered full term.6Infants born at 39 or 40 weeks of pregnancy are considered full term. Full-term infants have better health outcomes than do infants born earlier or, in some cases, later than this period. Therefore, if there is no medical reason to deliver earlier, it is best to deliver at or after 39 weeks to give the infant's lungs, brain, and liver time to fully develop.6,7,8Infants born at 41 weeks through 41 weeks and 6 days are considered late term.6Infants who are born at 42 weeks and beyond are considered post term.6 Office on Women's Health. (2010). 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Retrieved November 9, 2016, from Skip to main content Antenatal care - regular contact with skilled health personnel during pregnancy - is a core component of maternity care, grounded in a human rights-based approach. WHO recommends that women should have eight contacts with a health provider during pregnancy to screen for potential complications and treat problems as they arise including prevention of antepartum stillbirths.Although a large proportion of women access these services at least once during their pregnancy, less than half of all women in low-resource settings received antenatal care in their first trimester. WHO works to improve access to and quality of antenatal care across every population, including adolescent girls and in hard-to-reach areas or conflict settings. Digital health interventions, such as appointment reminders, have had a positive impact and are an ongoing area of work. By focusing on a positive pregnancy experience, WHO seeks to ensure not only a healthy pregnancy for every woman and baby, but also an effective transition to positive labour and childbirth and ultimately to a positive experience of parenthood. of all maternal deaths, stillbirth and newborn deaths could be averted with quality midwifery care Find out more of services can be provided by midwives, when educated to international standards Find out more outcomes were found to be improved through midwifery practice and philosophy of care