# Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean

Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean.
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# Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean

**REPORT OF A TECHNICAL CONSULTATION**

August 29-30, 2016
Washington, DC, USA

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# Acknowledgments

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"Adolescent pregnancy profoundly affects girls' life trajectories"
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# Preface

Adolescent pregnancy profoundly affects girls' life trajectories. It hampers their psychosocial development, contributes to poor health outcomes for the girls and their offspring, negatively affects their educational and employment opportunities, and contributes to the perpetuation of intergenerational cycles of poor health and poverty.

Despite recent economic growth and social progress on a number of fronts in Latin America and the Caribbean (LAC), adolescent fertility rates remain unacceptably high, the second highest in the world, with major inequities between and within countries. Girls from families in the lower wealth quintile, with lower levels of education, and from Indigenous and Afro-descendant communities are disproportionately affected by adolescent pregnancy. The rising trend in pregnancies in girls younger than 15 years is also highly concerning.

The Sustainable Development Goals (SDGs), and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) call upon all stakeholders to work toward a world in which every woman, child, and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.

Success stories from within the Region, and experiences in other regions with similar or lower levels of economic development, have demonstrated that it is possible to achieve rapid reduction in adolescent pregnancy. Based on global technical guidance and documented experiences, we know what works to prevent adolescent pregnancy. There is plenty of evidence in the Region that we are capable of successfully confronting public health challenges. The Americas are leading the world in the elimination of vaccine-preventable diseases, such as measles; the elimination of mother-to-child transmission of HIV; and the design of rapid and effective responses to emerging challenges, such as the Zika virus.

Application of the same commitment and the lessons learned in addressing other public health challenges to adolescent pregnancy could contribute to its reduction. National programs need to abandon what does not work and scale up what works, ensuring that girls living in conditions of vulnerability are reached effectively. Adolescent girls must be protected from sexual violence, and efforts must include engaging men and boys to become partners in the protection and empowerment of adolescent girls. Opportunities must be created for all girls, including adolescent mothers, to educate themselves, create a future, and participate in society.

National governments and communities in the Region must comply with the Convention on the Rights of the Child (CRC), the Mexico Declaration, the Montevideo Consensus on Population and Development, the regional goals for Universal Health Access and Coverage, and the SDGs, and regional partners must work with all stakeholders to end the injustice of adolescent pregnancy in our Region.

# Abbreviations

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| | |
|---|---|
| CARICOM | Caribbean Community |
| CEDAW | Convention on the Elimination of all Forms of Discrimination Against Women |
| CLADEM | Latin American and Caribbean Committee for the Defense of Women's Rights (Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer) |
| CLAP/WR | Latin American Center for Perinatology, Women and Reproductive Health (Centro Latinoamericano de Perinatología, Salud de la Mujer y Reproductiva) (PAHO) |
| COMISCA | Council of Ministers of Health from Central America and Dominican Republic (Consejo de Ministros de Salud de Centroamérica) |
| CRC | Convention on the Rights of the Child (United Nations) |
| CRR | Center for Reproductive Rights |
| CSE | Comprehensive sexuality education |
| DHHS | U.S. Department of Health and Human Services |
| ECLAC | Economic Commission for Latin America and the Caribbean (Comisión Económica para América Latina y el Caribe, CEPAL) (UN) |
| IACHR | Inter-American Commission for Human Rights |
| ICC | International Criminal Court |
| IDB | International Development Bank |
| IPPF | International Planned Parenthood Federation |
| LARC | Long-acting reversible contraception |
| LAC | Latin America and the Caribbean |
| M&E | Monitoring and evaluation |
| NGO | Nongovernmental organization |
| OAS | Organization of American States |

| | |
|---|---|
| OHCHR | United Nations Human Rights Council |
| ORAS/ CONHU | Andean Health Agency Hipólito Unanue Agreement (Organismo Andino de Salud Convenio Hipólito Unanue) |
| PAHO | Pan American Health Organization |
| PLANEA | Andean Plan to Prevent Teen Pregnancy (Plan Andino para la Prevención del Embarazo en Adolescentes) |
| PWR | PAHO/WHO Representative |
| RHR | Department of Reproductive Health and Research (WHO) |
| SDGs | Sustainable Development Goals (UN) |
| SGBV | Sexual and gender-based violence |
| SIP | Perinatal Information System (Sistema Informático Perinatal) |
| SMI | Mesoamerican Health Initiative (Salud Mesoamérica Initiative) |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| UB | University of Bedfordshire (United Kingdom) |
| UK | United Kingdom |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | U.S. Agency for International Development |
| WAS | World Association for Sexual Health |
| WB | World Bank |
| WDC | Washington, DC |
| WHO | World Health Organization |
| YFHS | Youth Friendly Health Services |

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*"Although total fertility (number of children per woman) in Latin America and the Caribbean (LAC) has declined over the past 30 years, **adolescent fertility rates have only dropped slightly** during that period and continue to be the second highest in the world"*

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# Executive summary

Although total fertility (number of children per woman) in Latin America and the Caribbean (LAC) has declined over the past 30 years, adolescent fertility rates have only dropped slightly during that period and continue to be the second highest in the world, surpassed only by those in sub-Saharan Africa.

Given the slow progress in mitigating this public health, developmental, human rights, and equality issue, Pan American Health Organization/ World Health Organization (PAHO/ WHO), United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF) held a technical consultation meeting on August 29–30, 2016, to take stock of the situation and develop consensus on strategic approaches and priority actions to help reduce adolescent pregnancy.

The 38 meeting participants included global and regional experts and partners, Ministries of Health and Education, subregional integration mechanisms, nongovernmental organizations, youth networks, and indigenous and Afro-descendant communities.

The meeting focused on adolescent pregnancy in LAC in the 10–14- and 15–19-year age groups and meeting objectives were as follows: 1) to review what is known about the status, drivers and impact of adolescent pregnancy in those age groups and identify knowledge gaps; 2) to analyze the status of and lessons learned regarding current regional and country-level approaches to preventing first and repeat adolescent pregnancy in those age groups to determine why progress has been slow, and identify areas for improvement; and 3) to reach consensus on priority actions, joint strategies, and recommended research to accelerate progress in the prevention and reduction of adolescent pregnancy in these age groups.

The meeting participants identified the following seven priority actions to accelerate the reduction of adolescent pregnancy in LAC:

1. Make adolescent pregnancy, its drivers and impact, and the most affected groups more visible with disaggregated data, qualitative reports, and stories.
2. Design interventions targeting the most vulnerable groups, ensuring the approaches are adapted to their realities and address their specific challenges.
3. Engage and empower youth to contribute to the design, implementation and monitoring of strategic interventions.
4. Abandon ineffective interventions and invest resources in applying proven interventions.
5. Strengthen inter-sectoral collaboration to effectively address the drivers of adolescent pregnancy in LAC.
6. Move from boutique projects to large-scale and sustainable programs.
7. Create an enabling environment for gender equality and adolescent sexual and reproductive health and rights.

The meeting urged regional and country-level stakeholders to prioritize these actions in compliance with the political commitments expressed in regional commitments such as the Mexico Declaration and the Montevideo Consensus, and to maximize the momentum generated by the Sustainable Development Goals (SDGs) and Global Strategy for Women's, Children's, and Adolescents' Health to increase investment in the health and wellness of adolescent girls in our Region.

“ ***LAC has experienced the slowest decline in adolescent fertility for the 15–19-year age group of all regions in the world*** ”



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# I. Introduction

Over the past 30 years, the total fertility rate (number of children per woman) in Latin America and the Caribbean (LAC) has declined substantially (from 3.95 in 1980–1985 to 2.15 in 2010–2015) *(1).* This decline has been associated with changes in macroeconomic conditions, including a rising trend in economic development in the Region. While the age-specific fertility rate (number of births per 1,000 women) in adult women (≥ 18 years old) declined significantly in most age groups, to half or less of 1980–1985 levels, the adolescent fertility rate had the slowest decline (from 88.2 to 66.5 *(1)*) and continues to be the second highest in the world, surpassed only by sub-Saharan Africa. LAC has experienced the slowest decline in adolescent fertility for the 15–19-year age group of all regions in the world *(2)* and has been cited as the only region with a rising trend in pregnancies in adolescents younger than 15 years *(3).*

In response to the lack of progress in the LAC region in the reduction of adolescent fertility, the Pan American Health Organization/World Health Organization (PAHO/WHO), United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF) held a two-day technical consultation meeting on August 29–30, 2016, to take stock of the situation and reach consensus on strategic approaches and priority actions to help move the Region forward in mitigating this public health, developmental, human rights, and equality issue. The meeting participants represented global and regional partners, Ministries of Health and Education, subregional integration mechanisms, nongovernmental organizations (NGOs), youth networks, and indigenous and Afro-descendant communities.

The aim of the meeting was to review current strategies, initiatives, and activities to strengthen national and regional collaboration and joint action to accelerate progress towards the prevention and reduction of adolescent pregnancy, with special emphasis on the prevention of pregnancies among girls younger than 15 years, and supporting adolescent mothers.

The meeting set out to achieve the following outcomes:

- Increased understanding of the current situation related to first and repeat adolescent pregnancies in the Region;
- Identified strategic opportunities needed to strengthen the response;
- Improved partnerships and efficiency in the allocation and use of regional resources for preventing adolescent pregnancy;
- Harmonized approaches aimed at prevention of pregnancy in the 10–14- and 15–19-year age groups.

The meeting agenda consisted of presentations, panel and plenary discussions, and small group working sessions. The meeting presentations and discussions addressed the following questions:

1. What do we know about adolescent pregnancy, its drivers and impact in LAC, and what are the knowledge gaps?
2. What has been done so far, and what are the lessons learned?

3. How can we accelerate progress in the prevention of first and repeat adolescent pregnancies in LAC?

This report summarizes the key discussions and recommendations emanating from the meeting, which can be used collectively as a “Call to Action” as well as a tool for regional stakeholders including national health, education, and social sector authorities and programs, regional partners, civil society, communities, parents, and young people, to intensify efforts, revise and update strategies, and scale up approaches that: 1) empower adolescent girls to prevent unplanned and unwanted pregnancies, 2) protect them from sexual violence, 3) improve their development opportunities, and 4) help them realize their right to the highest attainable standard of health and to participate fully in public and political life.

*“This report summarizes the key discussions and recommendations emanating from the meeting, which can be used collectively as a* ***‘Call to Action’*** *as well as a tool for regional stakeholders”*

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# II. Background

## ADOLESCENT PREGNANCY AS A PUBLIC HEALTH, DEVELOPMENTAL, HUMAN RIGHTS, AND INEQUITY ISSUE

Adolescence (age 10–19 years) is a critical period of physical and psychosocial development for young people, especially when it comes to their sexual and reproductive health (SRH) *(4).* Although this period is pivotal for both boys and girls, girls bear disproportionate risks for adverse SRH outcomes, including early pregnancy. Due to its linkage with poverty, social exclusion, and sexual and gender-based violence (SGBV), and early marriage/union, adolescent pregnancy disproportionately affects girls who are already marginalized and is aggravated by lack of access to comprehensive sexuality education (CSE), and SRH services, including modern contraceptives. Many girls who become pregnant are no longer in school or are obliged to abandon school because of their pregnancy, which therefore has a major long-term impact on their educational and employment opportunities, financial security, and ability to participate in public and political life. As a result, adolescent mothers are more vulnerable to poverty and social exclusion. In this context adolescent pregnancy contributes to the maintenance of the intergenerational cycles of poverty, exclusion, and marginalization, as children born to adolescent mothers are also at elevated risk of poverty and poor health outcomes, including early pregnancy.

Globally, adolescent pregnancy rates are higher among girls with no primary education compared with those who have received a secondary and higher education. Girls whose households are part of the lowest wealth quintile also have a higher chance of becoming mothers compared with those in the highest quintile in the same country *(2).*

Adolescent pregnancy profoundly affects girls' health trajectories, hindering their psychosocial development and contributing to poor health outcomes and elevated risks of maternal mortality and morbidity. Globally, complications of pregnancy and childbirth are the leading causes of death in young women aged 15–19 *(4).* The risks of maternal death are lowest for mothers in their late teens and early 20s, and highest in girls who give birth before age 15 *(5).* In low- and middle-income countries, the risk of maternal death for mothers younger than 15 years is twice that of older women *(3).* Approximately 16 million girls aged 15–19 years and 2 million girls younger than 15 years become pregnant each year. Of the 252 million adolescent girls aged 15–19 living in developing regions of the world, an estimated 38 million are sexually active and do not want a child in the next two years. About 15 million of these adolescents use a modern

contraceptive method; the remaining 23 million have an unmet need for modern contraceptives and are therefore at risk for unintended pregnancy *(5).* Unwanted pregnancies may end in abortions, which are often unsafe in this age group because of restrictive abortion laws. Even in the absence of restrictive laws, access to safe abortions may be limited by health systems or societal factors. Globally, an estimated 5.6 million abortions occur per year among women aged 15–19 in developing regions, and of these at least half can be classified as unsafe abortions *(5)*, which include abortions performed by persons lacking the requisite medical skills or in an environment not in conformity with minimal standards, or both *(6).*

Young maternal age is associated with lower offspring gestational age, birth weight, childhood nutritional status, and attained schooling *(7).* Globally, perinatal deaths are 50% higher among infants born to mothers under 20 years old than among those born to mothers 20–29 years old *(5).*

## BOX 1

### COSTS AND BENEFITS OF MEETING THE CONTRACEPTIVE NEEDS OF ADOLESCENTS

An estimated average cost of US$ 21 per user annually provides the necessary commodities, training, and supervision of service providers; upgrading of facilities and supply systems; and information and communication efforts to ensure that adolescents have access to modern contraceptives. Providing the unmet need for modern contraceptives of women aged 15–19 would annually avert 2.1 million unplanned births, 3.2 million abortions, and 5,600 maternal deaths.

Source: *(5).*

## ADDRESSING ADOLESCENT PREGNANCY

Based on review of the evidence and practical experience of policy-makers, program managers, and frontline workers from countries around the world, WHO issued the following guidelines for preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries *(8):*

1. **Reduce marriage before the age of 18**
   a. Policy-level actions: Enact legislation to prohibit early marriage.
   b. Individual-, family-, and community-level actions: Inform and empower girls; keep girls in school; discourage cultural norms that support early marriage.
2. **Create understanding and support to reduce pregnancy before the age of 20**
   a. Policy-level actions: Support multi-sectoral and comprehensive pregnancy prevention programs among adolescents.

b. Individual-, family-, and community-level actions: Educate girls and boys about sexuality; build community support for preventing early pregnancy and increase access to modern contraceptives, in particular long-acting reversible contraceptives (LARCs).

### 3. Increase use of contraception

a. Policy-level actions: Legislate access to contraceptive information and services; reduce the cost of contraceptives to adolescents.

b. Individual-, family-, and community-level actions: Educate adolescents about contraceptives; build community support for contraceptive provision to adolescents; enable adolescents to obtain contraceptive services (Box 1).

### 4. Reduce coerced sex

a. Policy-level actions: Enforce legislation to prohibit coerced sex under any condition.

b. Individual, family, and community-level actions: Empower girls to resist coerced sex; influence social norms that condone coerced sex; engage men and boys to critically assess gender norms.

### 5. Reduce unsafe abortion

a. Policy-level actions: Enable access to safe abortion and post-abortion services for adolescents.

b. Individual, family, and community-level actions: Inform adolescents about dangers of unsafe abortions; inform adolescents about where they can obtain safe abortions, where legal; increase community awareness of the dangers of unsafe abortions.

c. Health system–level actions: Identify and remove barriers to safe abortion services.

### 6. Increase use of skilled antenatal, childbirth, and postpartum care

a. Policy-level actions: Expand access to skilled antenatal, childbirth, and postnatal care; expand access to basic and comprehensive emergency obstetric care.

b. Individual, family, and community-level actions: Inform adolescents and community members about the importance of skilled antenatal and childbirth care.

c. Health system–level actions: Ensure that adolescents, families, and communities are well prepared for birth and birth-related emergencies, and be sensitive and responsive to the needs of young mothers and mothers-to-be.

> ***“Globally, perinatal deaths are 50% higher among infants born to mothers under 20 years old than among those born to mothers 20–29 years old”***

> *Adolescent girls with no education or only primary education are up to* ***4 times*** *more likely to initiate childbearing compared with girls with secondary or higher education*

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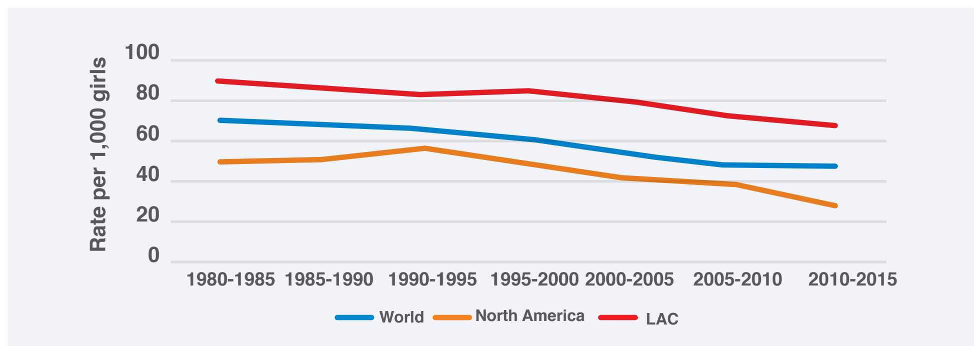
# III. Adolescent pregnancy in Latin America and the Caribbean

As a region, LAC has the second-highest adolescent fertility rate in the world, estimated at 66.5 births per 1,000 girls 15–19 years old for 2010–2015, compared to 46 births per 1,000 girls in the same age group worldwide *(1)*. Trends over time indicate the adolescent fertility rate remained stagnant in LAC from 1990 to 2000, followed by a slow downward trend over the past 15 years. In comparison, the global and North American trends show a sharper decline, as presented in Figure 1.

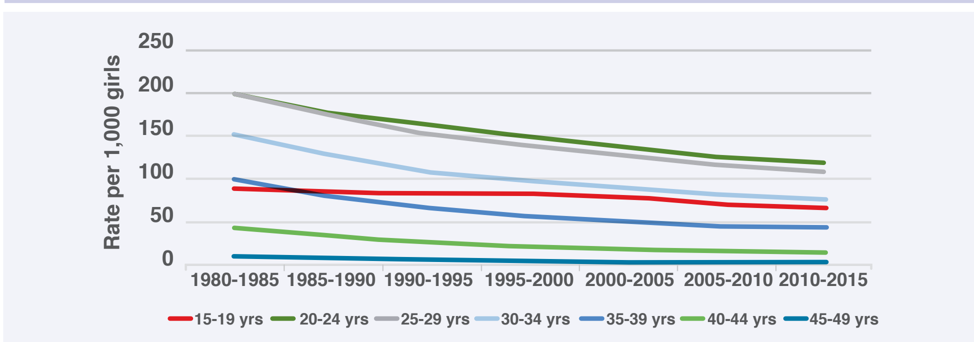
**Figure 1:** Trends in adolescent fertility rates (15-19 years) in the world, North America, and LAC, 1980-2015




*Source: (1).*

In contrast, there has been a marked decline in the total fertility rate in LAC—from 3.95 births per woman in 1980–1985 to 2.15 in 2010–2015 *(1)*. Figure 2 illustrates the slower reduction in adolescents' fertility rates compared with those for adult women during 1980–2015. Because the total fertility rate in LAC has declined, adolescent pregnancies now constitute a larger proportion of the total number of births. An estimated 15% of all pregnancies in LAC occur among girls younger than 20 years old *(9)*.

**Figure 2:** Trends in age-specific fertility rates in LAC 1980-2015

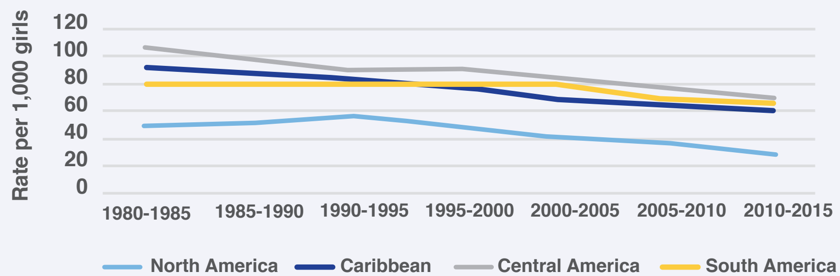



*Source: (1).*

Available data illustrates significant levels of inequality between and within subregions and countries in the Region. As presented in Figure 3, Central America has the highest adolescent fertility rate, followed by South America.

The estimated country-level adolescent fertility rates range from 17.2 births per 1,000 girls in Guadeloupe to 100.6 per 1,000 girls in the Dominican Republic (see Annex 1).

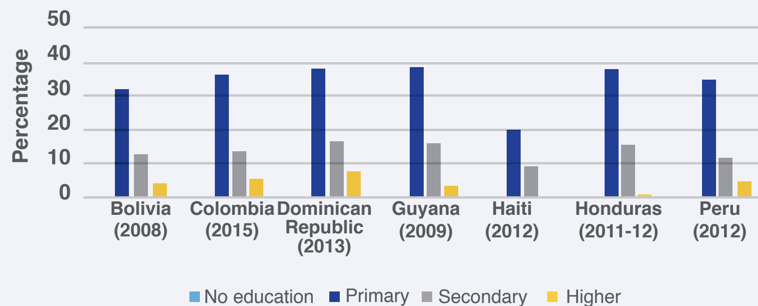
**Figure 3:** Trends in adolescent fertility rates in the Americas by sub-region, 1980-2015




*Source:* (1).

The majority of countries with the highest estimated adolescent fertility rates in LAC are in Central America, with the highest rates in Guatemala, Nicaragua, and Panama. In the Caribbean, the Dominican Republic and Guyana have the highest estimated adolescent fertility rates. In South America, Bolivia and Venezuela have the highest rates. Disaggregation of adolescent fertility data by level of education and wealth quintiles highlights the inequities within countries, as presented in Figure 4 and 5.

**Figure 4:** Percentage of females 15-19 years old who had begun childbearing by education level in selected LAC countries, 2008-2015

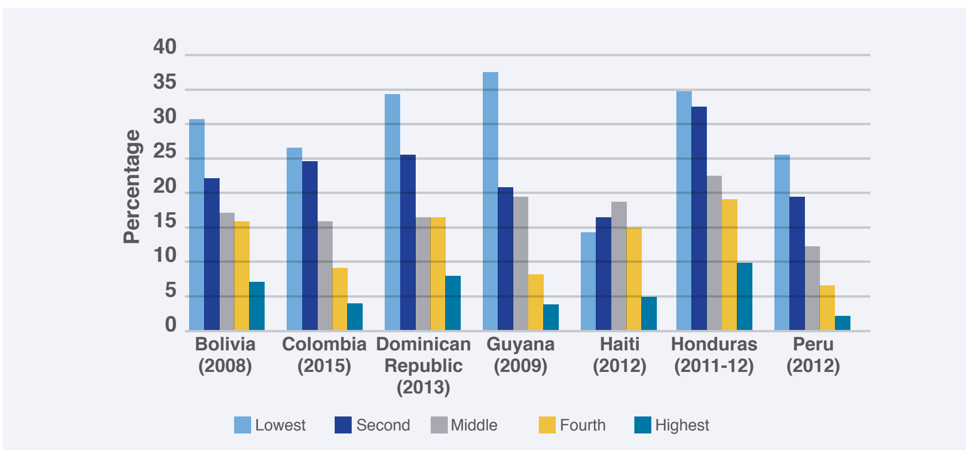



*Source:* (10,11).

In these countries, adolescent girls with no education or only primary education are up to 4 times more likely to initiate childbearing compared with girls with secondary or higher education.

Similarly, girls from households in the lowest wealth quintile are 3–4 times more likely to initiate childbearing compared with girls from the highest wealth quintile.

**Figure 5:** Adolescents (15–19 years) who had begun childbearing by wealth quintile in selected LAC countries, 2008–2015




*Source:* (10,11).

Census data in selected countries show that indigenous girls are also disproportionately affected by early pregnancy, with the highest percentages of adolescent mothers among rural indigenous girls (Table 1).

Meanwhile, adolescent fertility rates in the United States and Canada are below the global average and have been declining steadily over the past decade. The United States recently reported a record decline in adolescent fertility in all racial and ethnic groups, falling 8% from 2014 to 2015, to a historic low of 22.3 births per 1,000 females in the 15–19-year age group. Similar or greater declines were reported for Hispanic (8%) and non-Hispanic black (9%) females in this age group *(12).*

Reasons cited as contributing factors for this decline include declines in the proportion of teenagers who have ever had sex and, for sexually active teenagers, increases in the use of effective contraception and practices, as well as increases in teen pregnancy prevention programs *(12).*

**Table 1:** **Percentage of adolescent mothers by age group, type of residence (urban/ rural), and indigenous versus nonindigenous origin in selected LAC countries, 2010–2011**

| Country (census year) | Age group (years) | PERCENTAGE OF ADOLESCENT MOTHERS | | | | | |
|---|---|---|---|---|---|---|---|
| | | Indigenous | | | Nonindigenous | | |
| | | Urban | Rural | **Total** | Urban | Rural | **Total** |
| Brazil (2010) | 15–17 | 10.6 | 22.9 | **18.7** | 6.4 | 8.6 | **6.8** |
| | 18–19 | 26.8 | 46.9 | **39.4** | 18.2 | 26.6 | **19.5** |
| | 15–19 | 17.0 | 31.6 | **26.4** | 11.1 | 15.2 | **11.8** |
| Costa Rica (2011) | 15–17 | 8.5 | 20.3 | **17.0** | 5.3 | 6.7 | **5.7** |
| | 18–19 | 23.6 | 42.1 | **36.1** | 17.0 | 22.2 | **18.4** |
| | 15–19 | 15.2 | 28.7 | **24.7** | 10.0 | 12.6 | **10.8** |
| Ecuador (2010) | 15–17 | 9.0 | 9.6 | **9.5** | 8.3 | 11.9 | **9.6** |
| | 18–19 | 28.9 | 34.2 | **32.9** | 25.2 | 34.1 | **28.1** |
| | 15–19 | 17.4 | 18.5 | **18.3** | 15.0 | 20.3 | **16.8** |
| Mexico (2010) | 15–17 | 6.3 | 7.4 | **6.9** | 5.7 | 7.1 | **6.0** |
| | 18–19 | 23.4 | 27.4 | **25.3** | 20.6 | 25.8 | **21.6** |
| | 15–19 | 13.2 | 14.8 | **14.0** | 11.6 | 14.2 | **12.2** |
| Panama (2010) | 15–17 | 16.9 | 20.5 | **19.6** | 5.7 | 8.9 | **6.7** |
| | 18–19 | 38.8 | 54.2 | **49.7** | 19.1 | 28.6 | **21.7** |
| | 15–19 | 26.0 | 32.4 | **30.7** | 11.3 | 16.2 | **12.7** |
| Uruguay (2010) | 15–17 | 6.0 | 4.1 | **6.0** | 4.6 | 4.9 | **4.6** |
| | 18–19 | 20.2 | 25.8 | **20.4** | 16.9 | 21.9 | **17.1** |
| | 15–19 | 11.6 | 12.5 | **11.6** | 9.3 | 11.3 | **9.4** |

*Source: (13).*

Maternal mortality is among the leading causes of death in girls and young women between the ages of 15–24 in the Americas. In 2012, 1,887 young women in the Region in this age group died as a result of conditions arising during pregnancy, childbirth, and the early postpartum period *(14).* Although several countries have been able to provide good-quality maternal health care, adolescents, and especially those under 15 continue to face elevated risk of maternal mortality as a result of exposure to biological factors such as insufficiently matured reproductive systems, and socioeconomic and geographic factors such as poor health care access in remote rural areas, racial/ethnic minority bias, stigma and poverty. Other physical consequences and risks of early pregnancy include damage to the pelvic floor, pre-eclampsia, eclampsia, ruptured membranes, and premature delivery *(3, 4, 5, 8).* In addition to physical consequences, early pregnancy has

“ *Data on pregnancies in girls younger than 15 years are limited. UNFPA estimates that* ***2% of women of reproductive age*** *in LAC had their first delivery before the age of 15* ”





various mental health implications, including anxiety, depression, post-traumatic stress (particularly when the pregnancy is the result of sexual violence), suicidal thoughts and attempts, and suicide deaths *(4, 5, 8).*

## PREGNANCY IN GIRLS YOUNGER THAN 15 YEARS

Data on pregnancies in girls younger than 15 years are limited. UNFPA estimates that 2% of women of reproductive age in LAC had their first delivery before the age of 15, and cites LAC as the only region in the world with an increasing trend in child pregnancy *(3).* Main sources for information on very early adolescent pregnancy include 1) retrospective data collected in household surveys asking older women about their age at first delivery, 2) census data, and 3) vital statistics. The UN Economic Commission for Latin America and the Caribbean (ECLAC), UNFPA, and PAHO supported several countries in the analysis of pregnancy in all age groups (including < 15 years old) using census data, vital statistics, and special studies.

In 2015 Planned Parenthood International published a report based on a multi-country study of the health effects of forced motherhood on girls 9–14 years old *(15).* The study was conducted in Ecuador, Guatemala, Nicaragua, and Peru, and applied a mixed-method approach, including 1) in-depth interviews with young women who had given birth in the past two years, parents or guardians of young girls who were pregnant, and hospital staff who had attended pregnant adolescents; 2) review of clinical histories; and 3) collection and analysis of aggregate hospital statistics on births in children and adolescents.

Forced child pregnancy or motherhood is defined as a situation in which a minor under the age of 14 gets pregnant without having sought, and/or without wanting the pregnancy, and interruption of the pregnancy is denied to her, made difficult, delayed, or hindered *(16).* The Rome Statute of the International Criminal Court (ICC) considers a forced pregnancy a crime against humanity or a war crime, depending on the context and characteristics of the case *(17).* Box 2 summarizes the key observations from this study.

## BOX 2

### KEY OBSERVATIONS FROM "STOLEN LIVES: A MULTI-COUNTRY STUDY ON THE HEALTH EFFECTS OF FORCED MOTHERHOOD ON GIRLS 9-14 YEARS OLD"

**Pregnancy in girls under 15 years old had increased in all four participating countries**. In Ecuador, according to census data, it increased by 74% in the past decade, to approximately 4,000. In Nicaragua, the number of pregnant women 10–14 years old increased 47% over 9 years, from 1,066 in 2000 to 1,577 in 2009. In Guatemala, the reported number of deliveries in girls 10–14 years old increased from 4,220 in 2013 to 5,100 in 2014, and in Peru an estimated 1,100 girls 12–13 years old gave birth each year.

**In the majority of the studies, a large percentage of participants suffered some type of complication with their pregnancy** (63% in Peru, 71% in Ecuador), including anemia, nausea/vomiting, urinary or vaginal infections, and more severe complications such as pre-eclampsia, eclampsia, membrane rupture, premature delivery, and postpartum hemorrhage.

**In each of the studies, a significant proportion of children and adolescents who had given birth reported mental health issues** (55% in Peru, 91% in Ecuador, 100% in Nicaragua), including stress, fear, symptoms of depression, anxiety, and post-traumatic stress. In Peru and Nicaragua, 7%–14% of the study participants reported having contemplated suicide during their pregnancy.

**The majority of the study participants came from poor and extremely poor families who often lived on the outskirts of cities or in rural or semirural areas.** The girls tended to have low levels of education; some had never attended school. A large proportion of girls who had been in school had not returned to school post-delivery at the time of the follow-up interview (in Peru 77% dropped out, in Guatemala 88%).

**In all countries studied, having sex with a minor constituted a crime.** Often the aggressors were persons close to the girls, including cousin, stepbrother, stepfather, biological father, and neighbors.

**Criminalization of abortion and failure to provide emergency contraception and abortion services to girls who became pregnant as a result of criminal acts forces girls into motherhood,** which causes serious damage to their physical, psychological and emotional health, as well as their developmental opportunities.

**The biomedical focus on health services ignores the effect of unwanted pregnancies, rape, and sexual violence in general and particularly in minors**, and fails to provide adequate services to address their health needs in a comprehensive manner.

**Source: *(15)*.**

Following a high-profile case in 2015 involving a 10-year-old girl in Paraguay who became pregnant as the result of sexual abuse and was denied a therapeutic abortion, CLADEM, out of concern about the lack of visibility of pregnancies and maternities in adolescents under age 14 in the Region, commissioned a study in 14 LAC countries *(16)*. The case of "Mainumby" (a pseudonym used to protect confidentiality) involved a 10-year-old girl who became pregnant as a result of repeated sexual abuse allegedly perpetrated by a close relative. The pregnancy was discovered after her mother took her to the hospital for complaints of stomachache and swelling. At that time it was discovered that she was already 20 weeks into her pregnancy. After receiving medical advice that her daughter's life may be at risk if she carried the child to term, the mother requested that her daughter receive an abortion. After being denied an abortion, even though Paraguayan

law authorizes the termination of a pregnancy when the life of the woman or girl is at serious risk, Mainumby gave birth by Caesarian Section at the age of 11. This case drew attention from regional and international entities such as the United Nations Human Rights Council (OHCHR), the Inter-American Commission for Human Rights (IACHR), and CLADEM. Following a country mission, a group of United Nations human rights experts concluded that the country had failed in its responsibility to act with due diligence in the case of the 10 year old child, who was refused access to treatments to save her life and preserve her health *(17).*

Box 3 summarizes the key findings and conclusions of the study.

## BOX 3

### KEY FINDINGS AND CONCLUSIONS OF THE STUDY "CHILD MOTHERS: CHILD PREGNANCY AND FORCED CHILD MATERNITY IN LATIN AMERICA AND THE CARIBBEAN"

**There were no specific data on pregnancies or abortions in girls under age 14** for any of the countries studied except El Salvador, where pregnancies in that age group were recorded, and one-fifth to one-third resulted in childbirth. In the other countries, statistics on pregnancies were drawn from delivery data and thus only reflected a subset of pregnancies in girls under 14, since child pregnancies often don't go to term.

**In all 14 countries, engaging in sexual relations with girls younger than 16 years is considered rape**. With the exception of Brazil, Honduras, and Uruguay, kinship is considered an aggravating circumstance for statutory rape of minors or violation.

**Only six of the 14 countries presented statistics on the denouncement of sexual violations of girls under age 14**, and information regarding judicial investigation of the reported cases was scarce. In cases where denouncements were made, the level of impunity was very high, estimated to be up to 90%.

**In the countries that were studied, the abused girl's mother is often investigated, detained, and prosecuted**. It is likely that the mothers of the abused girls 1) also suffer violence and abuse and 2) are the main wage-earners/providers for their household, which would further victimize the household.

**Almost all of the countries studied had some type of protocol on violence against women, but none of the countries had protocols, guidelines, or policies designed to address the problem of sexual violence against girls in a specific and comprehensive manner**.

**Seven countries had state centers that provide care for and/or house pregnant adolescents and adolescent mothers, and all 14 countries had private entities that specialize in care for pregnant young women**. In some cases the pregnant girls were involuntarily housed in public or private institutions and forced to give their infants up for adoption.

**In the majority of the 14 countries, continuity of education was guaranteed by law, but about half of the pregnant girls interrupted their studies** due to health problems, discriminatory prejudices against pregnant girls or child mothers, and other circumstances. An estimated 40% of this group abandon their studies forever.

Source: *(16).*

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*“Sexual violence and gender norms about power and control* ***undermine girls’ agency*** *as well as their ability to prevent unwanted pregnancy”*

# IV. Meeting results: Accelerating the Reduction of Adolescent Pregnancy in Latin America and the Caribbean

The meeting results are organized in three sections according to the three main questions discussed during the meeting: **1) "What do we know about adolescent pregnancy and its drivers and impact in LAC, and what are the knowledge gaps?"; 2) "What has been done so far, and what are the lessons learned?"; and 3) "How can we accelerate progress in the prevention of first and repeat adolescent pregnancy in LAC?"**

### 1) "What do we know about adolescent pregnancy and its drivers and impact in LAC, and what are the knowledge gaps?"

The meeting participants acknowledged and discussed the multi-layered factors at the individual, relationship, community, and societal level contributing to the complex issue of adolescent pregnancy. The discussion drew from available information and the collective experiences and expertise from the meeting participants and their organizations. It was noted that at the individual level, pregnancy in adolescent girls is often not a deliberate choice but rather caused by a lack of information on SRH and restricted access to comprehensive SRH services, including effective contraception and emergency contraception, even after forced sex such as rape or incest. At the relationship level, sexual violence and gender norms about power and control undermine girls' agency as well as their ability to prevent unwanted pregnancy. The persistence of child marriage, including informal unions, in the Region also increases the chances of pregnancy in adolescence. At the community level, the reluctance of gatekeepers such as parents, schools, and religious leaders to acknowledge that adolescents are sexually active or that girls do not have sufficient protection against sexual violence from adults also impedes adolescents from: 1) learning about their SRH and 2) having tools and services to protect themselves. In addition, the status of motherhood as a cultural value or as a pathway out of poverty may lead to greater acceptance of early pregnancies at the societal, community, and individual level. At the societal level, under-investment in girls and women as human capital and large inequalities based on gender, wealth, and educational attainment affect aspirations of and opportunities for young girls. Similarly, national laws and policies in several LAC countries restrict access to contraceptive services and age-appropriate SRH education. If not carefully designed to protect confidentiality, laws and policies that may be designed to protect adolescents from harm, including sexual abuse, could serve as barriers to access SRH services *(21)*. Placing barriers on adolescents' access to confidential health services deters them from seeking the SRH care and information that they need to prevent unwanted pregnancies, sexually transmitted diseases, and other problems.

It was recognized that there is no single portrait of a teenage mother in LAC. For some girls, pregnancy is unintended and unwanted, resulting from lack of knowledge about their SRH and rights (SRHR), poor access to effective

methods of contraception such as long-acting reversible contraception (LARC), and restrictive laws and policies on contraception and abortion. Faced with real and perceived barriers to achieving success in education and/or employment, others may have deliberately chosen to become pregnant as an opportunity to gain adult status and/or as an avenue for upward social mobility. Some pregnancies may be prompted by traditional expectations for young women to prove their fertility and cultural understandings of motherhood as an esteemed condition. For others, pregnancy may have resulted from sexual violence or sexual abuse, and the absence of comprehensive post-rape care, including emergency contraception and safe abortion services.

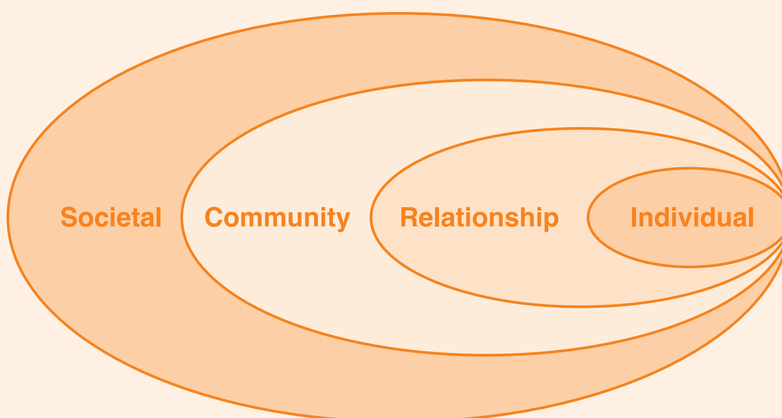
The participants noted the lack of disaggregated data and advanced analysis on adolescent pregnancy and its drivers, required to better understand the different dimensions of adolescent pregnancy on regional, national and sub-national levels, and inform targeted interventions.

The social-ecological model was used to frame the discussions on the drivers of adolescent pregnancy (Box 4).

The social-ecological model facilitates discussion of the multiple interacting influences on health behaviors operating on the individual, relationship, community, and societal level. The following box summarizes various drivers mentioned in the meeting presentations and discussions.

## BOX 4

### THE SOCIAL-ECOLOGICAL MODEL




**Individual:** demographic factors (i.e., age, gender, socioeconomic status, race/ethnicity, knowledge, skills, etc.)

**Relationship:** peers, family members, partners, etc.

**Community:** health workers and health services, school, neighborhood, workplace, community networks, social and cultural norms, etc.

**Societal:** societal norms, policies and legislation, government, media, industry, etc.

Source: (22).

## BOX 5

### SUMMARY OVERVIEW OF DRIVERS OF ADOLESCENT PREGNANCY IN LAC IDENTIFIED BY THE MEETING PARTICIPANTS

**Individual:**

- Puberty/neuro-development during adolescence and limited impulse control
- Lack of knowledge about sexuality and reproduction
- Early or forced sexual initiation
- Early or forced union
- Inconsistent use of contraceptives
- Misconceptions about contraceptives
- Future perspective/sense of self

**Relational:**

- Values and expectations from family, peers, teachers, etc., related to sexuality, pregnancy, violence, etc.
- Pressure from peers to have sex early
- Pressure from partner to have sex early
- Low levels of connectedness with adults at home, school, and/or in the community
- Limited family support and transfer of assets and positive coping skills
- Tolerance for or practice of sexual violence

**Community:**

- Lack of access to CSE at home, school, or in the community
- Lack of access to affordable contraceptives and health services
- Lack of supportive community assets and social capital
- Lack of supportive and empowering cultural and gender norms and values

**Societal:**

- Social norms, laws, and policies that do not acknowledge adolescents' sexuality and need for sexuality education and SRH services, including contraceptives
- Limited educational and employment opportunities for young people/girls
- Unequal gender norms and values
- Tolerance and acceptance of gender-based violence

The meeting participants concluded that while all of the afore-mentioned factors may play a role in the prevalence and distribution of early pregnancy in LAC, they may take on different forms and weights, depending on the national and subnational context.

The underlying gendered causes of inequalities that contribute to vulnerability and risk for early pregnancy ("gender drivers") were identified as highly relevant in the context of adolescent pregnancy in LAC. These drivers play out at the individual, relational, and community level, and can also be sustained in institutional or systemic responses such as service delivery protocols, legislation, and policy frameworks. Figure 6 summarizes institutional and contextual gender drivers related to adolescent pregnancy discussed during the meeting.

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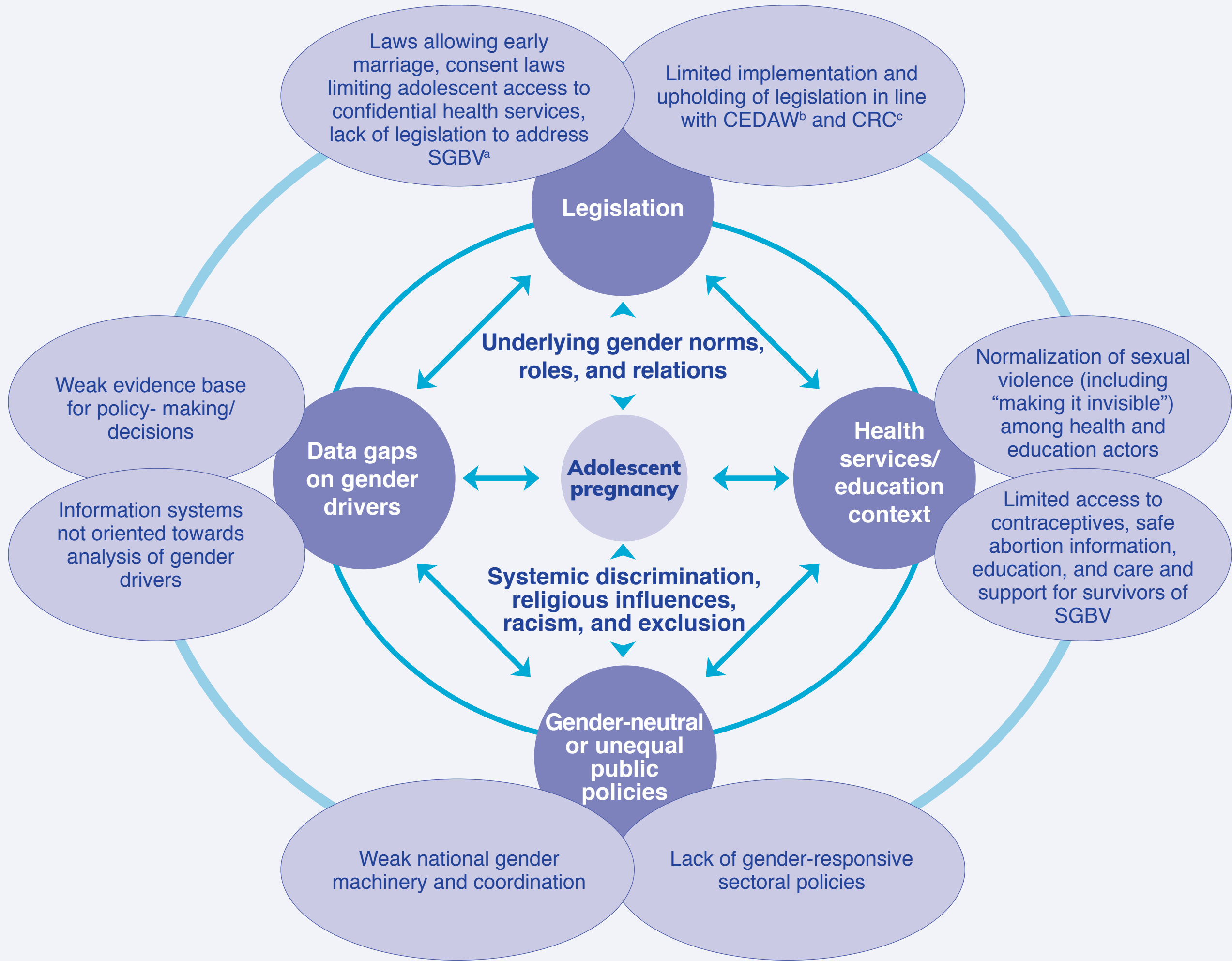
**Figure 6:** Web of institutional and contextual gender drivers related to adolescent pregnancy




*Source:* Prepared by Shelly Abdool (UNICEF), August 2015.
[a] Sexual and gender-based violence.
[b] Convention on the Elimination of all Forms of Discrimination Against Women.
[c] Convention on the Rights of the Child.

## 2) "What has been done so far, and what are the lessons learned?"

While there have been regional, sub-regional and national responses to address adolescent pregnancy in LAC, these have not yet succeeded in achieving substantive progress. All the sub-regions have developed multi-country plans or strategies, including the Andean Plan to Prevent Teen Pregnancy *(23),* the Strategic Plan for the Prevention of Adolescent Pregnancy in Central America and the Dominican Republic *(24),* the Integrated Strategic Framework for the Reduction of Adolescent Pregnancy in the Caribbean *(25),* and an informal intersectoral multi-country strategic framework to prevent and reduce adolescent pregnancy developed by the Southern Cone countries. These plans and strategies provide policy and operational platforms for sub-regional collaboration and generating political momentum. In addition, several countries, including the Dominican Republic, Peru, Mexico, and Honduras are implementing national adolescent pregnancy prevention and reduction strategies and plans *(26, 27, 28, 29).*

In 2008, the LAC Ministers of Health and Education adopted the Mexico Ministerial Declaration: "Educating to Prevent", committing to improve access to and the quality of comprehensive sexuality education for young people, to reduce sexual and reproductive health risks *(30).* The first session of the Regional Conference on Population and Development in Latin America and the Caribbean, held in 2013, generated the Montevideo Consensus on Population and Development, which called for investing in young people through specific public policies and articulated the regional commitment to effectively implement comprehensive sexuality education from early childhood, provide good-quality sexual and reproductive health services for adolescents and young persons that respond to their needs, introduce or strengthen policies and programs to prevent pregnant adolescents and young mothers from dropping out of schools, and eliminate unsafe abortions *(31).*

To date, the impact of these regional, sub-regional and country efforts has been limited, and adolescent fertility rates have remained stagnant in some countries and reduced moderately in others *(1).* For instance in the most recent national survey, Colombia noted a drop in the percentage of adolescents aged 15-19 years who are mothers or pregnant from 20.5% in 2005 to 17.4% in 2015 *(11).* The lack of systematic monitoring and evaluation of interventions and programs makes it difficult to understand why these efforts have not generated better results. A recent systematic review of published and gray literature on interventions to prevent unintended and repeat pregnancy among young people in low- and middle-income countries found very few reports from the LAC region *(32).* However, this is beginning to change with some study reports and case studies published in peer-reviewed journals and in-depth analysis conducted by regional partners *(33, 34, 35, 36).*

### 3) "How can we accelerate progress in the prevention of first and repeat adolescent pregnancy in LAC?"

Through extensive discussions over the course of the two-day meeting, the participants agreed on a number of proposed solutions for accelerating progress in reducing adolescent pregnancy in LAC. The proposed solutions are organized below under the following seven headings:

1. **Make adolescent pregnancy, its drivers and impact and the most affected groups more visible with disaggregated data and stories.**
   Enhanced data collection and evidence-gathering, both quantitative and qualitative, is critical to understand which population groups are most affected by adolescent pregnancy, what the drivers are, and what could be done to address these drivers and respond effectively. Data must be disaggregated by age, ethnic group, residence, education, employment and other socio-economic characteristics, in order to help inform and shape policies and programs at the national and sub-national levels and tailor them to local realities. Furthermore, the effects of unwanted pregnancy on individual girls' lives, especially in girls younger than 15 years old, must be made more visible through, for examples, real life stories in the media. These efforts can help to reach policymakers, community leaders and the public at large in order to gain support for investment and action.

2. **Design interventions to target the most vulnerable groups, ensuring the approaches are adapted to their local realities and address their specific challenges.**
   The LAC region is one of the most culturally diverse and inequitable regions of the world, and the factors fueling adolescent pregnancy take on different weights and forms between and within countries. In line with the core theme of the Sustainable Development Goals (SDGs) *(39)* and the Global Strategy for Women's, Children's and Adolescent's health *(40),* regional and country-level efforts must guarantee that investments reach the most vulnerable groups first, ensuring that no one is left behind. This requires building of stakeholder capacity to conduct inequity analysis and develop pro-equity approaches in the design, implementation and monitoring of interventions to address adolescent pregnancy.

   Approaches should be differentiated to address the specific circumstances and implications of pregnancies in adolescents younger than 15 years, and those among older adolescents, ensuring that the highest priority is given to protection of young girls against all forms of sexual violence, including incest and rape. There is an urgent need for generation of evidence on comprehensive approaches to address pregnancy in girls younger than 15 years. More efforts are needed to generate evidence on what works in the region to prevent early pregnancy, with a particular focus on the most vulnerable and marginalized groups such as indigenous adolescents.

3. **Engage and empower youth to contribute to the design, implementation and monitoring of strategic interventions**
   Meaningful adolescent and youth engagement in the design, implementation and monitoring of laws, policies and programs aimed at realizing their sexual and reproductive health and rights is critical for ensuring that interventions effectively

reach and take into account the local realities of their daily lives. When adolescents are at the decision-making table as equals with decision makers and other stakeholders, and are respected and supported to share ownership, resulting interventions are more likely to respond to their needs. The rights of adolescents both to make well-informed and well-supported decisions about their own health and wellbeing, and to contribute meaningfully to policy and programmatic decisions that affect their lives, must underpin all efforts.

4. **Abandon ineffective interventions and invest resources in applying proven interventions**
   The latest evidence emerging from systematic reviews on what works to prevent adolescent pregnancy and improve adolescent sexual and reproductive health *(32, 35, 37, 38)* is in line with WHO's recommendations on building community understanding and support about pregnancy prevention in adolescents, informing and empowering adolescents to make well-informed decisions about their sexual and reproductive health, increasing access to effective contraception, preventing marriage before 18 years, and preventing sexual violence and coercion *(8).*

   However, the meeting participants noted that many programs continue to use interventions that have been proven to be ineffective. For instance, despite the fact that programs like 'abstinence-only education' have been proven ineffective in equipping young people with the knowledge and skills to prevent unwanted pregnancy, they continue to be included in some country strategies and to receive political support and corresponding financing.

   The expert group put out a specific call to abandon interventions where there is evidence demonstrating inefficacy and to invest in the implementation of proven interventions with intensity and over a sustained period. Further, it called for multi-pronged interventions that simultaneously focus on multiple specific outcomes (e.g. providing adolescents with contraceptive information and services, working to change community norms and attitudes on adolescent sexuality, and putting in places laws and policies that legitimize such programming in line with international human rights treaties, recognizing adolescents' rights) and with strong systems for monitoring and evaluation. Box 6 summarizes a documented and published scale up experience in Colombia, and Box 7 provides a summary of recommended actions for each level of the ecological framework.

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## BOX 6

### SCALING UP THE YOUTH-FRIENDLY HEALTH SERVICE MODEL IN COLOMBIA

**In the seven years of implementation of the Youth-Friendly Health Services (YFHS) model in Colombia, more than 800 clinics were made youth-friendly. Five elements enabled the scale-up process:**

- Clear policies and implementation guidelines for YFHS
- Clearly defined inclusion criteria for user organizations and resource teams
- Establishment and implementation of an intersectoral and interagency strategy
- Identification of and support to stakeholders and advocates of YFHS
- Solid monitoring and evaluation

Colombia's experience shows that for large-scale implementation of youth health programs, clear policies and implementation guidelines, support from institutional leaders and authorities who become champions, continuous training of health personnel, and inclusion of users in the design and monitoring of these services are key.

Source: (33).

**5. Strengthen intersectoral collaboration to effectively address the drivers of adolescent pregnancy in LAC**

Intersectoral collaboration is widely recognized as critical for successfully preventing adolescent pregnancy, but is rarely implemented or incentivized to the necessary extent. Instead of working in sector-based silos, well-planned and continuously monitored partnerships and collaborations need to be established between and among UN agencies, government ministries, health care providers, NGOs, youth service organizations, and adolescents themselves. For example, the health and education sectors must capitalize on the potential of the virtuous cycle between health and education by securing strong political will to roll out comprehensive, human rights–based curricula for sexuality education for in-school and out-of-school adolescents along with efforts to reach them with the sexual and reproductive health services they need. Ensuring access to quality education, also for pregnant girls and adolescent mothers, and investing in social protection and meaningful employment opportunities are essential elements of a comprehensive multisector response to adolescent pregnancy *(35, 36, 37, 38).*

**6. Move from boutique projects to large scale and sustainable programs**

Interventions that are generating desired results are often caught in the pilot phase, and efforts

are piecemeal and scattered, donor-dependent, and often not aligned with institutional systems and structures that can foster scale-up and institutionalization. Similarly, programs that have been scaled up successfully, such as the comprehensive sexuality education and adolescent-friendly health services programs in Argentina and Colombia, need continued support to sustain the gains and have lasting impact *(33, 34).* This requires long-term political commitment and leadership, across sometimes changing administrations.

7. **Create and sustain an enabling environment for gender equality and adolescent sexual and reproductive health and rights.** As previously mentioned, adolescent pregnancy is caused by a complex web of factors operating at different levels of the ecological framework. Accelerating progress in the reduction of adolescent pregnancy will require addressing these levels of the ecological framework simultaneously through the development and implementation of packages of interventions that translate and adapt globally recognized standards and best practices to national and local contexts. These should be accompanied by clear result frameworks, time frames, and sound management and M&E frameworks. These packages of actions should respond to and support adolescents to prevent a first pregnancy, as well as reach pregnant adolescents and young parents to prevent repeat unplanned pregnancies. Interventions must utilize a rights-based approach to adolescent health and prioritize gender equality and the elimination of gender stereotypes.

In addition, greater attention should be devoted to promoting civil society engagement in order to build support for adolescent health, in general, and adolescent SRHR, specifically. Members of the community, including parents, teachers, and religious leaders, can all play important roles in keeping adolescents safe and creating opportunities for their futures. However, there is a considerable lack of awareness-raising and sensitization about adolescent sexuality among these groups. A robust civil society movement is essential for overcoming political resistance or inertia on this issue, and utilizing accountability mechanisms to remediate injustices.

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## BOX 7

### RECOMMENDED ACTIONS FOR EACH LEVEL OF THE ECOLOGICAL FRAMEWORK

| LEVEL | RECOMMENDED ACTIONS |
|---|---|
| **Individual** | -Educate adolescents about contraception<br>-Empower girls to decrease early unions and motherhood as means to gain economic security (e.g., conditional cash transfers)<br>-Keep girls in school<br>-Implement combined educational and contraceptive interventions for girls and boys |
| **Relational** | -Encourage and support communication on contraception between couples, within and outside unions.<br>-Promote parental engagement with and support for adolescent SRHR,<br>-Implement peer-focused approaches for the delivery of SRH services and CSE |
| **Community** | -Build community support for contraceptive provision to adolescents<br>-Make health service provision more responsive and friendly to adolescents<br>-Mobilize adults and community leaders to advocate for and support adolescent access to SRH information and services<br>-Engage boys and men to promote gender-equitable norms<br>-Foster zero tolerance for gender-based violence and child marriage |
| **Societal** | -Legislate access to contraceptive information and services<br>-Reduce the cost of contraceptives to adolescents<br>-Implement strategies to reach the most vulnerable adolescents with SRH services<br>-Implement social communication campaigns to promote adolescent SRHR and change harmful societal norms and attitudes, including those that condone SGBV |

*Sources: (8, 32, 33, 34, 38).*

# V. Moving forward

There was clear consensus among the meeting participants regarding the need to act now to address adolescent pregnancy in the Region in more comprehensive, evidence-based, and equity-focused approaches. The participants called for compliance with and implementation of the commitments articulated in various global and regional instruments, including the CRC, the Montevideo Consensus, the Mexico Declaration, and the Universal Health Coverage and Access resolution, to help guarantee equitable access for adolescents to CSE and health services, including modern contraceptives, and to foster a supportive environment in which all adolescent girls and boys can thrive.

This call to action is well aligned with recent global commitments, including the SDGs and the Global Strategy for Women's, Children's, and Adolescents' Health. Available data regarding the costs and benefits related to the prevention of adolescent pregnancy indicate that scaling up of programs and services is feasible and cost-effective, particularly when taking into account the health and development gains across both the life course and multiple generations. Regional and country-level advocacy efforts must emphasize the feasibility and strategic economic, political, and human rights benefits associated with investment in the prevention of adolescent pregnancy. Prevention and reduction of adolescent pregnancy will help improve the health and development of adolescents as well the survival, health, and well-being of their children, and the well-being of their communities and societies.

The momentum generated by the SDGs and the Global Strategy provides an opportunity and platform for countries to review and update their national strategies with a focus on a strong intersectoral response, ensuring that no adolescent girl is left behind.

Concrete actions to move forward with the recommendations from the technical consultation include: 1) review and revision of adolescent pregnancy prevention strategies and approaches in countries; 2) development and implementation of a regional operational research agenda to address the data and evidence gaps related to adolescent pregnancy in the Region; and 3) improved coordination between regional partners and implementation of a joint agenda that includes advocacy, capacity building and technical support to countries.

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# Annex 1: Trends in adolescent fertility rates by sub-region and country, 1980–2015

| COUNTRY | 1980–1985 | 1985–1990 | 1990–1995 | 1995–2000 | 2000–2005 | 2005–2010 | 2010–2015 |
|---|---|---|---|---|---|---|---|
| **North America** | **48.9** | **50.4** | **56.3** | **48.4** | **40.5** | **37.3** | **28.3** |
| Canada | 24.9 | 23.2 | 25.1 | 20.1 | 14.4 | 13.9 | 11.3 |
| Mexico | 97.8 | 88.5 | 79.8 | 84.1 | 76.7 | 71.2 | 66.0 |
| United States of America | 51.6 | 53.3 | 59.6 | 51.3 | 43.2 | 39.7 | 30.0 |
| **Latin America and the Caribbean (LAC)** | **88.2** | **85.4** | **82.5** | **83.5** | **78.7** | **70.4** | **66.5** |
| **Caribbean** | **91.6** | **87.8** | **81.8** | **77.8** | **68.5** | **64.7** | **60.2** |
| Antigua and Barbuda | 61.6 | 59.6 | 66.1 | 68.7 | 62.8 | 55.5 | 49.3 |
| Aruba | 53.3 | 52.0 | 49.1 | 47.3 | 41.1 | 33.4 | 26.6 |
| The Bahamas | 85.6 | 69.8 | 69.6 | 61.9 | 44.0 | 39.4 | 34.2 |
| Barbados | 70.8 | 49.9 | 57.9 | 52.0 | 49.1 | 47.9 | 46.9 |
| Belize | 151.2 | 131.6 | 121.7 | 106.3 | 91.2 | 76.2 | 69.7 |
| Cuba | 85.7 | 85.7 | 69.2 | 69.4 | 50.6 | 49.3 | 48.3 |
| Curacao | 50.9 | 52.0 | 51.5 | 43.5 | 36.7 | 34.1 | 35.5 |
| Dominican Republic | 110.6 | 110.2 | 114.3 | 111.0 | 109.6 | 108.7 | 100.6 |
| French Guyana | 90.9 | 86.6 | 104.7 | 111.8 | 106.0 | 80.3 | 82.6 |
| Grenada | 100.6 | 99.2 | 83.5 | 61.5 | 51.2 | 42.4 | 35.4 |
| Guadeloupe | 41.3 | 34.9 | 25.8 | 21.8 | 20.1 | 19.5 | 17.2 |
| Guyana | 114.4 | 94.6 | 99.1 | 94.6 | 100.2 | 94.1 | 90.1 |
| Haiti | 86.1 | 78.3 | 69.9 | 61.8 | 52.5 | 46.4 | 41.3 |
| Jamaica | 129.2 | 112.8 | 103.4 | 94.5 | 82.4 | 73.5 | 64.1 |
| Martinique | 35.4 | 33.3 | 28.7 | 26.0 | 24.5 | 24.0 | 21.1 |
| Puerto Rico | 69.6 | 66.4 | 73.2 | 72.4 | 64.4 | 50.0 | 47.3 |
| Saint Lucia | 148.6 | 120.8 | 94.6 | 69.8 | 62.0 | 61.4 | 56.3 |
| Saint Vincent and the Grenadines | 110.4 | 95.1 | 88.0 | 76.1 | 64.6 | 58.9 | 54.5 |
| Suriname | 77.8 | 71.2 | 65.3 | 59.9 | 55.2 | 51.3 | 48.1 |
| Trinidad and Tobago | 85.2 | 72.1 | 56.1 | 44.3 | 38.4 | 38.1 | 34.8 |
| US Virgin Islands | 86.4 | 82.1 | 77.0 | 64.5 | 49.4 | 50.0 | 47.3 |

| COUNTRY | 1980–1985 | 1985–1990 | 1990–1995 | 1995–2000 | 2000–2005 | 2005–2010 | 2010–2015 |
|---|---|---|---|---|---|---|---|
| **Central America** | **105.8** | **96.9** | **88.7** | **90.3** | **82.4** | **75.7** | **69.1** |
| Costa Rica | 97.1 | 95.3 | 91.8 | 83.2 | 69.8 | 64.5 | 59.1 |
| El Salvador | 119.5 | 108.2 | 98.7 | 91.1 | 85.3 | 76.7 | 66.8 |
| Guatemala | 138.5 | 126.8 | 120.6 | 113.8 | 104.2 | 93.2 | 84.0 |
| Honduras | 140.0 | 133.5 | 126.5 | 115.8 | 100.0 | 84.1 | 68.4 |
| Nicaragua | 154.0 | 160.1 | 146.2 | 125.2 | 113.2 | 104.7 | 92.8 |
| Panama | 111.1 | 102.6 | 92.5 | 94.0 | 85.9 | 81.9 | 78.5 |
| **South America** | **80.9** | **80.1** | **79.9** | **81.1** | **78.1** | **68.6** | **66.0** |
| Argentina | 74.2 | 73.4 | 73.2 | 69.8 | 65.0 | 60.6 | 64.0 |
| Bolivia (Plurinational State of) | 98.8 | 96.1 | 91.2 | 93.0 | 87.9 | 81.9 | 72.6 |
| Brazil | 79.8 | 80.6 | 80.0 | 83.6 | 80.9 | 70.9 | 68.4 |
| Chile | 66.0 | 65.6 | 63.6 | 60.8 | 54.5 | 52.7 | 49.3 |
| Colombia | 80.9 | 75.7 | 82.7 | 83.3 | 86.3 | 63.7 | 57.7 |
| Ecuador | 93.4 | 88.7 | 85.5 | 84.3 | 82.5 | 83.0 | 77.3 |
| Paraguay | 96.8 | 91.6 | 92.4 | 91.9 | 76.6 | 67.8 | 60.2 |
| Peru | 74.1 | 72.0 | 70.0 | 70.5 | 61.5 | 54.7 | 52.1 |
| Uruguay | 62.6 | 66.4 | 70.6 | 67.3 | 63.5 | 61.2 | 58.0 |
| Venezuela (Bolivarian Republic of) | 100.3 | 100.2 | 94.9 | 90.6 | 88.0 | 82.6 | 80.9 |

*Source: (1).*

[a] Number of births per 1,000 women in the 15–19-year age group.

# Annex 2: Meeting agenda

## ACCELERATING PROGRESS TOWARD THE REDUCTION OF ADOLESCENT PREGNANCY IN LATIN AMERICA AND THE CARIBBEAN: A TECHNICAL CONSULTATION

29–30 August 2016

Pan American Health Organization, Washington, DC

Room B

### OBJECTIVES:

- To review what is known about the status and drivers of adolescent pregnancy in the LAC Region in the 10–14- and 15–19-year age groups and identify knowledge gaps;
- To analyze the status of and lessons learned about current regional and country-level approaches designed to prevent first and repeat adolescent pregnancy in those age groups and identify areas for improvement;
- To reach consensus on priority actions, joint strategies, and recommended areas for future research to accelerate progress in the prevention and reduction of adolescent pregnancy in the 10–14- and 15–19-year age groups.

### EXPECTED OUTCOMES:

- Increased understanding of the current situation related to first and repeat adolescent pregnancies in the Region;
- Identification of the opportunities that are needed to strengthen the response;
- Improved partnerships and increased efficiency in the allocation and use of regional resources for prevention of adolescent pregnancy;
- Harmonized approaches to help prevent pregnancy in girls 10–14 and 15–19 years old.

### METHODOLOGY:

- Technical consultation with a mix of global and regional experts, country representatives, and regional partner participants;
- A meeting agenda that includes 1) brief presentations and panel discussions on relevant topics and 2) ample plenary and small group discussions;
- Compilation and organization of the results of the meeting discussions and concrete recommendations from meeting participants in a report that will be disseminated Region-wide.

# AGENDA

## DAY 1

| TIME | SESSION | PRESENTER |
| --- | --- | --- |
| 8.00–8.30 | Registration | |
| | **Opening and Introductions<br>Facilitator: Sonja Caffe (PAHO/WHO)** | |
| 8.30–9.00 | Greetings and opening remarks | Andrés De Francisco Serpa, PAHO<br>Luisa Brumana, UNICEF<br>Vicky Camacho, UNFPA |
| 9.00–9.15 | Meeting objectives and introduction of participants | Sonja Caffe, PAHO |
| | **Session 1: Lessons Learned from Adolescent Pregnancy Prevention Efforts in the Past Decade<br>Facilitator: Fernando Zingman (UNICEF)** | |
| 9.15–10.00 | Global and regional experiences and lessons learned from efforts aimed at the prevention of first and repeat adolescent pregnancy | Venkatraman Chandra-Mouli, WHO<br>Vicky Camacho, UNFPA<br>Rodolfo Gómez, CLAP/WR |
| 10.00–10.20 | Q&A | |
| 10.20–11.05 | Panel: Addressing drivers of adolescent pregnancy | Sonja Caffe, PAHO<br>Shelly Abdool, UNICEF<br>Gustavo Adolfo Lugo Vallecilla, Profamilia Colombia |
| 11.05–11.20 | Q&A | |
| 11.20–11.35 | Coffee break (15 min) | |
| 11.35–12.30 | Lessons learned from implementation of adolescent pregnancy prevention programs | Jaclyn Ruiz and Aisha Cody, U.S. DHHS<br>Oneka Scott, Guyana Ministry of Public Health<br>José Roberto Luna, UNFPA Guatemala |
| 12.30–13.00 | Q&A, discussion | |
| 13.00–14.00 | Lunch | |
| | **Session 2: Pregnancy in Girls < 15 Years<br>Facilitator: José Roberto Luna (UNFPA)** | |
| 14.00–14.45 | Panel: Childhood pregnancies in the Region | Vicky Camacho, UNFPA<br>Rodolfo Gómez, CLAP/WR<br>Sara Omi Casamá Congreso General Emberá de Alto Bayano |
| 14.45–16.30 | Group dialogue | |
| 16.30–17.00 | Closing Day 1 | Luisa Brumana, UNICEF |

| DAY 2 | | |
| --- | --- | --- |
| **TIME** | **SESSION** | **PRESENTER** |
| 9.00–9.30 | Reflections on Day 1 | Vicky Camacho, UNFPA<br>Sonja Caffe, PAHO |
| | **Session 3: Improving Efficiency and Impact**<br>**Facilitator: Luis Felipe Codina (PAHO)** | |
| 9.30–10.30 | Panel: Challenges and opportunities for a comprehensive approach to end adolescent pregnancy | Esther Corona, WAS<br>Alison Hadley, UB |
| 10.30–11.15 | Taking interventions to scale | Venkatraman Chandra-Mouli, WHO |
| 11.15–11.30 | Coffee break | |
| 11.30–13.00 | Small group work: Bringing it all together – How can we do better? | |
| 13.00–14.00 | Lunch | |
| 14.00–15.30 | Group work (continued) | |
| 15.30–17.00 | Presentation of results of group work & plenary discussion | Sonja Caffe, PAHO<br>Luisa Brumana, UNICEF |
| 17.00–17.30 | Conclusions and closing | José Roberto Luna, UNFPA<br>Luisa Brumana, UNICEF<br>Andrés De Francisco Serpa, PAHO |

# Annex 3: List of participants

| NAME | ORGANIZATION OR COUNTRY | POSITION |
|---|---|---|
| Shelly Abdool | UNICEF Regional Office, Panama | Regional Gender Advisor |
| Elvia Ardon | Secretaría de Salud de Honduras | Directora General de Normalización |
| Daniel Aspilcueta | Ministerio de Salud del Perú | Director Ejecutivo, Dirección de Salud Sexual y Reproductiva |
| Luisa Brumana | UNICEF Regional Office, Panama | Regional Health Advisor |
| Elida Caballero | Center for Reproductive Rights | Advocacy Adviser for Latin America & the Caribbean |
| Sonja Caffe | PAHO/WHO Headquarters, WDC | Regional Adolescent Health Advisor |
| Vicky Camacho | UNFPA Regional Office, Panama | Sexual and Reproductive Health Regional Technical Adviser |
| Kate Cassidy | USAID | Health Program Advisor for Latin America and the Caribbean |
| Venkatraman Chandra-Mouli | WHO, Department of Reproductive Health and Research | Scientist, Adolescents and at-Risk Populations Team |
| Luis Felipe Codina | PAHO Brazil | Representante Adjunto, PWR Brazil |
| Aisha Cody | U.S. Department of Health and Human Services | Health Scientist, Office of Population Affairs |
| Esther Corona | World Association for Sexual Health | International Liaison Committee Co-Chair |
| Fanny Corrales | Paraguay – Ministerio de Salud Pública y Bienestar Social | Encargada de la Dirección de Salud Sexual y Reproductiva |
| Rudolph Cummings | CARICOM Secretariat | Programme Manager, Health Sector Development |
| Andrés De Francisco Serpa | PAHO/WHO Headquarters, WDC | Director, Family, Gender and Life Course Department |
| Barbara Disckind | U.S. Department of Health and Human Services | Senior Writer, Office on Women's Health |
| Rodolfo Gómez | CLAP/WR | Asesor Regional en Salud Reproductiva |
| Amparo Gordillo | World Bank | Senior Economist, Health, Nutrition and Population |
| Alessandra Guedes | PAHO/WHO Headquarters, WDC | Regional Advisor, Family Violence |
| Nelson Armando Guzmán Mendoza | Executive Secretary for COMISCA | Director de Cooperación y Relaciones Interinstitucionales |

| NAME | ORGANIZATION OR COUNTRY | POSITION |
|---|---|---|
| Alison Hadley | University of Bedfordshire, Faculty of Health and Social Sciences | Director, Teenage Pregnancy Knowledge Exchange |
| Silvia Huaynoca | International Planned Parenthood Federation/ Western Hemisphere Region | Program Officer, Youth, Gender and Rights |
| Emma Iriarte | Mesoamerican Health Initiative (SMI); Inter-American Development Bank (IDB) | Executive Secretary |
| Ariel Karolinksi | PAHO Argentina | Consultor, Salud Familiar, Género y Curso de Vida |
| Gloria Lagos | ORAS/CONHU | Gerente de Líneas Estratégicas y Cooperación Internacional |
| Gustavo Adolfo Lugo Vallecilla | Profamilia Colombia | Director de Proyectos |
| José Roberto Luna | UNFPA Guatemala | Oficial de Educación y Juventud |
| Aracely Macias | U.S. Department of Health and Human Services | Office of Minority Health |
| Katherine Mayall | Center for Reproductive Rights | Senior Manager, Global Legal Program |
| Charlotte McDowell | Permanent Mission of Canada to the OAS | Senior Development Officer |
| Carmen Murguía | UNFPA Peru | Analista de Programa en Temas de Juventud |
| Sara Omi Casamá | Congreso General Emberá de Alto Bayano | Presidenta |
| Patricia Píriz Bonilla | Uruguay – Ministerio de Educación y Cultura | Coordinadora de Educación Sexual del Consejo de Educación Inicial y Primaria |
| Jaclyn Ruiz | U.S. Department of Health and Human Services | Public Health Advisor, Office of Adolescent Health |
| Marie Solange Sainvil | Haïti Ministère de la Santé Publique et de la Population | Chef de Service Santé des Jeunes et des adolescents |
| Maira Sandoval | Guatemala – Ministerio de Salud Pública y Asistencia Social | Coordinadora del Programa de Adolescencia y Juventud |
| Oneka Scott | Guyana Ministry of Public Health | Focal person for Prevention of Mother-to-Child Transmission of HIV |
| Adriano Tavares | PAHO Brazil | Consultor Nacional |
| Fernando Zingman | UNICEF Argentina | Especialista en Salud |
| Lindsay Menard-Freeman | Consultant | Rapporteur |

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