



# Adolescent Pregnancy in Latin America and the Caribbean

## Key facts



The adolescent birth rate (ABR) in LAC fell from 65.6 (2010–2015) to 60.7 (2015–2020), representing a 7.47% decrease in the ABR. However, wide variations persist between subregions and countries, and within countries (2).



The estimated number of unintended pregnancies in girls aged 15–19 years in LAC in 2019 was 2,115,000 (3).



The percentage of women aged 20–24 years who were first married or in union before age 18 years in LAC remained constant in the past 15 years, at 24.1 in 2003 and 24.7 in 2018 (4).



The estimated number of unsafe abortions in girls aged 15–19 years in LAC in 2019 was 876,000 (3).



Global and regional data on pregnancies in girls younger than 15 years is limited. Around 2% of women of reproductive age in LAC reported having their first delivery before the age of 15, and LAC is noted as the only region in the world with an upward trend in births among girls younger than 15 years (5).



The majority of LAC countries with data on very early pregnancy had birth rates between 1 and 5 births per 1,000 girls aged 10–14; the highest rate was reported by Venezuela, with 5 births per 1,000, followed by 2 per 1,000 for the Dominican Republic (6).

## Introduction

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.

Adolescent mothers (ages 10–19 years) face higher risks of eclampsia, puerperal endometriosis, and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birthweight, preterm delivery and severe neonatal conditions (1).

Despite recent socioeconomic growth in Latin America and the Caribbean (LAC), adolescent fertility rates in the region 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.

## Drivers of adolescent pregnancy in LAC

Adolescent pregnancy is not equally distributed between and within countries (5,8). In several LAC countries, girls from poorer, lower educated, rural, indigenous, and afro descendent groups tend to carry a disproportionate burden of early pregnancy (3).

Key drivers of early pregnancy in LAC include restrictive laws and policies, systemic discrimination, racism and social exclusion, health systems barriers, and unequal societal and gender norms, roles and relations (5).

As such, adolescent pregnancy is a reflection of interacting individual, relational and societal factors that contribute to increased vulnerability and decreased access to information, services and commodities, including contraceptives.

## Key facts



In 2014, 662 adolescent girls in LAC died due related causes during pregnancy, childbirth, and the early postpartum period (32 countries reporting) (7).



In surveys from seven countries conducted between 2008-2016, (Bolivia, Colombia, Dominican Republic, Guyana, Haiti, Honduras, and Peru), adolescent girls with no education or only primary education were up to 4 times more likely to initiate childbearing compared with girls with secondary or higher education (5).



In these studies, 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 (5).



Census data from 2010-2011 in selected countries showed disproportionate burdens of early pregnancy in indigenous girls, with the highest percentages of adolescent mothers among rural indigenous girls (5).



An estimated 28% of girls aged 15 to 19 years in LAC were using a modern contraceptive method in 2019 (4).



An estimated 1,958,000 adolescent girls aged 15-19 years in LAC had an unmet need for modern contraception in 2019 (4).

## Progress to date

During the past decade, adolescent pregnancy prevention policies and programs gained increased importance on national health and development agendas. There is consensus on the actions needed to prevent adolescent pregnancy (9, 10, 11).

However, some countries are still facing challenges in translating policies and programs into large-scale initiatives. In some cases, some evidence-based interventions such as comprehensive sexuality education (CSE) policies and programs or access to long-acting reversible contraceptives are not implemented.

Below, some country case studies show good practices in reducing adolescent pregnancy and what can be achieved with the application of good science and strong leadership and management. Some of the key factors for the success of these large-scale programmes include:

- Placing adolescent pregnancy prevention high on the national agenda, with clear multisectoral policies, programs, and services including implementation of evidence-based interventions—e.g., access to and utilization of modern contraception, particularly long-acting reversible contraceptives, CSE, social protection interventions, maintaining girls in school, empowering girls, addressing sexual violence, and ending early unions;
- Planning the scale-up effort;
- Managing the scale-up effort;
- Building support for pregnancy prevention programs and overcoming resistance;
- Ensuring monitoring of programs and policies and sustainability.



### **Jamaica: Successful large-scale sustained program for prevention of a second pregnancy**

Since 1978 the Women's Centre of Jamaica Foundation has, through its flagship Program for Adolescent Mothers (PAM), provided pregnant adolescents, young mothers, and their families and baby-fathers with education, life and parenting skills training, counseling, contraceptives, and school reintegration services. These services are designed to help young mothers continue their educational and personal development through a pregnancy and to prevent or delay second pregnancy until they have attained their educational, employment, and personal goals. The second adolescent pregnancy rate has remained below 2% over the years, and approximately 80% of the adolescent mothers who have been reintegrated into the formal school system complete their secondary education. The model was replicated in other countries, including Grenada, Saint Kitts and Nevis, Botswana, Gambia, and Kenya.

Source: (12, 13)

### **Chile: Substantial reduction in the proportion of births to adolescent mothers during 2010–2017**

Recognizing its high adolescent fertility rate (53.5 births per 1,000 adolescent girls aged 15–19 years in 2010), Chile adopted the regional 2007–2013 Andean Plan for the Prevention of Adolescent Pregnancy. The Chilean Government targeted a 10% reduction in the adolescent fertility rate in the 2011–2020 National Health Strategy and strengthened the National Comprehensive Health Program for Adolescents and Youth and the corresponding Strategic Action Plan. In 2017, the country reported 26.52 births per 1,000 adolescent girls aged 15–19 years.

A five-pronged approach to improve the health system's responsiveness to adolescents was developed for the 10-year strategy. New government circulars were issued on parental consent requirements, adolescents' autonomy, and protecting young people from sexual abuse. Further, several laws were consolidated into one framework, which defined and mandated different stakeholders' roles and responsibilities. The program built on functional systems by strengthening the capacity of front-line workers and implemented its strategy gradually, starting with regions with the highest need. To respond to the need for better data, a monthly statistical register was created to gather data on adolescents, disaggregated by age, sex, and risk factors.

The program drew legitimacy from regional/national plans and legislative frameworks. The Ministry of Health's media department made data on progress available to journalists to publicize the positive results. Intensive advocacy with scientific associations, NGOs, women's advocates, and young people helped to overcome resistance to contraceptive provision. However, the program strategically decided not to provide education on sexuality to avoid risk of opposition to the broader agenda.

Grounding the approach in the 10-year National Health Strategy ensured sustained human and financial resources through three governments of left- and right-leaning political parties. Positive results encouraged other stakeholders to collaborate.

Source: (9, 14)

## Uruguay: Progressive laws and policies, strong government-led multisectoral responses, and active civil society monitoring led to dramatic declines in adolescent fertility

Uruguay has seen a substantial decline in adolescent fertility in the past 25 years. The ABR peaked at 72 births per 1,000 adolescents in 1996 and remained largely unchanged until 2014–2015. A rapid decline began in 2016, and the rate reduced to 36 per 1,000 in 2018—half of what it was 23 years before, and nearly half of the average ABR in Latin America of 66 per 1,000 adolescents.

This progress was made possible through implementation of existing progressive laws such as the 2008 landmark law on the right to sexual and reproductive health, which notes that it is the duty of the State to guarantee the conditions for sexual and reproductive health and rights (SRHR) for all. It requires all sexual and reproductive health (SRH) policies and programs to ensure universal coverage at the primary level; to guarantee the quality, confidentiality, and privacy of services; to have human resources appropriately trained in both technical and communication skills; to incorporate gender perspectives in all actions and provide conditions for users to make decisions freely; and to promote inter-institutional coordination, emphasizing the contribution that the education sector could make to achieving adolescent SRHR.

The Government's strong political commitment to ensure that a rights-based approach to SRH was central to the public policy agenda was matched by equally strong civil society participation in monitoring the implementation of laws and programs. These measures and actions led to the development and implementation of a national SRH policy and an intersectoral strategy, which includes sexuality education, to prevent unintentional pregnancy among adolescents. One highlight of the strategy is that it gradually introduced contraceptive implants, thereby expanding the contraceptive method mix and promoting the right to free choice. These efforts had a direct impact on access to and uptake of quality free-of-charge or low-cost contraceptive services, as did the dissemination of information reaffirming the right to exercise one's SRHR and to seek assistance for voluntary termination of pregnancy.

Although the priority clearly has been prevention of adolescent pregnancy, the legal framework also assures access to quality maternal health care and emergency obstetric care for all pregnant women, including adolescents. In addition, to avoid social exclusion of adolescent parents, the Government put in place an array of social programs to address the needs of the most vulnerable adolescents.

Accompanying these interventions are activities to prevent rapid repeat pregnancies, including access to SRH services and the provision of CSE outside the school context. Furthermore, social protection policies and schemes are geared toward keeping girls and boys in school and reintegrating out-of-school adolescents into the education system, and to facilitating the integration of young people into the job market.

Source: (15–19)

## Costa Rica: Reduction of adolescent birth rates in 74 of the 82 cantons in ten years.

The adolescent birth rate in Costa Rica experienced ups and downs from 2000 to 2012 and started to go down rapidly in 2013, decreasing by more than eight percentage points, from 29.81 in 2013 to 21.55 in 2018. Factors attributed to contributing to this decline include a series of cultural, societal, and public policy changes, including the introduction of sexuality education in the school curriculum in 2013, retaining pregnant adolescents in the education system, increased availability of and expansion of the range of contraceptive options including long-acting reversible contraceptives, provision of post-partum and post-abortion contraceptives to prevent a consequent pregnancy, and strengthening of the response against sexual violence.

Source: (20, 21)

## Adolescent pregnancy and COVID-19

COVID-19 has disrupted adolescents' access to health services. In many places, health facilities have closed or limited their services. Clinical staff who are occupied with the COVID-19 response may have less time to provide services or lack the personal protective equipment to do so safely. Supply chain disruptions are limiting the availability of contraceptives and other commodities. Finally, adolescents may be unable to visit health facilities because of movement restrictions or may refrain from doing so because of fears about COVID-19 exposure. Meanwhile, evidence from previous crises and projections about COVID-19 impacts suggest that this pandemic will have important repercussions for adolescents' SRH and well-being. For example, the 2014 Ebola outbreak in Sierra Leone contributed to increases in adolescent pregnancies and in sexual and gender-based violence.



Projections from the United Nations Population Fund (UNFPA) suggest that, if the average lockdown (or COVID-19-related disruption) continues for six months, an additional 7 million unintended pregnancies and 31 million cases of gender-based violence could occur. Likewise, as a result of disruptions in prevention programs as well as impacts on household economic status, an additional 13 million child marriages and 2 million cases of female genital mutilation could occur in the next decade.

While the pandemic has brought immense challenges to the mission of universal achievement of SRHR, it may also prove to be an opportunity to advance some areas, by prompting innovative solutions to deliver select information and services to the poorest communities through digital means, or to better address the economic determinants of SRHR, given the intense attention currently being paid to the effects that the pandemic has been having on the livelihoods of the poorest.

UNFPA has developed a technical brief entitled *Not on Pause—Responding to the Sexual and Reproductive Health Needs of Adolescents in the Context of the COVID-19 Crisis*, which outlines adolescent-specific and other adolescent-relevant actions that can be taken by health systems and health service providers to respond to the SRH needs of adolescents in the context of the COVID-19 crisis (22).

Service delivery to adolescents in COVID-19 times needs to be informed by the following overarching considerations:

- Adolescents are a heterogeneous group;
- Adolescents—especially adolescent girls—are particularly vulnerable to increases in sexual abuse, unintended pregnancies, and gender-based violence;
- Adolescents are sexual beings;
- Data and evidence on adolescents' health needs and circumstances are lacking.

## Solutions

As indicated in Sustainable Development Goal # 3.7, the reduction of adolescent pregnancy requires ensuring universal access to SRH services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs, with particular attention to the first level of care (23). Robust evidence and global as well as regional best practices indicate that it is possible to successfully address adolescent pregnancy with political commitment and strategic investment in evidence-based approaches. Reduction of adolescent pregnancy equals an investment in the health, well-being, and development of current as well as future generations.



The evidence base on preventing adolescent pregnancy has grown in the last decade. We now know more about the scope of the problem, its complexities and contextual differences, and effective approaches to prevent and respond to adolescent pregnancy. Efforts have focused on preventing adolescent pregnancy through raising awareness and providing CSE and contraceptive services. Improving access to safe and effective pregnancy care and supporting adolescent girls to return to education or to find employment after a pregnancy have received relatively less attention. At the regional level, the Montevideo Consensus (24) contextualized and built on the language of the International Conference on Population and Development (ICPD), reinforcing the importance of addressing adolescent pregnancy.

In 2016, the Pan American Health Organization/World Health Organization (PAHO/WHO), UNFPA, and the United Nations Children's Fund (UNICEF) developed strategic approaches and priority actions to support the reduction of adolescent pregnancy.

### 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 intersectoral 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.

Nevertheless, gaps in knowledge remain, such as how best to prevent and respond to pregnancy in very young adolescents and how to deliver interventions with fidelity, quality, and equity in resource-constrained settings. Also, the persistence of teenage pregnancy and childbirth among the poor in LAC warrants special concern, as development alone does not seem to be prompting change in these outcomes. The cultural and social causes of this merit closer study.

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Adolescent Pregnancy in Latin America and the Caribbean. Technical brief, August 2020

PAHO/FPL/HL/20-0019

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