CONCEPT NOTE

International Interagency Meeting: Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean.

March 17-19, 2014
Managua, Nicaragua

Summary: The estimated rate of adolescent age-specific fertility (number of births per 1,000 women aged 15-19) in Latin America and the Caribbean (LAC) is among the highest in the world with indigenous and young women from lower wealth quintiles being most vulnerable to becoming pregnant1. Early motherhood impacts an adolescent’s health and wellbeing, education and life prospects, with young women being particularly vulnerable as they already face multiple challenges in exercising their right to the enjoyment of the highest attainable standard of health (“right to health”) and other related human rights and achieving their full potential2.

Furthermore, adolescent pregnancy entails high medical, social, and economic costs, including loss of productivity, for society. In order to successfully prevent adolescent pregnancy and its negative impact on individuals and society, it is important to identify the various risk and protective factors related to adolescent pregnancy in LAC. These factors are varied and are best understood through conceptual frameworks such as the Socio-Ecological Model. Indeed, this model provides a framework for identifying the type of factors impacting adolescent pregnancy at the individual, interpersonal, community and at the societal level, and understanding how these interrelate.

Some of the challenges governments in LAC currently face in their efforts to prevent adolescent pregnancy include a lack of policies, plans and laws formulated in a manner consistent with universal and regional human rights norms and standards; a lack of financial and political commitment by governments to adolescent Sexual and Reproductive Health (SRH) programs; weak strategic information systems; a lack of integrated and comprehensive health systems and services; a shortage in human resources trained in adolescent SRH promotion, prevention and care. Furthermore, current adolescent pregnancy prevention programs in LAC do not focus on most-at risk populations (including adolescents from indigenous or afro-descendant communities, from lower socioeconomic wealth quintiles, etc.); do not consider social determinants of health, human rights norms and/or standards or gender equality approaches; are not based on a life-course perspective; and are not being evaluated for their effectiveness3.

In order to reduce adolescent pregnancy rates in the LAC region, the Pan American Health Organization, in collaboration with the World Bank, UNICEF and UNFPA, with the financial support of the Royal Norwegian

1 The World Health Organization defines young people as individuals between the ages of 10 and 24 years old. Adolescents comprise the 10-19 year-old age group and youth the 15-24 year old age group.
Embassy, is organizing an international interagency meeting in Nicaragua to present the current state of adolescent pregnancy and its major risk factors in the LAC region. This meeting will discuss current evidence, lessons learned, universal and regional human rights law frameworks and best practices regarding adolescent pregnancy prevention in LAC. It will develop consensus on key evidence-based interventions for implementation at the local, national, and regional level in order to prevent adolescent pregnancy in the LAC region. The meeting will also allow for the dissemination and sharing of tools developed at the national and regional level to prevent adolescent pregnancy.

Background on Adolescent Pregnancy and Subsequent Motherhood in Latin America and the Caribbean:

Although the average of estimated adolescent age-specific fertility rates have declined slightly over the past two decades in the LAC Region (from 86 in 1995 to 66 in 2013) (Figure 1), the Regional estimated average is still high compared to the global estimated average of 52.7 (Figure 2), with Nicaragua having one of the highest estimated rates at 112.7.

Comparing the different countries within the Caribbean region (Figure 3), the highest adolescent age-specific fertility rates can be found in the Dominican Republic and Jamaica. Other Caribbean countries with relatively high adolescent age-specific fertility rates (over 40) include Barbados, Cuba, Grenada, Haiti, St. Lucia and St. Vincent and the Grenadines. The lowest rates are in the French islands of Guadeloupe and Martinique (19.5 and 22.5 respectively).

Figure 1. Estimated Trends in Age-Specific Fertility Rates by Sub-Region (Number of births per 1,000 women aged 15-19) in the Americas (1995-2010).


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Figure 2. Estimated Adolescent Fertility Rates by Country (Number of births per 1,000 women aged 15 to 19) in Latin America and the Caribbean, 2010.

As a result of these high adolescent-age-specific fertility rates, approximately 18% (1,980,000) of all births that take place in LAC today occur among adolescents aged 15-19— the second highest percentage of total live births to adolescent mothers than in any other part of the world, accounting for 11% (16 million) of all births globally. Furthermore, approximately 66,000 births occur amongst adolescents between ages 10-14 each year in the LAC region.

Comparing socio-demographical characteristics of young mothers in the Latin American Region, it is apparent that those from indigenous communities (between ages 15-24) are more likely to be mothers than their non-indigenous counterparts (Figure 4), and those young women in LAC from lower wealth quintiles (between the ages 15-19) are more likely to be mothers or currently pregnant compared to those from higher wealth quintiles (Figure 5).

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Early motherhood impacts an adolescent’s education and life prospects\(^\text{10}\). As shown in figure 6 and 7, adolescent mothers 10-20 years of age are less likely to complete secondary school in comparison to mothers 20-24 years of age, with indigenous young mothers being more likely to abandon school than their non-indigenous counterparts. Furthermore, adolescent mothers 10-20 years of age are less likely to be employed than mothers 20-24 years of age in most countries (Figure 8)\(^\text{11}\).


Figure 6. Educational outcomes by teen mother status in selected countries in LAC (most recent DHS available data).


Figure 7. Percentage of young mothers (ages 15-24) who abandon school, by ethnicity, in selected countries in Latin America (2011).

Adolescent motherhood also entails high medical, social, and economic costs, including loss of productivity, for society. As the figure below indicates Brazil and Paraguay lose an average of 10% and 12% respectively of their Gross Domestic Product (GDP) due to adolescent pregnancy and subsequent motherhood.

Figure 8. Employment outcomes according to teen mother status in selected countries in LAC (most recent DHS available).


Figure 9. Lifetime cost of adolescent pregnancy and subsequent motherhood of the current cohort of girls 15 to 19 years old, as share of annual GDP (2011).


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From a health perspective, early pregnancy, whether intended or unintended, is characterized by greater health risks, mentally and physically, for both the child and mother. For example, studies have found an association between age-at-first live birth and intimate partner violence. As figure 10 shows, the younger a girl is during her first live birth, the higher the likelihood of having reported physical or sexual violence by a partner ever. Also found is a high incidence of suicide among pregnant young women, indicating that poor mental health is related to adolescent pregnancy. Furthermore, studies have found that adolescent mothers under the age of 15 are four times more likely to die from maternal complications and are at a greater risk of suffering from anemia, toxemia, high blood pressure, placenta previa, eclampsia, puerperal infection, cephalopelvic disproportion and premature birth than older age groups.

In LAC, the maternal mortality rate among 10-14 year olds is 146.5 (per 100,000 live births) in comparison to 79.9 (per 100,000 live births) among 15-19 year olds (Figure 11). Furthermore, among young women 15-24 years of age, pregnancy, delivery, and puerprium were among the four leading causes of death in LAC from 2007 to 2010.

Figure 10. Percentage of women who reported physical or sexual violence by a partner ever, according to age at first live birth, among women who ever had a live birth at any time in their life in selected countries in Latin America and the Caribbean (most recent data available).


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Figure 11. Maternal Mortality Rate in Selected Countries in Latin America and the Caribbean by Age (2005-2009)


Risk and Protective Factors impacting Adolescent Pregnancy:

The risk and protective factors impacting adolescent pregnancy in LAC can best be understood through conceptual frameworks such as the Socio-Ecological Model (Figure 12).

Figure 12. The Socio-Ecological Model

This model provides a framework for identifying the type of factors impacting adolescent pregnancy and understanding how these interrelate. Factors can be risk factors (-) that increase the chance of adolescent pregnancy or protective factors (+) that reduce the chance of adolescent pregnancy.

The Socio Ecological Framework usually has four different levels: the individual level, the interpersonal level, the community level and finally the societal level. In each of these four levels there is a set of defined factors either preventing or promoting the health outcome.

**The individual level** includes the characteristics that influence behavior such as knowledge, attitudes, skills, beliefs, and age. At this level, most studies indicate that risk and protective factors for adolescent pregnancy include, but are not limited to, age at first sexual intercourse, civil status, use of contraception and enjoyment of other internationally recognized reproductive rights, alcohol and drug consumption, level of education, and/or socioeconomic status. Furthermore, although often overlooked and rarely mentioned, violence, including sexual violence, coercion and exploitation, is a risk factor that has been associated not only with early sexual debut, but with sexual risk-taking behavior and unintended pregnancy. Sexual coercion and sexual violence challenge young women’s ability to control their own reproductive decision making, as a basic human right, and health. Of course, a direct link between sexual violence and unwanted pregnancy exists when conception results from forced sex. However, adolescents who have been sexually coerced or abused at a young age may also be more likely than those who have not to continue patterns of sexual victimization and sexual risk-taking behavior throughout life, including a lack of self-protective behavior (e.g., reducing number of partners, using contraceptives), thus highlighting the indirect link between sexual violence and unintended pregnancy.

**The interpersonal level** examines close relationships that may increase or decrease the risk of adolescent pregnancies, including, but are not limited to, relationships with family, friends, partners, teachers and/or other community members. For example, studies have shown that adolescents with poor interpersonal relationships (i.e., poor parent-child communication, low parental monitoring, and a lack of family support) are more likely to engage in risky behaviors associated with adolescent pregnancies.

**The community level** refers to the areas where teens live, attend school, and work. At this level, most studies indicate that risk and protective factors for adolescent pregnancy include the availability (or lack there of) of schools, health care centers and/or after-school programs; the prevalence of community violence; the degree of work environment safety, etc.

**The societal level** refers to the macro systems and institutions that affect the health outcome of an individual. In the case of adolescent pregnancy, risk and protective factors at the societal level include, but are not limited to, the availability (or lack there of) of national sexual and reproductive health legislation, policies, programs and/or plans; the availability (or lack there of) of health and/or educational institutions; and/or the availability (or lack there of) of confidential sexual and reproductive health services and contraceptive methods to adolescents. Another highly important societal level risk and/or protective factor is the availability (or lack there of) of age-appropriate and medically accurate sexual education programs in schools. Indeed, according to the U.S. alliance for teen pregnancy, “comprehensive sexuality education ...provides [adolescents] with accurate information about human sexuality, reproduction and sexual health; presents opportunities to explore and understand one’s own

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22 [http://www.guttmacher.org/pubs/journals/3502109.html](http://www.guttmacher.org/pubs/journals/3502109.html)
23 Ibid.
values regarding sexuality; develops skills to communicate and relate to others in healthy, satisfying, meaningful ways; and supports the ability to make sexual decisions with integrity to one’s self and respect for others.  

In combination, the abovementioned risk and protective factors are often referred to as the Social Determinants of Health. Indeed, according to the WHO “the social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics”. By understanding the concept of social determinants of health, one will also gain a broader comprehension for the causes that impact adolescent pregnancy in their community.

**National Response to Reduce the Adolescent Age-Specific Fertility Rate in LAC:**

In the last couple of years, governments in LAC have made great strides in their efforts and commitment to promote adolescent SRH, including preventing adolescent age-specific fertility rates. As a result of these efforts many countries have experienced significant legislative and policy progress including, but not limited to, the development, approval and implementation of national laws, policies, programs, strategies and action plans related to adolescent health and development, in a manner consistent with universal and regional human rights norms and standards related to reproductive rights and the right to sexual/reproductive health, including adolescent SRH. The score card below highlights some of the results from said legislative and policy progress:

<table>
<thead>
<tr>
<th>The State of National Legislative and Policy Environments in Selected Countries in the Latin American and Caribbean (LAC) Region.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following country has…</td>
</tr>
<tr>
<td>A functioning National Adolescent and Youth Health and Development Program.</td>
</tr>
<tr>
<td>A National Adolescent and Youth Health and Development Strategy and Plan of Action.</td>
</tr>
<tr>
<td>A Universal Sexual and Reproductive Health Policy.</td>
</tr>
</tbody>
</table>

*The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.*

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27 Ibid.

28 The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.
<table>
<thead>
<tr>
<th>In the last two years undertaken a revision of their policies related to sexual and reproductive health.</th>
</tr>
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<tbody>
<tr>
<td>Been using international human rights tools, guidelines, norms and standards to develop and/or revise existing national health laws, policies and/or plans.</td>
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<tr>
<td>Been incorporating international human rights tools, guidelines, norms and standards into the existing adolescent health laws, policies and/or plans.</td>
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<tr>
<td>Mechanisms that permit the participation/consultation of young people in the development of laws, policies, and/or plans.</td>
</tr>
<tr>
<td>A National School Based Sexual Education Program.</td>
</tr>
<tr>
<td>An open and not limiting Abortion Policy.</td>
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</tbody>
</table>

**Key:**

- Yes
- No
- In progress

**Source:** Pan American Health Organization, 2013

**Interagency Response to Reduce the Adolescent Age-Specific Fertility Rate in LAC:**

In order to support National governments in LAC to reduce their adolescent age-specific fertility rate, various international agencies have allocated financial and human resources into programs, projects and individual activities that work to improve adolescent SRH, including preventing adolescent pregnancy. The following are examples of these efforts carried out by PAHO, the World Bank, the Meso-America Health Initiative 2015 (IDB), UNFPA and UNICEF,:
PAHO: Through the financial support of international donors including the Royal Norwegian Embassy in Guatemala, the Swedish International Development Agency (SIDA), the European Union, etc., PAHO has for the past two decades implemented a variety of programs, projects and individual activities to support: the establishment of regional legislative and policy environments for Adolescent SRH programs in a manner consistent with universal and regional human rights instruments; the development of human resources capacity in adolescent SRH; the expansion of adolescent SRH services; and the strengthening of regional, sub-regional and national strategic information systems. All their efforts have been carried out using a gender sensitive and human rights-based approach.

The World Bank: In 2010, the World Bank presented its "Reproductive Health Action Plan 2010-2015" to the Bank’s Executive Board (WB-RHAP 2010-2015), which provides the framework for efforts to improve reproductive, maternal, and newborn, health (RMNH) outcomes, particularly for the poor and the vulnerable, in the context of the Bank’s overall strategy for poverty alleviation and health systems strengthening. The plan fully endorses the multi-sectoral and partnership efforts to achieve better results and prioritizes 57 lower income countries with high maternal mortality and high fertility around the world. In particular, it focuses on the reproductive health needs of the youth; improving RMNH outcomes through health systems strengthening; and leveraging partnerships with governments, CSOs, academia, multilateral and bilateral partner organizations.

In Latin America and the Caribbean region, ten percent of the World Bank-financed active projects (27) include activities related to addressing MCH/RH. These services have been focusing on the main identified areas of need: prevention of neonatal mortality and teen pregnancy and development of quality maternal and child health care networks. Looking into the future, the main focus of the World Bank assistance is in the following areas: (i) strengthening vital registration, the backbone of accountability; (ii) improving adolescent health and preventing teenage pregnancy; (iii) improving the quality of maternal and child care; and (iv) preventing intra-family violence.

The Meso-America Health Initiative 2015: La Iniciativa Salud Mesoamérica 2015 es una asociación público-privada que tiene como objetivo reducir las brechas de equidad en salud en Mesoamérica que enfrentan sus poblaciones en extrema pobreza. La meta de la Iniciativa es respaldar los esfuerzos de los gobiernos de la región en el logro de los Objetivos de Desarrollo del Milenio en materia de salud, a través de inversiones focalizadas en el 20% más pobre de la población, principalmente mujeres y niños menores de cinco años. Con la coordinación y asesoría técnica del Banco Interamericano de Desarrollo, la Iniciativa Salud Mesoamérica 2015 está promoviendo un modelo de integración de servicios para el abordaje multifactorial de determinantes del embarazo adolescente. Esto, mediante estrategias de atención diferenciada a distintas poblaciones según niveles de exposición a riesgos, conectando las acciones desarrolladas en territorios por los servicios de salud, los centros educativos y las unidades de atención a cargo de servicios de protección especial. La clave del modelo es procurar por distintas vías, el contacto con el mayor número de adolescentes posible, con mecanismos de identificación de aquellos más vulnerables y que requieren tratamiento diferencial. El eje lo constituye el fortalecimiento del modelo de atención en salud para adolescentes, a lo que se suman las acciones de prevención de la deserción escolar por causa de maternidad o paternidad, servicios cualificados de atención profesional para trabajar con familias en los casos de mayor riesgo y, formación de recursos comunitarios para trabajo preventivo de pares. Las principales acciones desarrolladas en este contexto tienen que ver con mejorar la calidad de atención de servicios de salud materna, neonatal e infantil para las adolescentes en las áreas geográficas más pobres; mejorar la calidad, la utilización y acceso a servicios de salud sexual y reproductiva para los y las adolescentes; y, generar evidencias sobre buenas prácticas para la prevención y atención del embarazo adolescente.
Challenges Facing Adolescent Pregnancy Prevention Efforts in Latin America and the Caribbean:

Despite the great progress that LAC has experienced in terms of social and economic development over the past two decades, it is the only region in the world where adolescent pregnancy has remained relatively stagnant.29

There are various causes for this paradox. While social, economic and gender inequalities are recognized as crucial barriers to adolescent SRH in LAC, impeding structural factors include legislation and policies which are not consistent with universal and regional human rights law (including civil and criminal codes); weak strategic information systems; a lack of integrated and comprehensive health systems and services; a shortage in human resources trained in adolescent SRH promotion, human rights, prevention and care; the exclusion of family, community, schools and the media in SRH interventions; and fragile strategic alliances and intersectorial collaboration.30

Furthermore, current adolescent pregnancy prevention programs in LAC do not focus on most-at risk populations (including adolescents from indigenous communities, from lower socioeconomic wealth quintiles, etc.); do not consider cross cutting issues including social determinants of health, human rights or gender; are not based on a life course perspective; and are not being evaluated for their effectiveness.31

Proposal:

Responding to most of the above mentioned challenges, the Pan American Health Organization, in collaboration with the World Bank, UNICEF and UNFPA, with the financial support of the Royal Norwegian Embassy, is proposing a three day international interagency meeting on “Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean” to be held in Nicaragua from the 17-19th of March, 2014.

By holding the event in March of 2014, the meeting will hopefully seize relevant political windows of opportunity including the UN-System Task Team’s Report on the Post-2015 UN Development Agenda;32 the World Health Organization Resolution on Youth and Health (WHA A64.28);33 the recently approved PAHO Strategic Plan 2014-2019;34 and the five year PAHO/Royal Norwegian Embassy in Guatemala initiative “SRH Promotion and HIV prevention in young People using a Human Rights Framework in Central America and the Caribbean 2009-2014”.

Meeting Goal: Support PAHO Member states to use lessons learned and best practices, develop and implement evidence-based adolescent pregnancy prevention efforts, using a Human Rights, Gender and Equity approach.

Meeting Objectives:

• To present the current situation of adolescent pregnancy and its major risk factors in the LAC region;

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29 http://events.iadb.org/calendar/eventDetail.aspx?lang=en&id=3300
32 The UN-System Task Team’s Report on the Post-2015 UN Development Agenda includes the recommendation: “Young people must be subjects, not objects, of the post-2015 development agenda. They need access to the right kind of health (including access to SRHR) and education to improve their job prospects and life skills, but they must also be active participants in decision-making, and be treated as the vital asset for society that they are”. http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf
33 The World Health Organization Resolution on Youth and Health (WHA A64.28) urges member states to put the health (including SRH) on national agendas. http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_25-en.pdf
34 While the highest priority of the PAHO Strategic Plan 2014-2019 is to accelerate progress toward universal access to quality health care, it includes a specific indicator to decrease specific fertility rate in young women 15-19 years of age in LAC. http://www.paho.org/hq/index.php?option=com_content&view=article&id=8833&Itemid=40033&lang=en
• To discuss current evidence, lessons learned and best practices regarding adolescent pregnancy prevention and the access and utilization of SRH services by adolescents in the LAC region;
• To agree on key evidence-based interventions for implementation at the local, national, and regional level in order to prevent adolescent pregnancy in the LAC region;
• To disseminate and share current evidence, lessons learned, best practices, tools and instruments developed at the national and regional level to prevent adolescent pregnancy.

Meeting Expected Outcomes:

• A document on the current situation of adolescent pregnancy, including its risk factors in the LAC region;
• Consensus recommendation for action to develop and implement evidence-based adolescent pregnancy prevention efforts in the LAC region;
• A knowledge management site using different technologies including current evidence, lessons learned, best practices, tools and instruments developed at the national and regional level to prevent adolescent pregnancy.

Methodology:

Considering the challenges that governments in LAC are currently facing and cross cutting issues including social determinants of health, human rights or gender, we propose to use the Center for Disease Control’s (CDC) “Teenage Pregnancy and the Health Impact Pyramid” (Figure 13) as a conceptual framework for the international interagency meeting on “Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean”35.

Figure 13. The Teen Pregnancy and the Health Impact Pyramid.


The Pyramid involves five different levels: addressing socioeconomic factors; improving the context to encourage healthy decisions; promoting long-lasting prevention interventions; strengthening effective clinical interventions; and ensure sexual health education. Although all levels of the pyramid are important in adolescent pregnancy prevention, their impact varies. For example, addressing socio-economic factors which include improving educational attainment, promoting PYD, reducing poverty and decreasing disparities, in adolescent pregnancy prevention is approximately five times more impactful than providing sexual health education to students.

The meeting will bring together selected international experts in the field of adolescent health pregnancy, human rights specialists, persons responsible for adolescent SRH at National Ministries of Health, persons responsible for Sexual Education at National Ministries of Education, persons responsible for Adolescent SRH at PAHO at the Regional and National level, youth leaders and the media from 13 different countries in the Americas.

It will last three days and will focus on the current situation of adolescent pregnancy and its major risk factors in the LAC region. It will discuss current evidence, lessons learned and best practices regarding adolescent pregnancy prevention in LAC; and develop consensus on key evidence-based interventions for implementation at the local, national, and regional level in order to prevent adolescent pregnancy in the LAC region. The meeting will also allow for the dissemination and sharing of tools and instruments developed at the national and regional level to prevent adolescent pregnancy.

Collaborating Partners:

TBD: Proposed collaborating partners include the World Bank, UNICEF, UNFPA, and the Royal Norwegian Embassy.

Participants:

Participants will include selected international experts in the field of adolescent health pregnancy, persons responsible for adolescent SRH at National Ministries of Health, persons responsible for Sexual Education at National Ministries of Education, persons responsible for Adolescent SRH at PAHO at the Regional and National level, youth leaders and the media from the following countries:

<table>
<thead>
<tr>
<th>Argentina</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Chile</th>
<th>Colombia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costa Rica</td>
<td>Cuba</td>
<td>Dominican Republic</td>
<td>Ecuador</td>
<td>El Salvador</td>
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<td>Guatemala</td>
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<td>Honduras</td>
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<td>Mexico</td>
<td>Nicaragua</td>
<td>Panama</td>
<td>Paraguay</td>
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<tr>
<td>Trinidad and Tobago</td>
<td>Uruguay</td>
<td>USA</td>
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