Spotlight Initiative

To eliminate violence against women and girls

ACCELERATING PROGRESS TOWARDS THE REDUCTION OF ADOLESCENT PREGNANCY:

Towards a comprehensive approach

POLICY BRIEF

An initiative of the United Nations funded by the European Union

UNFPA

IPPF International Planned Parenthood Federation Americas and the Caribbean Region

Caribbean Observatory on Sexual and Reproductive Health and Rights

Monitoring • Mobilising • Advocating

RATIONALE

Adolescent pregnancy adversely affects the lives of young people, hampering their psychosocial development, contributing to poor health outcomes for the girls and their babies, negatively affecting their educational and employment opportunities, and contributing to the perpetuation of intergenerational cycles of poor health and poverty. Pregnant adolescents 10-19 years old often face heightened health risks, compared to women aged 20 to 24 years, including eclampsia, puerperal endometritis and systemic infections. Pregnancy and childbirth complications are the leading cause of death among girls aged 15 to 19 years globally.

Pregnancy also has an impact on adolescent girls' employment. For example, in Guyana, adolescent mothers were 13% more likely to retreat from the labour market than the adult mothers, have a 45% higher rate of unemployment than adult mothers, have a 10% lower monthly median income (representing USD 29.98 per month for each adolescent mother in 2019) and lower levels of educational attainment. This represents an estimated US$4,593,481 in losses with a consequential loss of US$1,036,244 in tax revenue and an additional US$420,108 lost due to maternal mortality. Unwanted adolescent pregnancies are a creature and progenitor of poverty and economic inequality with significant fiscal impacts for countries within the region. There is a need to respond not only through a human rights lens but also considering national and regional development, especially in achieving Sustainable Development Goals 3 and 5.

In the Caribbean region, adolescent fertility rates (AFR) were one of the highest in the world at 60.2 births per 1,000 girls aged 15-19 between 2010 and 2015. Despite a fall in the rate over the years, wide variations persist between sub-regions, countries, and within countries.[1] To sustain the progress in reducing adolescent pregnancy, there needs to be a comprehensive approach.

SITUATION IN THE CARIBBEAN

The projected ABR global target is 40 per 1000 for girls aged 15-19 for the 2020-2025 period, with Latin America and the Caribbean having a higher projected ABR than the global rate at 59[2].

Trends in adolescent fertility rates[3]

The **biggest AFR decline** was observed in **Jamaica** from 74.8 in 2000 to 32.0 in 2021.

Guyana had the highest AFR at 102.3 in 2000, which declined to 64.6 in 2022.

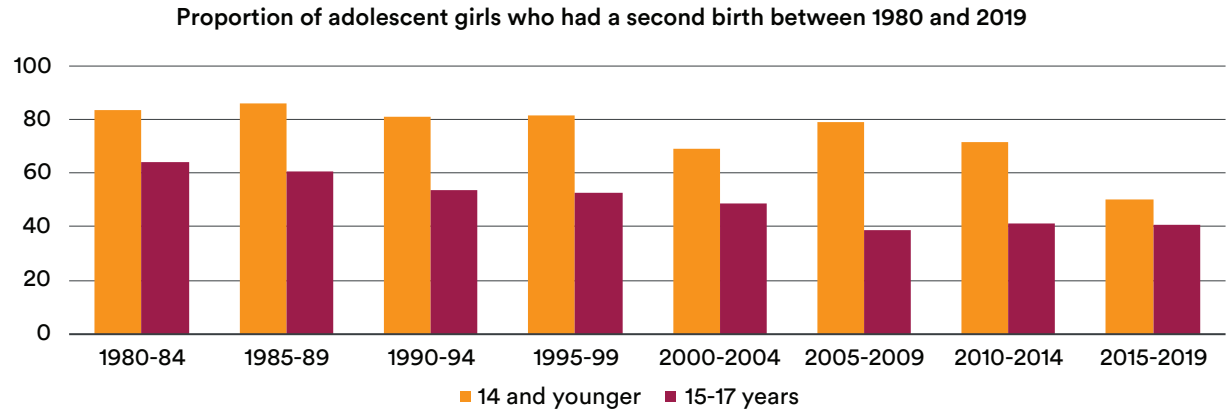
Grenada showed the smallest decline from 45.6 in 2000 to 32.1 in 2022.

Nonetheless, Latin America and the Caribbean succeeded in significantly reducing repeat adolescent births. Whereas 60 years ago, the region featured among the highest ratios of repeat adolescent childbearing, it now has among the lowest (see figure below).

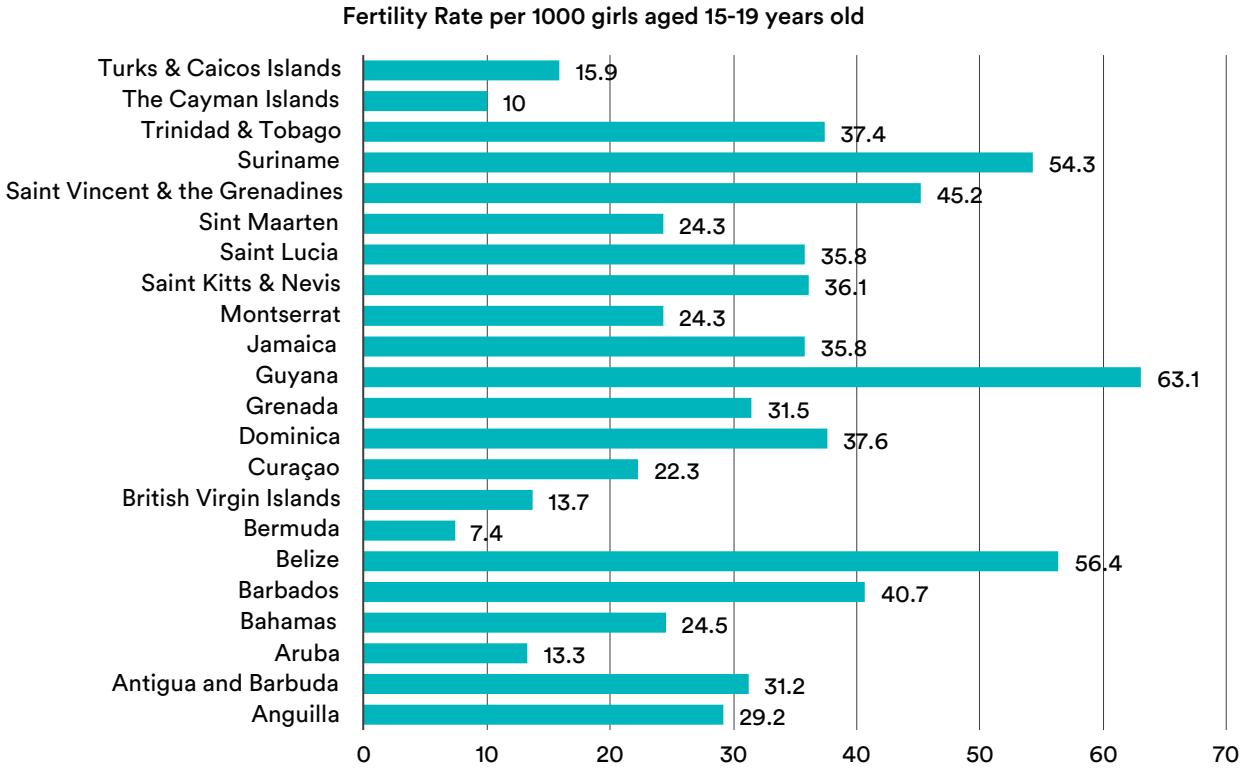
This has led to significant decline in the completed fertility within the region. Six decades ago, Latin America and the Caribbean had the largest difference, with 2.9 more births on average to adolescent mothers than to non-adolescent starters (7.7 and 4.8 births, respectively). Most recently, that difference has fallen to 1.4 births.

For example, in Jamaica, the Women's Centre of Jamaica Foundation is heavily investing in holistic development of adolescent mothers through education, life-skills training, support for families, including "baby-fathers" and sexual health education, which can be clearly linked to the reduction of repeat adolescent pregnancies.

1 United Nations, Department of Economic and Social Affairs, Population Division. World fertility 2019: early and later childbearing among adolescent women. New York: United Nations; 2020. (Document ST/ESA/SER.A/446).
2 United Nations Population Fund, State of the World Population 2022: Seeing the Unseen. The case for action in the neglected crisis of unintended pregnancy, 2022, 129.
3 PAHO and Index Mundi 2021– fertility rate among adolescents



Source: United Nations Population Fund, Motherhood in Childhood: The Untold Story (2022) 22.



Source: United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects: The 2022 Revision, https://population.un.org/dataportal/ <accessed 15 July 2023>.

According to the United Nations Population Division, five of the 22 countries under review are above the global ABR target: Barbados, Belize, Guyana, St. Vincent & the Grenadines and Suriname. Three of these countries are mainland Caribbean countries with significant indigenous populations. On the lower end are Aruba, Bermuda, British Virgin Islands, the Cayman Islands and the Turks & Caicos Islands with projected ABRs below 20 per 1000 girls aged 15-19 years old. These are all territories with relatively small populations and laws influenced by countries under whose administration they fall such as the United Kingdom or the Netherlands.

DRIVERS OF ADOLESCENT PREGNANCY

Socioeconomic and cultural factors

Adolescent pregnancy is disproportionately higher among the most disadvantaged women, including those who are poor, live in rural areas, have lower levels of education, belong to Indigenous and Maroon groups and lack knowledge about family planning and contraceptive use. Modern contraceptive methods and reductions in poverty, and income inequality (occasioned by increased access to education and employment), likely have contributed to the global shifts in the ABR in 2015-2020.

In all Caribbean countries, there were projected declines in AFR, though the reductions vary significantly among countries. There is also no clear correlation between the rate of decline and the level of increase in education spending as a percent of GDP. For example, Aruba had a high reduction in its AFR but showed a decrease in the proportion of education spending, while Belize, which had the greatest increase in their proportion of education spending, only had a 23% decline in their AFR. Barbados showed a slight decline in AFR, despite an increase of at least 1% in education spending. Further research is needed to determine the nature of the monetary allocation, that is, teachers' salaries, supplies or provision of SRH information, in identifying how this impacts ABR. It will also be important to identify who does not benefit from the education sector investments, such as out-of-school girls, and how these can be reached. Nonetheless, as AFRs are declining, young people seem to have more information, leading a reduction in adolescent pregnancies and improved health outcomes.

Shifts observes in education spending as a percentage of GDP and in AFR between 2010 and 2021

Countries with an ↗ increase of at least 1% in education spending:	**Shifts in AFR (15-29 years) (2011-2021)**	
Antigua & Barbuda (2012-2021)	Antigua & Barbuda:	↘ 17.5% decline
Barbados (2012-2021)	Barbados:	↘ 6.67% decline
Belize (2013-2021)	Belize:	↘ 23% decline
Curaçao (2012-2020)	Curaçao:	↘ 36.1% decline
Dominica (2015-2021)	Dominica:	↘ 17.4% decline
Guyana (2010-2018)	Guyana:	↘ 14.1% decline

Countries with a ↘ decrease of at least 1% in education spending:	**Shifts in AFR (15-29 years) (2011-2021)**	
Aruba (2010-2016)	Aruba:	↘ 64% decline
British Virgin Islands (2012-2020)	British Virgin Islands:	↘ 33% decline
St. Kitts & Nevis (2012-2021)	St. Kitts & Nevi:	↘ 15.6% decline
Turks & Caicos Islands (2012-2021)	Turks & Caicos Islands:	↘ 15% decline

Source: Data on Shifts in GDP taken from World Bank Data available at <https://data.worldbank.org/indicator/SE.XPD.TOTL.GD.ZS?end=2021&start=2010> accessed 31 August 2023

The importance of comprehensive sexuality education and use of contraceptives

An assessment of the implementation of Comprehensive Sexuality Education (CSE) in the region found that sexuality education cannot be considered comprehensive by international standards. Guyana and Jamaica provide the most content, and still fail to meet the international standard. Reviewing available Health and Family Life Education curricula across the region revealed that the Bahamas, Belize, Bermuda, Dominica, Guyana, St. Lucia, St. Vincent & the Grenadines and Trinidad & Tobago have very little to no content on sexuality, sexual behaviour or sexual and reproductive health

for ages 9-12. The lack of CSE impacts the prevailing culture of low and inconsistent condom usage among adolescents, multiple partners and limited knowledge on navigating sex and sexuality safely.

UNAIDS data demonstrates the region has generally low knowledge on HIV prevention, which can indicate equally low knowledge on contraception more broadly.

KNOWLEDGE ABOUT HIV PREVENTION AMONG YOUTH FROM 15-24 YEARS OLD (%)

Antigua and Barbuda:	85.67%	Jamaica:	39.04%
Bahamas:	4.4%	St. Kitts & Nevis:	51.3%*
Belize:	43.03%	St. Lucia:	62.2%**
Dominica:	52%*	Suriname:	41.9%**
Grenada:	62.3%*	Trinidad & Tobago:	60.2%**
Guyana:	48.6%		

*Represents an average of sex disaggregated data **Represents data on young women only

Source: UNAIDS, "AIDSinfo: Global Data on HIV epidemiology and response" https://aidsinfo.unaids.org <accessed 16 July 2023>

Antigua & Barbuda is the only country where over 80% of youth have accurate knowledge on HIV prevention. In Guyana, Belize and Suriname, this knowledge ranges from 41.9% to 48.6%, though they have the highest ABRs in the region. Bahamas has the least knowledge among youth but the ABR is below the global average. In Trinidad & Tobago, knowledge among youth is over 60% and the ABR is relatively low. This dissonance may be explained by general awareness raising around HIV & safe sex rather than targeted education. The data highlights the urgent need for access to and full and consistent implementation of CSE.

LAWS AND POLICIES ACROSS THE REGION: THE NEED TO ADDRESS GAPS & BARRIERS

Of the 22 countries, 12 have lower ages of consent to sexual activity than the ages of access to SRH services. This incongruence creates a legislative gap whereby adolescents can legally engage in sexual activity without being able to access the commodities and services to reduce the risk of pregnancy and other consequences. This incongruence needs to be resolved in law given the implications for the ABR across the region.

Minimum age of consent to sexual activity

Services	Minimum Age	Countries
Persons 18 and over can access all services available as adults.	No specific law	Bahamas, Barbados, Dominica, Grenada, Montserrat and St. Kitts & Nevis
Testing & Treatment Services	16 years	Antigua & Barbuda, Belize, Guyana, Jamaica, St. Lucia and St. Vincent & the Grenadines.
Persons 21 and above can access all services available as adults.	No specific law	Aruba, Curaçao, Sint Maarten, Suriname
Parentage Testing	Anyone under 18 years old	Belize
Parentage Testing	16 years	Anguilla, Trinidad & Tobago, Turks & Caicos

Source: UNFPA Legislative Analysis of Sexual and Reproductive Health and Rights in the English- and Dutch-speaking Caribbean, 2023

Adolescents accessing SRH Services without parental consent

Sexually active adolescents need access to SRH services without parental consent. For example, in Belize and Suriname, which have one of the highest AFR in the region, there is a lack of clear laws and policies to access SRH services and commodities, though adolescents are legally allowed to engage in sexual activity. In countries without specific laws allowing minors to access SRH services, only Barbados is above the global average AFR. Guyana, Belize and St. Vincent & the Grenadines are above the global average AFR, however, in two of these countries there is an incongruence within their laws. The laws in St. Vincent & the Grenadines are aligned and their AFR is the lowest of the three countries. There is a need to lower the age of consent to access SRH services to coincide with the age of consent to sexual activity.

Ratification and comprehensive policies and programmes

The Committee on Economic, Social and Cultural Rights confirms the right to "access to health-related education and information, including on sexual and reproductive health".

Several countries across the region ratified key international and regional human rights conventions and programmes of action to respond to the SRH needs of adolescents. These highlight the need for Caribbean states to ensure comprehensive policies and programmes to reduce adolescent pregnancies.

20 Ratified **International Covenant on Economic, Social & Cultural Rights (ICESCR)**
Countries include Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago

22 **American Convention on Human Rights**
Countries include Barbados, Dominica, Grenada, Jamaica, Suriname, Trinidad and Tobago

6 Ratified the **Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW)** and the **Convention on the Rights of the Child (CRC)**
Countries include Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Curaçao, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sint Maarten, Suriname, The Cayman Islands, Trinidad and Tobago, Turks & Caicos Islands

The need for strong political leadership, coordination and partnerships

There is a need for strong political leadership, coordination and partnership with a wide variety of stakeholders. It is also important to introduce clear, enabling laws and/or policies for the provision of SRH information and services and ensure congruence between laws on consent to sexual activity and laws on accessing SRH services. This must be supported by a policy framework that clearly outlines the roles and responsibilities of key stakeholders.

RECOMMENDATIONS FOR DECISION-MAKERS

1. Examine and document effective strategies in addressing adolescent pregnancies.
2. Improve data collection on AFR across the 22 countries to develop an accurate reflection of the country-specific situation to inform policy and planning.
3. Amend laws to align age of consent to sexual activity with age of access to SRH services to allow for sexually active adolescents to access available medical information and services as needed.
4. Implement age-appropriate and culturally sensitive CSE for adolescents in the region with robust monitoring frameworks.
5. Establish strategic partnerships with stakeholders outside the formal education system to ensure that all adolescents can access SRH information.
6. Ensure medical professionals are indemnified from legal challenges for the provision of SRH services and information below the legal minimum age where the adolescent is unwilling or unable to obtain parental consent.
7. Governments take a leadership role in fostering positive social change to reduce negative attitudes to adolescent sexuality that create barriers to accessing accurate information and services through capacity building of parents, frontline health workers, medical professions and public education campaigns.

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