Andrew L. Cherry · Mary E. Dillon
Editors

International Handbook of Adolescent Pregnancy

Medical, Psychosocial, and Public Health Responses

Springer

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Preface

This volume is a result of the certainty that we can learn from each other. Especially, there is a great deal to be learned by studying the way people from different cultures and from different countries respond to a socially defined individual behavior, such as adolescent pregnancy. This volume provides a multitude of views on adolescent pregnancy that can help our thinking move from the oversimplified *constructs* based on our own cultural perspective to a construct that is built upon a foundation of biological science (e.g., a knowledge of child development, and sexual and reproductive development), issues common to all adolescents, particularly girls. These differences between the way people from various countries respond to adolescent pregnancy, as will be observed in these chapters, is the result of religious and cultural beliefs specific to individual groups and individual countries.

In the early years of the twenty-first century, the number of adolescent girls worldwide passed a population milestone of 500 million. Among these adolescent girls, about 16 million a year start their family as a teen mom, accounting for 11 % of births globally. The children born to adolescent girls, however, are not distributed equally from country to country. Some 95 % of these children, born to adolescent girls, are born in the developing, least developed countries, and the United States. Consequently, inadequate pre and postnatal care in these countries and communities makes pregnancy and childbearing the leading cause of death and disability among adolescent girls and their children (UNICEF 2012).

This reality about the number of adolescent pregnancies and childbirth for some is an alarming turn of events and a serious threat to the social and economic order. For others, this observation shows a failure of families to provide adequate sexual information and a failure of governments to protect the inalienable rights of adolescents, particularity the inalienable rights of girls. For those who see adolescent sexuality as a problem, particularly when it is reframed as a problem of morality, the focus is on stopping adolescent sexual behavior and thus stopping adolescent pregnancies and abortions. For those who view adolescent sexual behavior as a normal part of adolescent development, the focus is on sexuality education, the preventing of unintended pregnancy, and the delay of pregnancy. From this perspective, adolescent

sexual and reproductive health programming is designed to empower girls and boys to act responsibly and thoughtfully if they do choose to engage in sexual behavior. Sexual and reproductive services would include accurate information on contraception and emergency contraception, and the abundant availability of condoms for both boys and girls. What will become apparent in these chapters is that in most countries adolescent mothers and their children will face challenges that may limit their educational achievements, impede occupational success, and it will increase their chances of living in poverty. It will also become apparent that the rates of adolescent pregnancy vary across countries from being almost non-existent, to rates as high as 100 births to adolescent mothers per 1,000 live births. Based on these variations, the philosophies, policy, and programs can be compared in terms of the rate of adolescent pregnancy and childbearing.

This volume was compiled and written by a team of international scholars. These researchers and practitioners provide original chapters that critically examine country-specific perspectives and programming related to adolescent pregnancy in its historical, religious, and cultural contexts. Demographics on adolescent pregnancy and childbearing will be used to help describe medical, social, and legal issues. These chapters will also report on programs providing sex education, birth control, maternal and childcare health provisions, and public policies that are intended to address concerns about adolescent pregnancy.

In this volume, the first eight chapters address the major issues associated with adolescent pregnancy. The chapter, "An International Perspective on Adolescent Pregnancy" provides an overview of issues related to international adolescent pregnancy. The next seven chapters present issues and context, which are not country specific but impact adolescents to a serious degree in many countries. These chapters include biological, sexual and reproductive health, and mental health issues. They also cover adolescent fathers, LGBTQ adolescent mothers and fathers, and issues associated with adolescent pregnancy as a feminist issue and the effect of viewing adolescent pregnancy as a social problem.

The remaining 31 chapters are country specific. These countries are in different regions of the world: *North America*: United States, Canada; *Central and South America*: Argentina, Chile, Colombia, Costa Rico, Mexico, Nicaragua; *Europe*: France, Germany, Ireland, Netherland, Portugal, United Kingdom, Spain, Sweden, Switzerland; *Central and Eastern Europe*: Russia, Eastern Europe; *Africa*: Indonesia, Nigeria, South Africa, Uganda; *Middle East*: Iraqi, Turkey; *Asia and Pacific*: Australia, India, Japan, Philippines, South Africa, and Vietnam. Taken as a whole, this volume provides a wide-ranging source of information about different and similar issues related to international and country-specific adolescent pregnancy and childbearing.

Finally, both content and style of writing vary among the authors of these chapters. These variations reflect the differences in the authors' style and perspective on adolescent pregnancy. Since these differences in

stylistic approaches among the authors may be useful to the reader, they were retained in their original context, as much as possible.

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An International Perspective on Adolescent Pregnancy

Mary E. Dillon and Andrew L. Cherry

Keywords

Adolescent pregnancy · Contraception · Maternal and child mortality · Moral regulation · Sexual behavior · Sexual and reproductive health · Sexual education · Sexual initiation · Unintended pregnancies · Unsafe abortion

> The conceptions of life and the world, which we call "philosophical" are a product of two factors: one, inherited religious and ethical concepts; the other, the sort of investigation which may be called "scientific." One of the few unifying forces is scientific truthfulness, by which I mean the habit of basing our beliefs upon observations and inferences as impersonal, and as much divested of local and temperamental bias, as is possible for human beings.
>
> (Bertrand Russell, A History of Western Philosophy, 1954, pp. xiii, 836)

Introduction

The purpose of the introductory chapter is to provide an overview of adolescent pregnancy from an international perspective. It is an overview of the response by different countries from around the world to adolescent pregnancy. The methodology used to develop this international perspective started with a survey of the literature that defines the salient issues being studied and addressed by policy-makers, providers, practitioners, and researchers. Then, using scientific studies of adolescent pregnancy conducted in different countries in different regions of the world, responses and outcomes are compared. Based on this process, what becomes evident when examining adolescent pregnancy at the international level is that in the broadest of terms (the biological perspective), girls experience pregnancy and childbirth in much the same way. At the psychosocial level, girls experience pregnancy and childbirth in very different ways.

We use the World Health Organization (WHO) definition of *adolescence* as an age range between 10 and 19 years. We also use the United Nations' categories for the countries that these girls live in. The categories are *developed*, *developing*, and *least developed* countries (See Appendix A for a list of countries identified by the United Nations as *developed, developing*, and *least developed* countries). These national variations in the medical, psychosocial, and public health response to adolescent pregnancy can hopefully educate us and give us a better understanding of the complexities of adolescent pregnancy from a worldview.

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This overview will also highlight issues related to adolescent pregnancy that are important for a comprehensive understanding of why and how the response and concerns vary from country to country and region to region. What will become evident is that issues, which are a major concern in one country, may not be relevant in another. For instance, child marriage and early adolescent childbirth is not a major concern in countries where religion, tradition, and culture support child marriage even when it may be illegal under the constitutional laws of a particular country. As is true in many countries where tradition has a strong influence on family and marriage, girls as young as 13 may be wed. In these countries, the physical and psychosocial development of the girl who marries when they are very young is an issue for policy-makers, medical staff, and health professionals who provide services to adolescents. In these countries, adolescent girls and young women typically lack adequate control over their reproductive decisions. If the teen mother is expected to lower her health burden, she must be educated about the health and psychosocial implication of teen pregnancy and empowered by the state to protect herself and her child's well-being. Having a basic understanding of the primary issues and problems associated with adolescent pregnancy in the context of different countries will provide a background for determining the effectiveness of sexual education, required medical services, support services, and programming that may improve an adolescent's sexual and reproductive health.

Grouping countries by their stage of economic development also has many advantages in a study of adolescent pregnancy and childbirth. For one, some 70 % of teen births around the world are among girl's living in developing countries (UNICEF 2012a). For another, organizing data using standard definitions allow for comparison between studies and replication of studies.

Using this schema, differences in countries categorized among the *least developed countries* may be for trained attendants during delivery and adequate medically based health care. In all countries, adequate health care is associated with better survival rates for mothers and their babies and with fewer complications before, during, and after pregnancy. This is especially needed in countries where early childbirth often results in fistulae and other injuries.

In *developing countries* where health care is more available than in most *least developed* countries, the situation may be quite different. The focus may be on some aspects of providing *adequate* medical and social services to reduce adolescent maternal and child risks. In these countries, the major challenges being addressed are often the ability of the country's public health sector to provide adequate and effective contraception, prenatal and postnatal care, and well-baby programs.

In *developed countries*, issues related to adolescent pregnancy are not typically about limited resources to meet the national challenge of adolescent pregnancy. The debate centers on what sexual and reproductive health services can be provided to adolescents without encouraging higher rates of teen pregnancy. This conundrum over what services will prevent or more realistically reduce adolescent pregnancy is less about effectiveness of specific services and more about being a *hot-button* political and conservative religious issue. In some developed countries, questions about public sexual education and the degree to which contraception should be available to adolescents can quickly turn into a raging debate over how young is too young for a child to begin to receive sexual education and contraception. Furthermore, efforts to appease a public perception that sexual education will increase adolescent sexual experimentation, pregnancy, and childbirth have all but paralyzed the public policy debate in countries such as the United States and the United Kingdom. Corollary issues and emotional debates related to adolescent pregnancy can make it extremely difficult for helping professionals to provide empirically based, pragmatic adolescent sexual and reproductive health services.

The Greatest Risks of Adolescent Pregnancy

The greatest risk for an adolescent mother and her child is the *mother's age*, *delaying or failing to receive prenatal care,* and *the social and political response* to her pregnancy. These are critical issues in all countries, even in developed countries. Albeit, the reasons differ across countries as to why an adolescent was too young at her first birth and why she did not receive prenatal care; the negative birth outcomes are similar. In developed countries such as the United States, when pregnant teens are not using prenatal care, the reasons are *not* related to the lack of available prenatal services; the reasons are more associated with the adolescent's lack of knowledge, and the humiliation girls must deal with before receiving prenatal care. The numbers in the United States are astonishing. Some 85 % of US teen pregnancies are unplanned, and 72 % receive no prenatal care at all (Holgate 2012). This is an irrefutable crisis among US teen moms and their children; a crisis that everyone acknowledges and agrees is a crisis. A crisis that everyone agrees requires a public response. There is also concurrence that the medical costs related to mothers who do not receive prenatal care far exceed the cost of providing prenatal care. Given this level of endorsement, the question is why do so few pregnant teens receive prenatal care? It is not that professionals lack the technology and programming that restrict the level of teen use of prenatal care. There are a number of good options available to increase the use of prenatal care among adolescents. A widespread and visible public campaign in and out of the schools that informs adolescents about the importance of prenatal care to the mother's health and the health of their child would increase utilization. Employing the social media in a public campaign could significantly increase teen use of prenatal care. Knowing that it is possible to increase utilization, the question is why are there no public campaigns to increase use in the United States?

The answer is that teen pregnancy in the United States is framed as a moral issue rather than a medical issue. When teen pregnancy is framed and thought of as a moral issue, public campaigns encouraging teens to start prenatal care early in their pregnancy have the perceived downside of sending an implicit message that US society approves of teen sexual behavior and teen pregnancy. As a moral issue, providing prenatal care is unacceptable despite the collateral damage. The only acceptable programs related to teen pregnancy are those that reduce teen sexuality. If suppression programs were successful, it is true that the total number of girls that need prenatal care would be reduced, but it would not necessarily reduce the percentage of girls who do not receive prenatal care. The unnecessary human toll from a lack of prenatal care would continue.

As logical and cost-effective as these types of *least harm* strategies are, suggesting such programs in countries such as the United States can be wrought with public anxiety and resistance. What is often lost in the discourse is the history of how teen pregnancy has evolved and changed and continues to evolve. A history of adolescent pregnancy that informs and helps explain some of the public and political barriers to scientifically based programming and services is presented below (Catalano et al. 2012).

Brief History of Adolescent Pregnancy

During the earlier 1950s, the problem of teenage pregnancy in the United States became one of the few social issues that virtually everyone could agree on. For all intent and purpose, unwed teenage pregnancy became a symbol of the deteriorating state of national morality. In failed efforts to curb the acknowledged problem, over the years, adolescent pregnancy has been treated as a juvenile justice problem (1920s through the 1950s), as a psychological problem, and as being an epidemic (in the 1980s) that was allegedly on pace to destroy family and the morality of the people of the United States.

The perception of deteriorating moral standards has fueled a public outcry over the number of pregnant unwed teenagers, unwed teen births, and teen abortions. Religious leaders and conservative groups claimed that teenage pregnancy was more than just an individual transgression; teenage pregnancy was also a threat to the very existence of the greater society. Using rhetoric that associated teen pregnancy with a national crisis of morality, it was easy for claims-makers to sway the public. Defined as one more example of the breakdown in the moral fiber of the country, unwed teenage pregnancy became, in the view of the public, a serious problem that required aggressive intervention and effective prevention.

These assumptions about adolescent sexual behavior, however, were based on a construct of motherhood that was designed to serve conservative political and religious purposes rather than to improve the sexual and reproductive health services to adolescent girls of childbearing age (Phoenix and Woollett 1991). Moreover, the scientific literature reveals that adolescent pregnancy is a social construct of reality that describes pregnancy as a problem for the adolescent mother, her child(ren), and the state as the governing political and economic body (Breheny and Stephens 2007).

Historically, when a natural human behavior that may be problematic, such as adolescent pregnancy, is defined as an individual moral transgression that inflicts harm upon the society at large, it can be difficult to implement effective policy and programming to reduce the behavior. This, in part, explains why so many countries have unacceptably high rates of adolescent pregnancy, childbearing, and mortality. As briefly described above, using a failed model based on a vague moral standard to deliver prevention services typically results in ineffective adolescent sexual and reproductive health services, support, and restrictions on the availability of contraception services. Even in light of a decades-long decline in adolescent pregnancy worldwide, much of the professional literature and almost all of the religious and political rhetoric continue to define adolescent pregnancy as a behavioral problem. As will be shown, this is a failed approach that will not serve society or the individual in the twenty-first century.

Consequently, when an assessment of the magnitude and effect of adolescent pregnancy on the individual and community is based on the assumption that unwed sexual behavior is a moral transgression (especially among adolescents), it is impossible to identify and develop programming to improve the sexual and reproductive health of adolescent girls, boys, and women of childbearing age. Among many examples, adolescents in the United States are at a high risk for sexually transmitted infections (STIs)—including HIV and AIDS—and other sexually related problems, in large part, because national sexual education policy does not require pragmatic and accurate sexual education be taught in the schools (Cherry et al. 2009).

Not surprisingly, based on the level of risk, US adolescents have some of the highest rates of STIs, pregnancy, childbirth, and abortion among all developed and many developing nations. For instance, well known for decades, untreated STIs can lead to serious long-term health consequences. In the United States, the Center for Disease Control (CDC) estimates that undiagnosed and untreated STIs cause at least 24,000 women each year to become infertile (CDC 2008). By 2010, the CDC reported that young people in the United States between 15 and 24 years of age, who made up only 25 % of the sexually experienced population, account for nearly 50 % or 10 million new STI cases yearly. The CDC also reported that 40 % of adolescent girls who admit having sex also reported having had a sexually transmitted disease. Most adolescent health experts point out that these numbers could be effectively decreased with better sexual education in the schools. As it stands, the CDC reported in 2012 that about half of all new HIV infections in the United States occurred among teenagers (Neergaard 2012).

As adolescent pregnancy began to decline in the 1990s, the narrative changed and became a debate over using a liberal or conservative model to prevent teenage pregnancy. Cordial and sincere at first, the tone of the debate began

to change when the scientific evidence mounted in favor of *least harm* approaches (least harm models are considered liberal programs by many conservatives). In defense of traditional morality, teen pregnancy was again reframed and in the twenty-first century has evolved into another proxy in the cultural wars.

Moral Regulation and Adolescent Pregnancy

One of the mechanisms that contribute to the variation in international adolescent pregnancy rates is social policy that promotes an ideology of moral regulations. Using these types of social policy, conservative politicians and policy-makers hope that moral regulation can influence adolescent choices regarding sexual behavior, childbirth, and abortion. Within conservative groups, the assumption (although not often articulated as such) is that the state can be the instrument to create a moral citizenry using *social steering* (Cunningham-Burley and Jamieson 2004). Too often however, in the case of adolescents, the consequences of moral regulation are an increase in unintended adolescent pregnancies and abortions. This is supported by the differences in adolescent pregnancy, childbirth, and abortion rates in the developed countries. The United States and the United Kingdom have the highest adolescent pregnancy rates among all developed countries. Compared to other developed nations such as Sweden, Germany, and Canada, the United States and the United Kingdom have adolescent pregnancy and abortion rates that are more in line with developing countries than other developed countries.

Social steering, the mechanism described here, can be formulated from any ideology, liberal or conservative. It can be loosely defined as, "action through which a social actor or social system is moved from one position to another by the intentional decisions of a political authority" (Cunningham-Burley and Jamieson 2004). Primarily used to explain the intervention of a welfare state, social steering is the mechanism that is employed with all political or economic ideological doctrine to cause change or support public norms and beliefs. Typically, when a specific ideology is being promoted by social steering, it is based on a set of assumptions benefiting one group or class of people (most often a dominant group) over all people within their community. The purpose of social steering is to influence social and family life in one direction or the other. The concern about the use of social steering to promote a specific ideology is often called *life politics.* In the case of adolescent pregnancy, the concern is over the impact of private decisions made by adolescent girls (i.e., decisions related to sexuality, moral behavior, and social and family obligations) on the greater public good.

The belief system that provides the moral foundation and direction, which differs from nation to nation, typically has its roots in the state religion or de facto state religion. These religious dogmas have both a direct and an indirect effect on the lives and sexual developmental experience of adolescents.

Religiosity and Adolescent Pregnancy

Religiosity, which has been proposed as instrumental in delaying adolescents initiating sexual intercourse, has been found to be negatively associated with contraceptive use (Kirby 2007). In one study of sexually active adolescents from the United States, greater family religiosity was associated with lower contraceptive consistency and unrelated to the number of sexual partners (Manlove et al. 2008). Similarly, in other international studies, girls from high moral traditionalism were associated with a lower likelihood of using condoms at first sex (Štulhofer et al. 2007). A lack of accurate or blunt sexual education around safer sexual practices among preadolescents and adolescents from decidedly religious families is an important contributing factor to unsafe sexual behavior.

Although the debate endures, constructive change has been slow. Under the prevailing patriarchal dominated social system, policies that attempt to control the sexual and reproductive

activity of girls and young women are still viewed as promoting the best interest of the social order and the state (Stephens 2003). In this context, adolescent sexuality will continue to be one of the most important health issues that challenge society and the helping professionals in the twenty-first century. Parenthetically, this unnecessary health burden created and levied on adolescents and their children comes full circle in that everyone in society pays. Making decisions about the types and quantity of care and who receives services based on a moral model that enforces, sanctions, and punishes those who break the rules (an approach to adolescent sexuality that has prevailed for better than a century in the United States) has been tried and does not reduce risk associated with adolescent pregnancy. This seems especially true with using deterrent models that criminalize sexual behavior. In China, an extreme case, draconian laws forbidding more than one child per family may have been effective in slowing population growth, but the laws criminalize women who tried to have a second child. Perhaps not as well documented, this is not an isolated example of punishing pregnancy. Girls in most countries who become pregnant are treated like juvenile delinquents or criminals. In the first half of the twentieth century, adolescent girls in the United States who became pregnant out of wedlock were often sent to reform school until they were 21 years of age. In Europe, girls who became pregnant after being raped and then refusing to marry the rapist could be sent to reform school until the age of legal adulthood. Given this historical background and the reality that it is unrealistic to prevent a biological imperative like teen sexual behavior, models incorporating a *least harm* approach seem to be a logical option, if, in fact, the goal of the intervention is to reduce harm associated with adolescent pregnancy.

Complexity of Adolescent Pregnancy

Based on a scientific health construct, teenage girls participating in sexual behavior could not be diagnosed as having a psychiatric disorder or psychological problem. Instead, based on a scientific paradigm, teenage sexual behavior is viewed as a natural, albeit a complex phenomenon that is many faceted and exists within a prevailing culture.

Culture can be understood as a social structure (specific to a likeminded group of people) composed of survival strategies, religious decrees, traditions, customs, rituals, and human nature. Culture continues to evolve as process that manipulates and controls human nature. Culture sets roles, customs, and limits for individuals and groups. One of the major forces that shape a culture's response to adolescent pregnancy is related to age-old conventions related to property rights. In most cultures, women and children were viewed as chattel, as a man's property.

Although the physical and mental stages of development are the same, the pathways to a sexual union differ, expectations for boys and girls differ, and the reaction and response from adults differ. Internationally, these characteristics can be organized into a set of typologies related to the different aspects of adolescent sexuality and pregnancy. Using a formulation of significant characteristics related to adolescent pregnancy, and the tendency of these characteristics to cluster within given countries and regions, specific clusters can be used to define common types. In this case, these typologies represent different adolescent health nexuses of national tradition, religion, and political dominance.

These typologies (or similar national responses) are important to social scientists because they are categorically different. As a rule, studying unique differences in response to a comparable stimulus, or a perceived problem, increases our understanding of the response and the context in which the stimulus occurs. Helping professionals—and the public—need to know that we have learned a great deal from these comparisons and studies about adolescent sexuality and pregnancy since the 1950s, when the primary concern was over "unwed" adolescent mothers not the pregnancy per se or, for that matter, adolescent sexual and reproductive health (Cherry et al. 2001). Particularly in the early 1990s, when moral constructs could not

explain the significant global decline in adolescent pregnancy, parochial assumptions about the cause of teen pregnancy finally began to give way to scientific theory.

Nonetheless, many in the helping professionals, who grew up during a period when terms such as *adolescent pregnancy*, *teenage pregnancy*, and *teen moms* were commonplace, do not realize that these terms were not used in the United States or other countries until the late 1960s and early 1970s (Vinovskis 1988, 1992). Furthermore, these professionals, during their university training, were not prepared to work in a global environment where 50 % of people in the world are under 25 years of age, where there are one billion adolescents 10–19 years of age, and where 70 % live in developing and the least developed countries (Hindin et al. 2009). It is a world where 82 million girls (70,000 a day) between 10 and 17 years of age marry before they reach their 18th birthday (UNFPA 2003). It is a world in which 16 million girls between the ages of 15 and 19 become pregnant each year accounting for 11 % of global births. It is a world in which 95 % of all children born to adolescent girls are born in the developing and least developed countries. Consequently, inadequate prenatal care and postnatal care in these countries and communities make pregnancy and childbearing the leading cause of death and disability among adolescent girls and their children (UNICEF 2012b).

In contrast and as another example of the complexity of adolescent sexuality in the United States, prenatal care and postnatal care are available to all girls despite the ability to pay. Nevertheless, girls in the United States living in economically struggling families and communities (like girls living in relative poverty almost everywhere in the world) have the highest rates of pregnancy, childbirth, and fertility in the United States.

The complexity and simplicity of adolescent sexual behavior, pregnancy, and childbearing became more understandable when the increase in adolescent pregnancy in the 1970s was followed by a decrease in international adolescent pregnancy that occurred between the late 1970s and the 1990s. This astonishing rise and fall of teen pregnancy rates caught everyone, both professionals and the public, off guard and with no explanation. The complexity was revealed by the breath of the variations in the problems and negative outcomes associated with adolescent sexuality. The simplicity was in the biological mechanisms associated with adolescent pregnancy. These biological mechanisms are global and cut across nations, races, economics, social status, and moral convictions. These are the physical complications related to the girl's age and level of maturity when she becomes pregnant and tries to carry the birth to full term. The younger the girl is when she becomes pregnant, the greater the likelihood that she will experience complications during her pregnancy and delivery (WHO 2008). When the biological complications are removed from the amalgam or list of adolescent pregnancy and childbearing problems, the remaining attendant problems are caused by social mechanisms. Examining the social context in which girls become pregnant, that is the differential influence of poverty, tradition, culture, religion, and the political agenda on adolescent fertility, results in underscoring many of the grave social consequences of these differential influences.

The question then is what combination or combinations of tradition, culture, religion, and the political environment explain why half of all adolescent births occur in just seven countries: Bangladesh, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Nigeria, and the United States (Population Division 2009)? Before examining adolescent pregnancy in different countries, a global survey describing adolescent pregnancy and related issues will help put the various national responses in perspective.

Global Statistics on Adolescent Sexual Behavior

The universal concern over adolescent pregnancy and childbirth is warranted not because of moral issues but because of the need for sexual

and reproductive health services required to meet the educational and health needs of adolescents (almost 20 % of the world's population). In 2012, the world population reached seven billion people. Of that number, over three billion people were younger than 25 years of age. Adolescents (10–19 years of age) accounted for about 18 % (1.2 billion) of the world's population. That makes this the largest generation of young people to ever populate the earth. Moreover, the effect of this younger generation is global. Even so, the influence adolescents are able to exercise in a given country fluctuates, in part, because the percentages of adolescents vary from country to country. The percentage of the youth population by country runs from a low of 9 % in Spain to a high of 25 % in Uganda. In the United States, adolescents make up about 14 % of the population.

The level of attention paid to young people and their development is important, since, in this generation of young people, one of the most important preventable risks for a girl will continue to be related to her sexuality. Furthermore, adolescent pregnancy and childbearing will be a serious health threat in countries, for example, such as the United States, where teen pregnancy is considered a social problem, where there is a tradition of child marriage, for instance in Nicaragua (22 % married or in unions) and Nigeria (29 % married or in unions), and in the developing and least developed countries where intergenerational poverty persists (ICRW 2012; UNICEF 2011, 2012b).

Globally, in 2012, there were over 260 million girls 15–19 years of age. They accounted for about 11 % of all births worldwide (over 16 million births). These birthrates, however, varied from a low of 4 per 1,000 adolescents in Europe and 36 per 1,000 adolescents in Asia, to a high of 108 per 1,000 adolescents in Africa. What is even more revealing is almost 90 % of adolescent births in the world occur in the *least developed* and *developing* countries. Based on these findings and despite the decline in the overall adolescent birthrate worldwide, childbearing among adolescents is still considered to be too high, especially in some countries in sub-Saharan Africa, Latin America, and the Caribbean.

Adolescent Pregnancy by the Numbers

The statistical picture that follows was developed from the best and most recent statistics available in 2012.

- The number of adolescents who give birth by country can be tremendous. In brief, only about 2 % of adolescents give birth in China, while 18 % of births in Latin America and the Caribbean were to adolescent mothers. In sub-Saharan Africa, adolescents make up 50 % of mothers who give birth.
- Globally, girls aged 15–19 from the lowest socioeconomic groups are three times more likely than their economically better-off peers to give birth in adolescence and have twice as many children.
- Among the 260 million girls aged 15–19, in 2012, some 11 % (30 million) lacked access to effective contraceptive protection.
- Of the 30 million girls who could not access contraception, at least 16 million were married and wanted to delay pregnancy and childbirth; some 10 million were unmarried and sexually active; 3 million were both married and unmarried, who use traditional methods.
- The average adolescent birthrate in *developing* countries was more than twice as high as that in *developed* countries, with the rate in *least develop*ed countries being five times as high as in *developed* countries.

Pregnancy Among Very Young Adolescents is a Significant Problem

- In low- and middle-income countries, almost 10 % of girls become mothers by 16 years of age, with the highest rates in sub-Saharan Africa and south-central and Southeastern Asia.

- The proportion of women who become pregnant before 15 years of age varies enormously even within regions—in sub-Saharan Africa, for example, the rate in Rwanda is 0.3 % versus 12.2 % in Mozambique.

Risks Spectrum among Pregnant Girls

- In Africa, complications of pregnancy and childbirth are the leading cause of death among adolescent girls aged 15–19.
- An estimated 2.2 million adolescents, around 60 % of them girls, are living with HIV, and many do not know they are infected.
- Overall, the levels of correct knowledge about HIV among older adolescents aged 15–19 remain low, with fewer girls having correct knowledge than boys.

Adolescent Pregnancy Poses a Danger for the Mother

- Although adolescents aged 10–19 years account for 11 % of all births worldwide, they account for 23 % of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth.
- Fourteen percent (14 %) of all unsafe abortions in *least developed* and *developing* countries are among girls aged 15–19 years.
- Roughly 2.5 affected by complications from unsafe abortion than are older women.
- In Latin America, the risk of maternal death is four times higher among adolescents younger than 16 years than among women in their twenties.
- Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. Some of these are anemia, malaria, STIs (including HIV), postpartum hemorrhaging, and mental disorders such as dysthymia and depression.
- As many as 65 % of all cases of obstetric fistula occur during adolescent childbearing and result in dire consequences for the girl's lives, physically and socially.

Adolescent Pregnancy can be Dangerous for the Infant

- Globally, stillbirths and infant death in the first week of life are 50 % higher among babies born to mothers 10–19 years of age than babies born to mothers 20–29 years of age.
- Deaths during the first month of life are 50–100 % more frequent if the mother is an adolescent versus older mothers; the younger the mother, the higher the risk.
- The rates of preterm birth, low birth weight birth, and asphyxia are higher among the children of adolescents. All of which increase the chances of death or a future of avoidable health problems for the baby.
- Pregnant girls are more likely to smoke and use alcohol than are older women, which can cause many problems for the child during gestation and after the birth.

Adolescent Pregnancy Adversely Affects Communities

- In many countries and communities, girls who become pregnant are forced to leave school. This has long-term implications for them as individuals, their families, and communities.
- Studies have shown that delaying adolescent births could significantly lower population growth rates, potentially generating broad economic and social benefits, in addition to improving the health of adolescent mothers and their babies.

Progress to Date

- Rates of adolescent childbearing have dropped significantly in most countries and regions of the world since the 1990s.
- Age at first marriage is increasing in many countries, as are rates of contraceptive use both among married and unmarried adolescents.
- Educational levels for girls have risen in most countries, and job opportunities have expanded.

Higher education levels are closely associated with later childbearing and improved economic circumstances.

The Stage of Life Known as Adolescence

The early emotional and physical foundation of *sexuality* is a confluent state that evolves into human maturation. Sexual maturation must be nurtured and supported by the community. What can be too often lost in a pragmatic discussion or heated debate about adolescent pregnancy is that it occurs during the appropriate stage of human development. Furthermore, the females and males being characterized using adult terminology are still girls and boys. The word *girl* is used instead of *female* as a way of reminding readers that these girls, even pregnant, are still very young and immature. They have little experience and power with which to negotiate the adult world. Adolescence is an essential period of biopsychosocial maturation. This includes both physical and psychosocial sexual development. Adolescence is a time in human development when one is no longer considered a child but too young to be considered an adult; it is a period of transition.

Adolescence is also an important period in one's life where we learn to accommodate relationships. This is a period when the need for relationships and the need of individualism find a balance that promotes health, family, and career. This is also a period, by the design of nature, that young people become sexually aware and active. This is a normal and appropriate set of behaviors and physical discoveries about one's body in adolescence. Consequently, becoming sexually active (given age-appropriate knowledge and relationship skills) can be one of the most positive experiences in the adolescent's life. Under normal circumstances, it can lead to rewarding romantic and loving relationships, and a healthy adult life.

The adolescent experience, however, is not universal. Mead (1948) who contrasted the adolescent experience in the North America with the adolescent experience in the South Pacific was one of the first social scientists to question the universality of the adolescent sexual experience. As has been identified since Mead, there are a number of important issues related to adolescent sexuality that are observable in different countries and regions of the world. These are issues that may be observed to some degree within a country or region but are minor problems or no problem at all in another country. One such issue is sexual education.

Sexual Education

The question that echoes daily in newspapers around the world is how can we keep our children safe. In newspaper stories about child molestation, rape of minors, STIs and HIV/AIDS, the question is always, *what can we do to make our children safer?* The answer is to provide them the tools they need to protect themselves from sexual injury and harm. We cannot protect our children from all harm, but we can protect children from ignorance about their sexuality. In turn, children can use the knowledge about human sexuality to protect themselves and assist adults who want to protect children from harm. Children who understand human sexuality are active participants rather than passive participants in maintaining their sexual and reproductive health and safety. Because of the intrinsic risk of sexual harm to children and adolescents who do not receive comprehensive sexual education, a growing cadre of professionals is asserting that a child's right to this knowledge is a human right. When a class of people (in this case children and adolescents) is being deprived of knowledge that would better protect them from harm, access to that knowledge is a human right. Parents and conservative religious groups do not have an absolute right to deny children this basic human right of sexual knowledge.

Children have a right to truthful and accurate sexual information and education. Access to accurate, age-appropriate sexual information is a child's inalienable right. It is the only way a

child can make informed decisions about the consequences of theirs and others sexually related behaviors.

The need for accurate sexual information and education is of primary importance globally. For instance, international household survey data representative of developing countries collected by UNICEF show that approximately 11 % of girls and 6 % of boys between 15 and 19 years of age report that their first sexual experience occurred before they turned 15 years of age (UNICEF 2011). Providing accurate sexual and reproductive health education and services to young children before their first sexual experience can reduce sexual exploitation, STIs (including HIV/AIDS), abortions, and childbirth in early adolescence. Considering that an adolescent's level of sexual knowledge is predictive of their sexual health; considering that a sizable number of children become involved in sexual behavior during early adolescence; considering that girls are more likely to have engaged in early sexual behavior than boys; and considering that girls are less likely to use contraception—is it any wonder that sexual education is the only viable health intervention that has been effective in reducing the consequences of early sexual behavior in adolescents.

The concept that age-appropriate and accurate sexual education has to be the centerpiece of any program to improve adolescent health is not in dispute. What is hotly debated in many countries particularly in the United States are questions of when and what? When framed primarily as an effort to prevent teen pregnancy, such as in the United States, the consequences of the prevention efforts result in increases in sexually transmitted disease, pregnancy, and abortions. Approaching the task of providing sexual education from a justice perspective is different. The reasoning for providing accurate age-graded sexual information, from a justice perspective, is because it is an inalienable right of all people even children and adolescents to have accurate information about their sexual and reproductive health. The state has no right to withhold or conspire to withhold essential information that is needed by its people. In terms of human sexuality, the state's role is to ensure that each person receives age-appropriate human sexual education. This does not exclude the influence of family, parents, or the religious community. Parents and peers are very influential on adolescent sexual behavior. Religion can also be significant in delaying sexual initiation, but when religious ideology prevents the dissemination of accurate sexual education, religious ideology is also associated with a failure to use a condom at first sexual intercourse. Furthermore, efforts to appease a segment of the public still convinced that sexual education is inappropriate for children and will increase adolescent sexual experimentation, which results in condemning children to the very future that these public protesters want to prevent.

An example of this conundrum has been portrayed using the experience of implementing sexual education in the United States. In her account, Irvine (2004) provides a retrospective study of the history of the wars over sex education and the impact of the politics of sexual speech in the United States. Observing the clash as a struggle between professional sexual educators/advocates and the politicized Christian Right, this narrative explains the critical function that sexual speech plays in how public sexual education is delivered in the United States. Exploiting public fear about sexual education that emerged during the 1960s, Irvine followed the Christian Right whose leaders chose sex education as one of their first battlegrounds to regulate sexual morality. Strategically correct, they believed that by controlling sexual speech, they could control public sexual education and public belief on morality. This gave the leaders of the Christian Right tremendous financial and political power.

In retrospect, it is even more comprehensible. When extremists use sexual shame and fear to galvanize opposition to sex education, namely by framing sex education as radical, dangerous, and immoral, a climate was created where it was

and still is hazardous to advocate for explicit sexuality education. The results in 2012—antagonists continued to paralyze sexual education in public and private schools in the United States. Even in the face of national public support for sexual education, sex education is framed as dangerous and immoral and usurps family prerogative.

This is especially tragic in the United States and other countries where public sexuality education has been restricted, distorted, or prohibited. Even though some continue to question the contribution made by comprehensive sex education, cumulative research since the 1970s consistently demonstrated that comprehensive sex education programs are far more effective at reducing the initiation of sexual activity, STIs, and teen pregnancy than *abstinence-only* educational approaches (Kohler et al. 2008).

There is also little doubt both scientifically and logically that restricting, distorting, or prohibiting sexuality education increases adolescent pregnancy. Every survey, study, and examination conclude that factors associated with higher teen pregnancy and abortion rates in the United States when compared to countries with low adolescent pregnancy are related to the national approach to sexual education. In countries where sexual education focuses on the rights and responsibilities of adolescents who experiment or become sexually active, increases adolescent knowledge and access to contraceptives, and employs mass media campaigns to reinforce appropriate sexual development and behavior, early sexual initiation, STIs, pregnancy, and abortion are less than in countries who use morality-based educational approaches *such as abstinence-only* (Moore 2000). In a study by Weaver et al. (2005), the link between school sex education policy and adolescent sexual health in Australia, France, the United States, and the Netherlands was compared. Comprehensive sex education was identified as one of the key determinants contributing to the positive sexual health outcomes of young people in Australia, France, and the Netherlands.

When comparing sexuality education in the Netherlands and the United States, the evidence is overwhelming and irrefutable. By their own admission, although "sexual education is not perfect" in the Netherlands, their approach to sexual education is regarded as a positive, rights-based approach to adolescent sexuality and sexual health. Starting from the premise that children are naturally curious about sex and sexuality, and that they need, want, and have a right to accurate and comprehensive information about sexual health, the materials used in the educational programs in the Netherlands are clear, direct, and use age-appropriate language and are presented in attractive layouts.

In the Netherland model, safe sex is the focus. The sexuality curriculum is designed to provide children and adolescents the knowledge needed to protect themselves from STIs, HIV/AIDS, and pregnancy. Responsible sexual behavior is emphasized through the reoccurring message that if one decides to take part in a sexual act, the preadolescent and adolescent will know how to do so safely. Their age-graded sexual education provides information about safe and unsafe sex, different types of contraceptives, where to obtain contraceptives, how to use them correctly, and how to negotiate contraceptive use with their partner.

Sexuality education in the Netherlands helps and encourages preadolescent and adolescents to think critically about their sexual health, including their sexual desires and urges. Materials used in Dutch programs encourage both boys and girls to develop skills in communicating their sexual desires to their boyfriend or girlfriend whether they decide to continue to remain abstinent or become sexually active. Skills include appropriate assertiveness, the ability to discuss personal values, and the ability to establish personal boundaries (Fergusona et al. 2008). The results—the Netherlands has one of the lowest rates of adolescent pregnancy and one of the highest rates of contraceptive use among adolescents globally.

Sexual Education in Early Childhood

How young is too young to begin sexual education? This is an honest question given our historical context and the lack of sexual education in the lives of most people. The answer is that sexual development begins at birth and continues throughout life. Sexual education needs to be aligned with a child's sexual development. Just like we teach and educate our child from the time of their birth, the individual behaviors and skills needed to prosper and succeed in life; we need to educate children about their bodies and about behaviors that are appropriate and emotionally fulfilling from inappropriate behaviors that could be harmful.

Parents ask why do children need to know about sex? The reasoned response is that children need sexual knowledge to able to protect themselves from adults in a highly sexualized global culture. Even the casual observer is aware of the threat to children because of their sexual immaturity, lack of knowledge about the subtlety of sexual assault, and the risks of STIs. In the mind of many who oppose sexual education for children, particularly sexual education for very young children, many who believe and in many cultures, the tradition is that young children do not need to know about sexuality until they start puberty. The reality is, however, that data from studies and surveys from around the world show that children are vulnerable to a broad range of sexually related battering, for example, early sexual debut, unwanted pregnancies, unsafe abortion, pregnancy-related complications, STIs (including HIV/AIDS), and numerous other sexually related health problems.

The other question that parents and laymen often ask is: Why do governmental bureaucrats want to sexualize children? The answer comes from the government's effort to identify and implement public policy. When the government [franchise—mandate] is grounded in the principle of *the common good*, the policies that best meet these principles are those that are theoretically implemented. Governing philosophy, based on the principle of *the common good,* that drives the provision of public health and social services related to sexual and reproduction health is the concept that public policy should provide the best possible sexual and reproductive health for as many people as possible. Furthermore, individuals should have equal opportunities that include the rights and conditions needed to access health services and the right to make decisions about their own bodies, and government policies should promote and foster positive attitudes about individual sexuality.

One of the better examples of the actualization of government policy to promote positive individual sexuality is Sweden. Sexual education in Sweden has a long and rich history. Without sounding too naive, most citizens share the same common belief in the value of "high quality information and comprehensive sexuality education as a way of equipping children and adolescents with the attitudes, knowledge and skills they need to make informed choices now and in the future; enhance their independence and self-esteem; and help them to experience their sexuality and relationships as positive and pleasurable" (IPPF European Network 2007).

Elise Ottesen-Jensen, in 1933, was one of the primary architects and founders of the Swedish Association for Sexual Education. This organization played a major role in reforming contraception and abortion laws, and introducing sexual education in the public schools in Sweden. Voluntary sexuality education in elementary schools was started in 1942. The first official teachers' manual for sexual education instruction was published in 1945 and revised approximately every 10 years. In 1954, a sexual education lesson was aired on the radio for the first time. In 1955, Sweden became the first country in Europe to establish compulsory sexuality education in all of its public schools (Parker et al. 2009).

The most recent Swedish policy guaranteeing the right to effective sexual reproductive health services is delineated in Sweden's International Policy on sexual and reproductive health (2006).

This policy gives women and girls the right to shape society and control their own bodies and sexual lives. Sweden's International Policy on sexual and reproductive health and rights in addition to guaranteeing "high-quality information and comprehensive sexuality education" for all children also guarantee safe and legal abortions, and education, prevention, and treatment services related to STIs and HIV/AIDS (Ministry for Foreign Affair-Sweden 2006). This is a comprehensive model based on health science. It has been articulated in more detail in the Swedish Education Act of 2011. The education curriculum is grounded in the principles laid out in previous Swedish policy related to compulsory sexual education and is in compliance with the *UN Convention on the Rights of the Child* (Committee on the Rights of the Child 2011).

For the government to protect the legal rights of girls, high-quality information and comprehensive sexuality education have to begin when the child's education begins. To protect the legal rights of girls, it also means using age-appropriate comprehensive sexual education materials. Obviously, this implies that the educational materials used for all children and adolescent sexual education must be empirically tested and selected for their demonstrated positive impact (Card and Benner 2008).

There are also time-tested sexual education materials available in the United States designed for very young children. These materials have been produced not by organizations or by government but by individuals who view sexual development and sexuality as a positive and natural part of life. It is a part of life that nourishes our need for intimacy and helps realize our drive for human bonding. To realize one's sexual potential and health in a responsible way, accurate knowledge is a prerequisite. An example of one such child's book is: *Mommy Laid An Egg! or Where Do Babies Come From?* written and illustrated by Babette Cole, which is published in 1996 by Chronicle Books. The author won the Los Angeles Parent Magazine Book Award for its non-sentimental look at childbirth from a child's perspective. The story begins with the parents sitting down with their children and telling them old wives' tales about where babies come from, "You can make them out of gingerbread," and "Sometimes you just find them under rocks." Amused at their parents' lack of knowledge, the children tell the story of where babies come from using child-like illustrations that appeal to very young children.

A similar children's book was written by Peter Mayle and illustrated by Arthur Robins called, Where Did I Come From? It was published by Little Brown & Company in 1984. Although it may be a bit old-fashioned for some, in this children's book the "facts of life" are explained in a humorous and matter-of-fact way. The author uses the correct names for the body parts and accurately describes intercourse, pregnancy, and childbirth. On the other hand, euphemisms that entertain very young children such as sperm dressed up in tuxedos and orgasm as a big sneeze make it entertaining and funny to very young children.

Model Sexual Education Curricular

The two most unique characteristics related to adolescent pregnancy in the United States are Federal policy and programs to exclusively fund *abstinence-only* sexual education, and the highest rate of adolescent pregnancy in the developed world (HHS 2006). A program called Smart Moves endorsed by the Boys and Girls Clubs of America (http://www.bgca.org) promotes a curriculum that operationalizes the *abstinence-only* sexual education goals. The program is designed for children between the ages of 6 and 15. The intended goals are to help children develop self-awareness, decision-making, and interpersonal skills and to help preteens identify and resist peer, social, and media pressures to use drugs and become sexually involved. The goal for teenagers is to help them develop social resistance, assertiveness, problem-solving skills, and decision-making skills. As might be expected, these goals are difficult to accomplish when accurate and comprehensive sexual knowledge is excluded from the curricular (Roth et al. 1998). A student in a masters-level social work research

class described one such example. She taught sexual education to seventh graders (11- and 12-year-old students). Because the teachers did not want to say words, such as "oral, anal, and vaginal sex," to "such young children," they present to the student the following list of words (Personal Communication, July, 3, 2012).

Mucous membranes	Bodily fluids
Vagina	Blood
Anus	Vaginal fluids
Mouth	Breast milk
Eyes	Semen
Nose	
Ears	
Penis	

The seventh graders are told that if any one of the mucous membranes comes in contact with the bodily fluids, disease can be spread. For the purpose of the sexual education class, the seventh graders are told that when mucus membranes come into contact with bodily fluids, it is described as being "sex." The students are asked, "Is there just one way of having sex?" The answer should be "No!" The teachers emphasize and reiterate that there are multiple actions that qualify as sex. Fortunately or unfortunately, in the United States, most 11- and 12-year-old children have learned enough about sexual behavior from peers, television, and the Internet to know that what they are learning in the sexual education classes has little or nothing to do with reality. This is sexual education in name only.

Despite the conspicuous importance of *abstinence-only* sexual education in the United States, there are curriculums available that are more in line with public health models and goals of sexual education that is in compliance with the *United Nations Convention on the Rights of the Child* and the *European Convention on Human Rights*. Curriculum and activities based on these conventions promote sexual and reproductive health for toddlers, children, and adolescents through their secondary education. The curricular is guided by the sciences with almost no deference to religious pushback. In the United States, one of the non-governmental organizations that advocates for the right of all children to accurate and comprehensive sexual education and sexual health services is Sexuality Information and Education Council of the United States (SIECUS) (http://www.siecus.org/pubs/guidelines/guidelines.pdf). This organization offers curriculum that is suitable for most parents in the United States even though in many states the departments of education would find the curricular offensive, if not "erotic." Nonetheless, it is far better than the typical state approved sexual education curricular currently being used in the United States.

SIECUS curricular for preschool sexual education is comprehensive and age appropriate. When the only goal of sexual education is to provide the knowledge and skills needed to help each child develop as normally as possible in all areas of life, there is a great deal of agreement. The SIECUS curricular is based on *best practices* in sexual education of preschoolers. It is similar to one of the better models for a preschool sexual education curriculum, the Swedish model (Edgardh 2002).

The underlying assumption is that by "providing education that gives knowledge and promotes a child's self-esteem, the child will be able to understand his or her own will and desires, and have the ability to say 'yes' or 'no' in sexual matters" (Centerwall 1996). Starting with the knowledge that every child is an individual and intrinsically different, this type of sexuality curriculum focuses on four broad areas:

1. Providing accurate and appropriate information about sexuality,
2. Giving students opportunities to develop their attitudes, values, and beliefs about sexuality,
3. Helping students develop relationships and interpersonal skills, and
4. Providing student's instruction and practice in developing personal and sexual responsibility.

A list of issues that need to be covered in a comprehensive sexual education curricular can be found in Appendix D at the end of this chapter.

Sexual education guidelines for preschoolers (ages 1–5) start with the knowledge that toddlers are more interested in pregnancy and babies than the act of sex. Consequently, toddlers should have age-appropriate general knowledge about "where babies come from." They should be able to name all the body parts including the genitals. By the age of two, children should know the difference between male and female, know the correct body part names for the male and female genitals, and be able to distinguish males from females. Between two and five years of age, children should understand the basics of reproduction (i.e., a man and a woman make a baby together and the baby grows in the woman's uterus). Children should understand privacy issues about their own bodies and know that while other people can touch them in some ways, people cannot and should not touch them in other ways. Moreover, the child should be empowered to demand that inappropriate touch be stopped and to report inappropriate touch to parent(s) and authority figures.

Between six and eight years of age, children should be able to identify sexual harassment and abuse. They should have a basic understanding that some people are heterosexual, homosexual, and bisexual. They should also know what the role is in sexuality in relationships. Children should know about the basic social conventions of privacy, nudity, and respect for others in relationships. Children should be taught the basics about puberty toward the end of this age span. This includes the role of sexual intercourse. As the statistics verify, many children will experience some pubertal development before age 10 and some will be involved in sexual activities that lead to an unwanted pregnancy and exposure to STIs.

Between the ages of nine and 12, children need to be taught about safer sex methods and know how emergency contraception works. They need to understand what makes a positive relationship and what makes for an unhealthy relationship. By 12 years of age, preteens need to be able to determine whether depictions of sex and sexuality in the media are true or false, and realistic or not, and whether the depictions are positive or negative.

Sexual education for adolescents between 13 and 18 years of age needs to continue to provide adolescents with accurate information about sexuality; to develop and clarify their attitudes, values, and beliefs about sexuality; to continue to help students develop relationships and interpersonal skills; and to provide students instruction and practice developing personal and sexual responsibility.

Having accurate knowledge about sexuality and acting responsibly in sexual matters is the best way to protect oneself from STIs; for girls, sexual knowledge is necessary to prevent unwanted pregnancy and unsafe abortion as the first step. Another critical issue for children is the availability and access to contraception.

The Contraception Controversy

Without the sexual knowledge from accurate information about human sexuality that prepares the adolescent to manage the hazards, they do not know the risks of unprotected sex and the benefit of using condoms during their first and subsequent sexual intercourse (including anal and vaginal intercourse). Even with the knowledge that forearms the adolescent, knowledge that ensures the adolescent understands how to protect themselves, if contraception such as male condoms and females condoms are unavailable or difficult for adolescents to obtain, adolescents will still be unable to protect themselves. Knowledge about and availability of contraception is the only way we can keep our children safe. Knowledge without the tools needed to use the information, however, has the same effect and eventual outcome as not having the knowledge in the first place. Both sexual education and the availability of all forms of contraception, including safe unrestricted abortion, are essential if the rate of adolescent STIs and unintended adolescent pregnancy is to be decreased and eventually becomes a rarity.

The United States is a case study of the failure to require truthful and national sexual education and to provide preadolescents and adolescents unrestricted access to contraception. While its people's wealth and prosperity may be unmatched, and while its university educational infrastructure and military are second to none, the stunning absurdity of many of its political, religious, and social leaders in meeting the basic human needs of its poor and disenfranchised is perplexing. This moral venality is unmistakably reflected in the way states in the United States and federal authorities respond to the need for effective sexual education policy and the provision of contraception to preadolescents and adolescents.

After spending billions of dollars in the United States on sexual education limited to abstinence-only educational programming, the scientific evidence that shows the abject failure of abstinence-only education is undeniable. Abstinence-only programs have been associated with increases in the negative effect on sexual behavior, contraceptive use, the rate of STIs, and the number of young people engaging in high-risk sexual behaviors (Hindin et al. 2009).

The Virginity Pledge: One of the interventions used in abstinence-only programming that has been studied extensively is the *virginity pledge*. Over the years, researchers report mixed outcomes for adolescents making a virginity pledge. Reported findings show no conclusive evidence that virginity pledging delayed sexual initiation among adolescents. The findings did show evidence and confirm that virginity pledges significantly reduced the likelihood of these adolescents using condoms during their first sexual experience (Martino et al. 2008; Rosenbaum 2009).

Adolescents' Use of Contraception

Typically, adolescent use of contraception is low, which increases the risk of adolescent pregnancy. Adolescents are also less likely to use condoms and more likely to have unprotected sex than adults, which increases the risk of contracting STIs. Why the low utilization of contraception? The answer to this is: fundamentally, because adolescent girls have far less access to condoms, contraception, and family planning services than adult women.

Adolescent girls are the most vulnerable; the younger the girl, the more vulnerable she is. Adolescent girls are more likely to engage in unprotected sex and less likely to use condoms and other forms of contraception than boys and adult women. The explanation for the rate of girls participating in risky sexual behavior is principally related to differential power relationships. In too many cultures, adolescent girls have little power and ability to insist that their partners use a condom. STIs among adolescent girls may be the consequence of unprotected sex with a number of short-term partners, but for the most part, globally, STIs occur among girls who are involved with long-term unfaithful partners, often older men and husbands. The risk is often greater for adolescent girls who are in socially and economically marginalized positions, and when sexual activity takes place within a context of coercion or violence, or when involved in survival sex (Dehne and Riedner 2005).

Family Variables and Contraception Use: A broad range of genetic and family variables affect adolescent contraception and condom use. Genetic influences such as early physiological development, early age of menarche, and levels of hormones put girls at risk. Contextual and structural features of families such as parent's education, income, marital status, and sibling composition influence sexual behavior and participation in unprotected sex. Parenting styles and practices including attachment parenting, aware parenting, Christian parenting, concerted cultivation, nurturing parenting, punishment based, and strict parenting influence sexual behavior and participation in risky sexual behavior (Miller et al. 2001).

Poverty and Contraception: Overwhelming evidence, based on international research, implicates poverty as a primary cause of earlier initiation of sexual intercourse and lower use of contraception. Subsequently, while fewer adolescents experience intense and extended

poverty in Western Europe than do adolescents in the United States, fewer Western European youth also grow up under the socioeconomic conditions that are conducive to unintended pregnancy, childbearing, and the use of abortion (Santelli and Schalet 2009).

Predictors of Contraceptive Use: Common variables associated with contraceptive and condom use have been identified across studies of adolescent sexual behavior (Koyamaa et al. 2009). Positive attitudes about condoms, using a condom at first sexual intercourse, talking with one's first sexual partner about using condoms, self-efficacy around condom use, optimism about the future, higher family income, higher education, less frequent sexual experience, and shorter sexual relationships were predictors of condom use (Maria 2007; Hargreaves et al. 2007).

Statistics on Contraception: The unmet need for contraceptives among adolescents is more than twice that of married women (UNFPA 2008). In 2004, only 13 % of sexually active sub-Saharan African girls aged 15–19 used contraception. Only 26 % of adolescent girls in Somalia have heard of HIV/AIDS, and only 1 % knew how to protect themselves against contracting HIV (Zlidar et al. 2003).

STI Prevalence

A sexually active teenager who does not use contraception has a 90 % chance of conceiving over the first year of sexual activity and of contracting a STI (Pregnant Teen Help 2011). In a single act of unprotected sex with an infected partner, teenage girls in England have a 1 % chance of acquiring HIV, 30 % are at risk of getting genital herpes, and 50 % have a chance of contracting gonorrhea and chlamydia (CDC 2009). Chlamydia trachomatis is the leading cause of ectopic pregnancy and can lead to infertility. Chlamydia can also cause discharge and pain, but is usually asymptomatic, so the sufferer may never know they are infected.

Unfortunately, chlamydia rates continue to increase each year in the United States with older teen girls having the highest rates of chlamydia. Between 1989 and 2008, reported chlamydia rates rose from 102 to 401 cases per 100,000 people in the United States (CDC 2009). The CDC, in 2007, reported 1,108,374 total cases of chlamydia. Over 35 % of cases were among children between 10 and 19 years of age. Some 13,629 cases were among children 10–14 years of age, 379,418 cases were among adolescents 15–19 years of age, and young adults 20–24 years of age accounted for 402,595 cases (CDC 2008).

Worldwide, STIs (syphilis, gonorrhea, chlamydia, and trichomoniasis) are the main preventable cause of infertility, particularly among females. In pregnant women with untreated early syphilis, 25 % of pregnancies result in stillbirth and 14 % in neonatal death. Moreover, the incident of curable STIs has increased worldwide from an estimated 333 million cases in 1995 to a yearly number of 448 million cases in 2005 (WHO 2011).

In 2007, adolescents and young people (15–24 years of age) accounted for an estimated 45 % of new HIV infections worldwide. These young people needed to know how to protect themselves from HIV, and they needed the means to do so from birth. Access to sexual education, contraception, and family planning services would reduce the current level of need for testing and counseling related to HIV-infected children and adolescents (UNICEF 2011).

Sexual education and access to condoms are the most effective strategies for reducing STIs, including HIV/AIDS. The problem is that even when sexual education and access to condoms are unrestricted, other cultural and societal characteristics coalesce to discourage sexual education and the use of condoms by adolescents. A major culprit in the calculus to keep our children safe is the attitude of family and society.

The Dutch View on Contraception

An example of a thoughtful philosophy about children and a child's sexuality can be found among the Dutch. One of the primary reasons

that children and adolescents in the Netherlands are more likely to use contraception and to use more effective methods of contraception than US adolescents is that Dutch children have greater access to sexual and reproductive healthcare services because a majority of the Dutch people want children to have access to sexual healthcare services (Santelli and Schalet 2009).

Dutch parents and healthcare providers came to realize that sexual intercourse was a normal part of development for many adolescents. The issue then evolved from prohibition to individual responsibility and healthy relationships. It was a national effort among healthcare providers, policy-makers, educators, and members of the media who lead the normalization of adolescent sexuality. Ensuring that young people had access to reliable contraception by providing different public forums for the discussion of sexuality and relationships was a key element in developing a cadre of supporters (Jones et al. 1986; Ketting and Visser 1994). This normalization of adolescent sexuality and of adolescent contraceptive use in the Netherlands can help point researchers, practitioners, and policy-makers toward steps that should be tried in other countries to reduce some of the problems associated with adolescent sexuality, including unintended pregnancy.

Regardless of public sentiment across all social strata in all countries, girls who have not received accurate and adequate sexual education, specifically adequate information on effective contraception, have higher rates of unintended pregnancy than their peers who have received age-appropriate sexual education. In the developing and the least developed countries, the risk factors include the lack of knowledge about contraception and a lack of access to effective contraception.

Even among girls who wish to postpone pregnancy or delay a second pregnancy, too often have little or no access to contraception. While in developed countries, where effective contraception is available, laws and restrictions (related to the availability of contraception for girls) tend to result in higher adolescent pregnancy, abortion, and childbearing rates than in countries where sexual education and contraceptives are readily available to both girls and boys.

Adolescent Patterns of Sexual Initiation

Sexual initiation is one of the major milestones in human life. In terms of adolescent pregnancy, the issue is early sexual initiation. There is unassailable evidence to show that there is a strong relationship between a girl's "age of sexual initiation" and an "increased risk of serious physical and emotional problems in her and her child's lifetime." Based on this known correlation, there are several assumptions that are used by prevention and educational programs. (1) The earlier the sexual initiation, the greater the likelihood the girl will become pregnant at an earlier age and have more children in her lifetime, (2) the younger the adolescent mother, the more likely the mother and child will experience serious physical and emotional problems including death, and (3) the younger the adolescent mother, the more likely a pregnancy will change the life trajectory of the young adolescent mother and that of her child(ren) (Madkour et al. 2010).

Obviously, this is a short list, but these three consequences account for a majority of the problems associated with adolescent pregnancies and their related physical and emotional problems. What is as important is these correlations are found across countries and regions worldwide. This is where policy and programming come into play. A public policy could reduce the health burden of adolescent pregnancy and should include programs and support for the adolescent and her child(ren). Financial supports and educational programs (sexuality, parenting, etc.) are essential.

The average age of initiation of sexual intercourse has stayed fairly similar in developed nations since the 1950s. Particularly in Europe, the age of sexual initiation has changed little over this time period (Teitler 2002). The

average age is comparable across gender and social status (teens from both rich and poor families) at approximately 17 years of age. Although the age of initiation of sexual intercourse is also roughly 17 in the United States, European adolescents are more likely to use contraception that results in discernibly lower rates of STIs and pregnancy (Santelli et al. 2008). While the overall rates of condom use among teens in the United States and Europe tend to be similar during sexual behavior, the use of a condom at the first sexual intercourse is much lower. Additionally, European adolescent girls tend to start and use hormonal methods for birth control earlier than girls in the United States. For instance, in the Netherlands, 61 % of 15-year-old sexually active girls in 2006/2007 reported using birth control pills at last sex, compared to just 11 % of sexually active 15-year-old girls in the United States. (Santelli and Schalet 2009).

Adolescent Pregnancy Primarily Affects Developing Countries

While adolescent pregnancy affects the girl and her family first and foremost, high rates of adolescent pregnancy also affect developing and least developed countries more than developed countries. In these countries, adolescent pregnancy jeopardizes the health and well-being of both adolescent and adult mothers and their families. An unplanned pregnancy adds an additional burden on these countries' health systems and impedes their socioeconomic development.

The extent of these problems varies and is related to national resources and priorities. When rates of teen pregnancy began to fall in the 1990s, the rates fell worldwide, which included dropping rates in developing countries. Despite this drop, evidence suggests that the problems associated with adolescent pregnancy in developing countries are as serious in 2012 as they have been for decades. In developing and in the least developed countries, maternal and perinatal morbidity and mortality are elevated. This, of course, is a reflection of the prevailing conditions in each country such as the level and extent of poverty, the percentage of people who are malnourished, the degree to which infectious diseases are controlled, and the degree to which adequate and modern health care is provided to pregnant adolescents. The level of available comprehensive sexual health services for children and adolescents affects the rates of maternal and perinatal mortality. Sexual education for children and adolescents, and the degree of availability of modern contraceptives to children and adolescents, coupled with interventions to prevent repeat pregnancies is imperative (Molina et al. 2010).

Unintended Pregnancies

Adolescent girls and women too often become pregnant sooner than they want or when they do not want additional children. These unintended pregnancies are particularly widespread in developing and in the least developed countries. Unintended pregnancies in the Middle East and North Africa are especially troubling. Since the beginning of the twenty-first century, between 15 and 60 % of pregnancies in Middle Eastern and North African countries were estimated to be unintended. In Egypt, contraceptive failure has been reported to account for as much as 30 % of unintended pregnancies (Roudi-Fahimi and Monem 2010).

There are a number of cultural, religious, and economic explanations for these high rates of unintended pregnancies. The lack of access to a preferred contraceptive method or the incorrect uses of a method are major contributors. In other cases, child brides and young women have little or no control of their own fertility. They are often vulnerable to social pressure from their husbands and family members and do not have the power to decide for themselves whether or when to become pregnant (Roudi-Fahimi and Monem 2010).

Early Pregnancy

Pregnancy among very young adolescents is a significant problem in the developing and in the least developed countries. Adolescent problems associated with pregnancy and childbearing are not easily remedied and are associated with physical and emotional immaturity. Girls can become pregnant before their bodies are mature enough to carry and deliver a child. These are realities. The plethora of other problems that make up an almost unending list of negative outcomes among pregnant children and adolescent girls are socially inflicted. The vast majority of harm experienced by these girls is needless and totally uncalled for. The avoidable harm often comes from not developing or withholding age-appropriate medical interventions for young pregnant girls. Even physical complications among young pregnant girls can be minimized if the moral issues are left out of the tertiary prevention calculus. Aruda et al. (2010) suggest that pregnant teens often present at medical facilities with physical complaints not necessarily related to pregnancy. Because prenatal care and postnatal care are critical to positive outcomes for the adolescent mother and her child, medical protocol should include pregnancy screening, diagnosis, assessment, and referral if needed.

Rapid Repeat Pregnancy in Adolescence

Rapid repeat pregnancy is defined as a subsequent pregnancy within 24 months of the previous pregnancy outcome. In developed countries, the numbers of repeat pregnancies for an adolescent are typically low, but in developing and in the least developed countries, the numbers are much higher. These repeat pregnancies among adolescents contribute to poor health outcomes for both the mother and her children. Consequently, preventing repeated pregnancies is one of the goals of virtually all pregnancy prevention programs.

Based on a series of studies, researchers report findings that repeat adolescent pregnancies for the most part were unwanted. Nevertheless, a repeat pregnancy resulted from the adolescent being pressured to have sex, coerced into not using birth control, being unable to implement safe sex behaviors, or failing to use contraception because of the intensity of the mood. Interventions reported as effective were strategies that increased the life choices available to girls that improve their social and economic circumstances and sexual education included in appropriate, high-quality sexual and reproductive health services for girls (Milne and Glasier 2008; Herrman 2007).

Child Marriage

In societies and countries where girls in their early teens are given by their parents to be married to older men, child and adolescent pregnancy is not considered a problem. Often, however, these too early pregnancies can result in severe damage to sexual and internal organs (Holgate 2012). Child marriage, defined as marriage before the age of 18, and early marital sexual activity are health risks for child brides and married adolescents. Obstetric complications such as obstetric fistulae, miscarriage, premature births, stillbirth, sexually transmitted diseases, cervical cancer, malaria, and unsafe abortions are associated with early marital sexual behavior. These marriages typically involve older male partners who may have been sexually active for many years and may introduce HIV into the marriage (Nour 2006). In parts of north Nigeria, it is common for girls to marry before the age of 15. Some girls are married as young as 7 years of age. In Niger and Chad, over 70 % of girls are married before the age of 18 (Hindin et al. 2009; UNFPA 2005). Everyday, over 70,000 adolescent girls between 10 and 17 years of age are married and nearly 40,000 give birth each day (UNFPA 2003).

In some of the more conservative Muslim sects in countries such as Nigeria, many continue to practice child marriage even though it is illegal nationwide. Although the practice is approved by religious leaders, one requirement of the marriage is that the husband not engaged

in sexual intercourse before the child bride is physically mature—this directive is not uniformly obeyed. The numbers of clinics that specialize in the treatment for obstetric fistulae and the number of cases of obstetric fistulae are evidence of widespread too early marital sexual activity.

In some African tribes, a man pays a bride price to the girl's family in order to marry her; the younger the girl, the higher the bride price. Parents of these prepubescent brides are far too often extremely poor and need the bride price to feed, clothe, educate, and house the rest of the family. These early marriages may also result in the child bride dropping out of school even if she does not become pregnant (Nour 2006).

Within marriage, girls may feel pressure to prove their fertility. They may engage in unprotected sex because they are powerless to demand that their husbands allow them to use contraception or demand that their husbands use a condom. They may fear possible side effects of contraception. They may be misinformed about the risk of pregnancy or STIs. They may not have access to or cannot afford a modern method of contraception. And many girls are more concerned with the safety of contraception and condoms than the safety of an unintended pregnancy (Hindin et al. 2009).

Maternal and Child Mortality Among Adolescents

It has been demonstrated at the local and national level that neonatal and post-neonatal mortalities are rare medical events given modern medical standards of practice (Chen et al. 2008). Given this knowledge, two logical questions are: Why is the mortality rate so high among pregnant and parenting adolescents in the least developed countries? And why do so many girls and their babies die each year? One obvious answer is crass political indifference. We know that fragile family structure, limited long-term resources, and social supports rather than age are the major contributors to poor outcomes of adolescent pregnancy (Ventura et al. 2011). Being a pregnant adolescent, in and of itself, does not place the adolescent in a high-risk group, as long as the adolescent receives adequate prenatal care (Mahfouz et al. 1995). We also know how to eliminate adolescent maternal and child mortality. Surely not a stellar example, but adolescent morbidity and mortality in the United States declined 13 % since the 1980s among young people between 15 and 24 years of age. Improved sexual and reproductive health services for children and adolescents, and the ability of adolescent girls to access modern contraception and abortion services without parental permission helped in reducing both morbidity and mortality (Sells and Blum 1996). The effect of increased restrictions on adolescent access to contraception and safe abortions in the United States that began in the first decade of the twenty-first century is likely to slow progress. In countries such as Nigeria and other developing countries, when policy-makers restrict abortion for moral and religious reasons, ignoring evidence-based approaches, one consequence reported widely in the research is a high rate of unsafe abortions, resulting in death and injury (Okonofua et al. 2009).

Given the current disgraceful state of adolescent sexual and reproductive health services provided in most of the world, the statistics on maternal and child mortality among adolescents are scandalous. International statistics compiled by the Reproductive Health Response in Crisis organization make the case for this indictment.

- The birthrate for girls 15–19 years of age in the least developed countries is 116 per 1,000 women versus 37 per 1,000 women for developed countries and 53 per 1,000 women for the world.
- Every year, 14 million adolescent girls between 15 and 19 years of age give birth without the assistance of a skilled birth attendant.
- Complications from pregnancy and childbirth are the two leading causes of death for 15–19-year-old girls worldwide.
- More than one million infants and approximately 70,000 of their adolescent mothers die each year in developing countries.

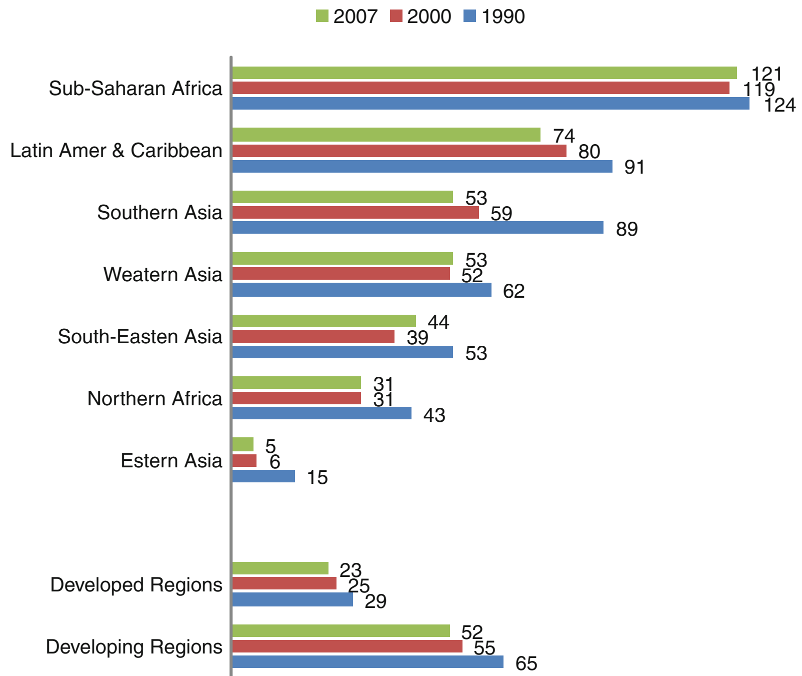

Fig. 1 Adolescent (15-19 years of age) pregnancies per thousand 1990–2007 by regions of the world. *Source* United Nations (2010a)

- Adolescents account for 23 % of the overall burden of disease due to pregnancy and childbirth.
- Maternal mortality was found to be twice as high for women aged 15–19 years and five times higher for girls aged 10–14 years compared to women aged 20–29 years (RHRC 2010).

Unsafe Abortion Among Adolescents

One consequence of restrictive law related to access to abortion is a high rate of unsafe abortions resulting in death and injury. A survey conducted by Okonofua et al. (2009) revealed that politicians and policy-makers were guided by moral and religious forces not evidence-based approaches. Again, international statistics reveal the consequences of misguided policy-makers. An estimated 19–20 million unsafe abortions take place every year, 97 % of these are in developing countries in Africa and South America. Of these, approximately 4 million are performed on adolescent girls under 20 years of age (RHRC 2010). Of this number, an estimated 2.5 million unsafe abortions performed on adolescents took place in developing countries. Of the unsafe abortions that involve adolescents, most were conducted by untrained practitioners and often took place in hazardous circumstances and under less hygienic conditions (Grimes et al. 2006). Figure 1 shows the infant mortality rate in 1990 and in 2007 for children less than 5 years of age. This figure shows the rate per thousand live births. Improvements in sexual and reproductive health benefit all women and their offspring. You will notice that, among developed regions of the world, the rate of infant mortality was cut by 50 % (from 12 to 6 infant deaths per thousand). During the same period (1990 and 2007), developing regions cut their rate of infant mortality by 30 % (from 100 to 72 infant deaths per thousand). Infant mortality rates for children under five dropped by 28 % between 1990 and 2008 worldwide (Fig. 2).

Violence and Adolescent Pregnancy

The other condition that influences adolescent pregnancy that is too often overlooked is the level of violence experienced by girls. Violence

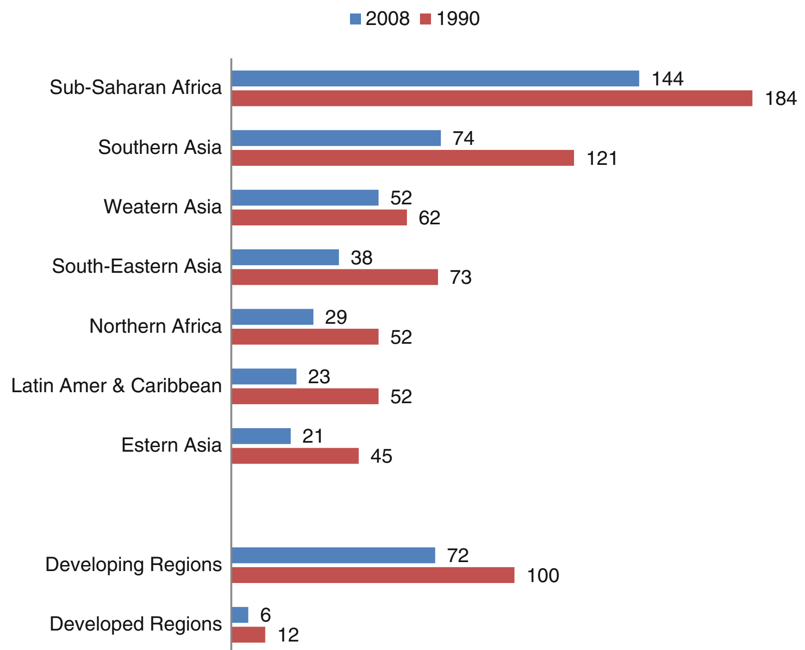

Fig. 2 Under-five mortality rates per thousand live births 1990 and 2008 by regions of the world. *Source* United Nations (2010a)

is widely reported by girls 15–19 years of age, especially girls in a relationship. Large numbers of these girls have experienced domestic violence, sexual violence, and far too often both.

Sexual Abuse: In studies that compared women with no history of sexual abuse with women who experienced sexual abuse, the differences clearly show that violence experienced in childhood affected adolescent pregnancy rates. Risk factors include gender, a younger age, substance use/abuse, family constellation, parent–child conflict, and mother disengagement. Women who experienced sexual abuse only in childhood were 20 % more likely to experience an adolescent pregnancy. Women who experienced sexual abuse only in adolescence had a 30 % greater chance of experiencing an adolescent pregnancy. If additional sexual abuse is experienced, women who experienced sexual abuse in both childhood and adolescence had an 80 % greater chance of experiencing an adolescent pregnancy. During childhood and adolescence, attempted rape and rape were associated with an increase in adolescent pregnancy. This association between sexual abuse and pregnancy was reduced as the age at first intercourse increased and among adolescents with high levels of education (Francisco et al. 2008; Young et al. 2011).

Intimate Partner Violence and Unintended Pregnancy: Reproductive control including pregnancy coercion by male partners to become pregnant and birth control sabotage (partner interference with contraception) are associated with partner violence and risk for unintended pregnancy. In one study by Miller et al. (2010), 35 % of young women reported physical or sexual partner violence. Over half (53 %) also reported reproductive control; 19 % reported experiencing pregnancy coercion; and 15 % reported birth control sabotage. Both pregnancy coercion and birth control sabotage were associated with unintended pregnancy.

Armed Conflict and Adolescent Pregnancy

Often lost in the chaotic and brutal circumstances of war are the women and girls who experience rape and sexual exploitation that leave them pregnant and with STIs such as HIV/AIDS, too often in circumstances where public health services, such as reproductive health care,

are inadequate or unavailable. Moreover, rape during armed ethnic conflict is commonly used as a deliberate act of terror related to genocidal strategies. These human atrocities, although slower than widespread death, were used in an all-out effort to destroy minority ethnic groups in Bosnia-Herzegovina, in Darfur, in Rwanda, and in other ethnic conflicts (McKay 1998).

In Darfur, for instance, babies born of rape during that ethnic conflict were called "Janjaweed babies." These children had little future in the mother's ethnic group. Acts of infanticide and abandonment of these helpless victims were widespread. One victim was reported to say, "They kill our males and dilute our blood with rape. They want to finish us as a people, end our history." Of an estimated 80,000–265,000 who died in Darfur, the evidence shows that the first stage in this strategy was to destroy ethnic villages by killing the men and boys and raping the women and girls. The second stage was to force those still alive into isolated refugee camps where starvation, illness, and rape are used to continue the genocide (Scheffer 2008).

Rape as a sexual form of genocide in Africa has been instrumental in fueling the HIV/AIDS pandemic there. HIV/AIDS has devastated the children by leaving millions of children orphaned. As reported by Machel (1996), HIV/AIDS has killed teachers and health workers and has crippled public health and sexual reproductive health resources. HIV/AIDS has been recognized by the United Nations Centre for Human Rights, other international organizations, and African human rights groups as a global threat to peace and security and urges solutions that address the compounded effects of HIV/AIDS and armed conflict on children.

Street Children

Girls and boys who grow up on the streets in urban centers around the world are at risk for sexual exploitation (including survival sex), STIs, rape, unwanted pregnancies, and death (Pinheiro 2006). The number of street children who are girls is unknown. In urban areas where the number of street children has garnered the attention of advocacy groups and the press, politicians and local leaders typically disagree with the extent of the problem and vigorously disputed the estimates. Since the 1990s, advocacy groups have reported that globally, there may be as many as 100 million children living in the streets of the world's cities and towns (Thomas de Benitez 2007; UNICEF 2002, 2005).

In many countries, children of single mothers, mothers without a stable marriage or resources, impoverished families, displaced families, and refugees (and for many other reasons) frequently end up living in the streets (Thomas de Benitez 2007). In developed countries such as the United States, street children are most often referred to as "homeless children." These children are often victims of domestic violence and economic hard times. The children may be runaways, thrown-out, or forsaken (Zide and Cherry 1992).

There is no mistake that global adolescent pregnancy is viewed differently in various countries and regions of the world. Even so, for the most part, adolescent pregnancy is viewed negatively. Public resistance in most countries, however, has resulted in a lack of political will to provide adequate sexual and reproductive services that can resolve many of the problems that are associated with maternal morbidity and mortality among adolescent girls and their children. We know the risk and protective factors involved and how to enhance protective factors to reduce the burden of adolescent pregnancy for girls and their community. This is a moral imperative that should be given the importance it is due.

Protective Factors and Adolescent Pregnancy

Globally, there are over 127 million adolescent and young adults between the ages of 15 and 24 who are illiterate. Among these girls, the vast majority are found in South Asia and sub-Saharan Africa. This is a serious challenge to efforts focused on reducing teenage pregnancy. In most of the world's *developing* and the *least*

developed countries, secondary school enrollment, literacy, and employment are lower among girls and young women than among boys and young men. This is important for several reasons. When the adolescent mother's schooling is interrupted, despite the reason for her pregnancy, the adolescent mother, her offspring, and her community are harmed. In the United States, only about 50 % of teen moms finish high school before they are 22 years of age. Among adolescent girls, who do not give birth, approximately 90 % finish high school before they are 22 years of age (Holgate 2012). This is a condition that responds to related public programming.

The importance of social capital in the life of adolescent girls and the role it plays as a risk factor associated with adolescent pregnancy are evident in studies about the impact of foster care on the life trajectory of girls in foster care. A review of these studies shows that girls who are or have been in foster care tend to report twice as many teen pregnancies as girls in similar contextual environments and circumstances but who were never in foster care. Given the same environmental context, girls whose fathers were in the home during their childhood are significantly less likely to become pregnant than girls with no father figure in their home (Holgate 2012).

As is obvious, a number of the risk factors mentioned above are static or very difficult to change with social policy. There are, however, a number of risk factors that are created by tradition and culture. These risk factors can be affected by social policy. One such risk factor that is not fixed in this list is *adolescent ignorance about their sexual and reproductive health*. Compounding the risk of sexual and reproductive ignorance, in the developing and least developed countries, there is often tradition and religious orthodoxy that sanctions very young girls to marry. In these countries, where very young girls are allowed or forced to marry, the girls face risks related to pregnancy and childbirth before their bodies are fully mature and are able to accommodate a pregnancy and childbirth. Although not intractable, these threats to the health and well-being of girls can only be reduced and hopefully eliminated by religious, political (local and national), and international support for the human rights of girls worldwide.

There are individual and social conditions that are more malleable and increase the individual and community's capacity that have been shown to be effective in reducing STIs and unintended pregnancy. These characteristics can improve the life trajectory of girls despite their social and economic status.

Resiliency

One of the theoretical perspectives that inform practitioners in their efforts to prevent risky adolescent behavior (in this case sexual behavior and pregnancy) is the concept of resiliency. Examining the risk and protective factors that differentiate girls who experience an early pregnancy and girls who delay their first pregnancy can contribute to the development of policy and services that support a girl's decision to delay pregnancy and childbirth. Among the protective factors are parents and family. Parents need to be educated about the vital role that they can play in shaping their child's sexual behavior, that is, if the teenager has a parent or surrogate parent that is a positive role model. In the public mind, however, adolescent pregnancy is a threat to the young mother's health and has tremendous social costs. This is a self-fulfilling assumption; it does not have to be the reality.

Factors associated with prenatal and postpartum care and health have been studied in both the adolescent mothers and their children. The results of this line of research have clearly shown that in the majority of countries, educational and health programs for both female and male children and adolescents have been shown to increase an adolescent's assets and protective factors. Of these, family planning services that are easily accessible and private have been shown empirically to be highly effective.

Evidence from studies conducted in countries around the world shows that success in the prevention of adolescent pregnancy includes

comprehensive sexual education, the existence of preferential sexual and reproductive health services for adolescents, the widespread availability and handout of modern contraceptives geared to the adolescence stage of development, and the existence of an information network that appeals to children and adolescents (Card and Benner 2008; Molina et al. 2010). Although not as directly related to reproductive health services, a social environment that provides girl's options in life that do not include or encourage adolescent pregnancy is also needed to reduce adolescent fertility.

Opportunity and Aspirations

Hope humbly then; with trembling pinions soar;

Wait the great teacher death, and God adore.
What future bliss, he gives not thee to know,
But gives that hope to be thy blessing now.
Hope springs eternal in the human breast:
The soul, uneasy and confin'd from home,
Rests and expatiates in a life to come.
Alexander Pope,
An Essay on Man, Epistle I, 1733

A hypothesis that came out of our last major examination of global teen pregnancy was the influence of a girl's aspiration. We know that girls are growing up in economically disadvantaged families and communities, where the rate of substance abuse and other socially constructed problem behaviors is elevated; girls are at an increased risk of early pregnancy and for multiple pregnancies and births during adolescence. We know girls who do not succeed in school (starting in prekindergarten) will be at greater risk of an early pregnancy and for multiple pregnancies and births during their adolescence. We also know that girls who have few aspirations and do not believe that there will be opportunities in their future to fulfill their aspirations are at a higher risk of early pregnancy and multiple pregnancies and births during their adolescents (Moore et al. 1998). *Conversely, girls living and growing up in any environment despite the toxicity who aspire to an adult life and career that would be threatened by an adolescent pregnancy and motherhood are more likely to delay pregnancy and to use a condom and contraception when they experiment or begin to engage in sexual intercourse* (Cherry et al. 2001)*; and they are more likely to choose abortion or adoption if they do become pregnant* (Moore et al. 1998).

One of the most powerful protective factors in adolescence is *aspiration* grounded in the realistic knowledge that opportunity awaits. This does not mean that these girls will suppress their developing sexual instincts, but it does mean that they will act much more in their own best interest when they do give into their nascent sexual drive.

Researchers have just begun to explore the role of aspiration in the life trajectory of children and adolescents. Understandably, aspiration much like adolescent pregnancy is a complex issue, which cannot be attributed to one single cause; instead, numerous factors determine a child's level of aspiration. Ambition emerges from an expectation for success. It is grounded in past experiences and depends on the success possible in the girl's environment, girls that may be living in poverty and opportunities that may or may not be available in their community (Newby et al. 2011).

At the individual level, children who have strong and realistic career goals are more likely to stick with educational curriculum that may produce long-term gains, even when they described the curriculum as difficult and boring (Newby et al. 2011). When a girl has a strong dislike of school, and drops out of school, it increases a girl's positive perception of childbirth. Moreover, when pregnancy is met with negative attitudes from school officials, it tends to have an adverse impact on the girl's aspirations and career goals (Hosie 2007).

To reduce adolescent pregnancy and the impact of adolescent pregnancy on the life trajectory of girls, we can raise the aspirations of girls by supporting their educational and career goals. Without opportunity, however, aspirations are pipe dreams at best. For girls, dreams have often been foiled by the culture they live in. For many girls in the least developed countries, the dream is to get a secondary education. For girls

from many conservative Muslim countries, the dream is an education and a career. In developed countries, girls dream that one day they will be able to break through the "glass ceiling": a level of attainment that has been reserved for their male counterparts. As it turns out, aspiration may not totally depend on a girl's family, teachers, and her community or national laws protecting female's rights. A girl's aspiration is also shaped by mass communication.

Aspiration as a Social Construct

One of the boldest hypotheses we explored in the last book we published, examining global teen pregnancy, came out of the idea that a major influence, which all girls were exposed to, had precipitated a global response among girls that included delaying childbearing. We were looking for a stimulus that had similar meaning for girls worldwide.

A phenomenon that met these criteria was modern-day *mass communication.* No longer are ideas shaped and limited to local leaders and writers of a few acceptable books. Today, mass communication is the market place of ideas. Western ideas of a modern society in particular have widespread appeal (whether the information is accurate or not, or is just sensationalized.) They are the ideas that homogenize our thinking and behavior. In our first book, in 2000, adolescent pregnancy was described using the Western social construct of adolescent pregnancy in every country studied, regardless of the poor fit with the culture or prevailing cultures in a specific country. This still seems to be the case today. *Mass communication* also affects our ideas about adolescent pregnancy indirectly? This has been true especially among adolescent girl.

In the mid-1980s, women in Western society were coming into their own; they were increasing in numbers in universities and other degree programs that had long been dominated by men such as law, medicine, and business. Even in the United States, by the mid-1980s, women were earning 50 % of all master's degrees. Events not lost on girls in the developing and least developed countries. Particularly in northwestern Europe, women are seen as making great progress and from a far they seem to have almost unlimited opportunity. In northwestern Europe, marriage is no longer the only choice or strategy for supporting and raising children. The women's rights movement has forever changed and will continue to change the social, economic, and political landscape of the world. Access to education, employment, health and social services, decision-making power, and the freedom to decide has been transformative for women, although it still has a long way to go as it relates to equity. In terms of life trajectory, it will continue to be transformative for girls worldwide. So, as innovations in communication have connected the world's people, what girls see other girls and young women doing in the movies and how young women are portrayed on television and on the Internet have opened up the possibilities and the roles girls and young women may never have aspired to before. They are no longer just placed on earth just to bear children. Moreover, no nation, organization, or group controls the message.

In our theory about the impact of mass communication on the aspirations of girls and subsequent adolescent pregnancy, we recognize that media in democracies generally operate under a combination of libertarian and social responsibility. Moreover, although many countries have free speech as a goal, most political leaders are concerned with preserving their national cultures. These politicians face off against Western, modern media powerhouses from the United States, the European Union, Japan, Mexico, Brazil, and Internet news sources, such as Al Jazeera, that produce content for Arab-speaking countries. Nonetheless, because of the ability of powerful media to bypass official government censorship, the ability of governments to dictate the message or control the broader media message sector has become harder (Hanson 2011).

Consequently, the mass media message that resonates with girls and young women around the world is media on modern countries where girls and young women hold many different and important roles in society. Furthermore, these

girls know the countries where girls and women have equal rights and make decisions for themselves.

Sexual and Reproductive Health

The most effective approach to preventing unintended adolescent pregnancy is grounded in social justice, gender equality, scientifically based knowledge and informed decision-making about medical, public health, and social policy needed to support and provide necessary maternal and child health care. For this level of knowledge to make a difference globally, in the life of adolescent girls, it is necessary to raise the standards of the poorest and most destitute people living in the low-income countries in the world. In terms of the cost to provide essential sexual, reproductive, and child health programming to the girls and women struggling and dying from a lack of maternal health care in the 50 low-income countries in the world, it would cost under 20 billon US dollars a year to provide adequate sexual, reproductive, and child health programming to these 50 low-income countries (PMNCH 2011). This is less than a third of the fortune of the world's richest billionaires (the Carlos Slim Helu family has $70 billion, in the United States, and Bill Gates has over $60 billion). A serious international expression of commitment to justice and humanity is needed to reduce the burden of pregnancy on adolescent girls. A start is the commitment expressed in the United Nation's Millennium Development Goals (MDGs) initiative.

United Nation's Millennium Development Goals

The UN initiative, which was designed to make profound improvements in the lives of women, especially adolescent girls, was the MDGs. The MDGs are international objectives that were agreed to in 2000 by all 193 member states and 23 international organizations to be achieved by 2015. There are eight MDG goals (United Nations 2010b).

1. *Eradicate severe poverty and hunger*. Cut in half the proportion of people living on less than US $1 a day by 2015.
2. *Achieve universal primary education.* Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.
3. *Promote gender equality and empowering women*. Eliminate gender disparity in primary and secondary education, by 2005, and in all levels of education by 2015.
4. *Reduce child mortality rates*. Reduce the mortality rate of children under five by two-thirds by 2015.
5. *Improve maternal health.* Reduce by three-quarters the maternal mortality rate and achieve universal access to reproductive health information.
6. *Combat HIV/AIDS, malaria, and other diseases*.
7. *Ensure environmental sustainability*.
8. *Develop a global partnership for development*.

These goals are intended to provide a way of measuring and monitoring the progress of the developing and least developed countries in terms of global development. In the view of some, the MDGs have changed the debate about global development. In the view of some critics, the cost of supporting the international monitoring activities has diverted scarce resources from direct services. Likewise, they point out that progress made in monitoring the achievement of these goals is not the same as meeting the goals (Schmidt-Trauba 2009).

Despite the criticism of the method and limited goals of the MDGs, there is support for the poorest people of the world who are being left behind. How can we not support these struggling masses, the majority who are children and women? Estimates are that in 2012, some one billion people were living on less than US $1 a day.

Limitation and Lessons Learned

There are many limitations and problems that will be encountered when studying the phenomenon of adolescent pregnancy in different

countries. The official numbers will often be difficult to find and confirm. In some countries, the numbers may differ within the same country, and in other cases, the numbers may be unavailable or suppressed for political, for religious, or for other reasons. While these problems make answering the *What*, *Where*, and *When,* questions about the medical, psychosocial, and public health responses to adolescent pregnancy in some countries more difficult than in others, the numbers and types of responses are only a part of the story. The restrictions and limitations imposed on information about adolescent pregnancy are in themselves observations that can be analyzed and reported on.

Another important focus of adolescent pregnancy in different countries, that is as interesting or more interesting than the numbers and restrictions, is the answer to the questions *Why* and *How* has culture in a country affected the phenomenon of adolescent pregnancy as biology, child development, adolescent health, and adolescent reproductive health. This perspective, as it turns out, becomes a convergent view of the country and the culture that shaped its unique characteristics.

In an effort to understand the international response to adolescent pregnancy, it is obvious that the biological perspective cannot explain the wide variations in the medical, psychosocial, and public health responses. Other perspectives are needed to answer the questions why and how. *Why* do they vary? *How* did these differences come to be?

To answer the *Why* and *How* questions, the ecological perspective has much to offer. Because of its sensitivity to the influences of culture, it is a good addition to the biological perspective. Where the biological perspective can tell us what is needed, the ecological perspective can tell us what role culture played in how services are or are not provided. Using the ecological perspective, the story of adolescent pregnancy is yet another account of the cultural and religious conflicts that people in different countries have been struggling with for eons.

Conclusion

Some professionals saw the worldwide decline in teen pregnancy in the 1990s as a result of effective pregnancy prevention programming. Others attributed the decline to religious campaigns promoting abstinence. Still others interpreted the decline as confirmation of the dominance of globalization over provincial customs. Researchers saw the phenomenon as an opportunity that could provide information on events and characteristics of influences that coalesced to cause this global change in a teenage girl's sexual behavior. Today's adolescents are the next generation of parents, workers, and leaders. To fulfill these roles to the best of their ability, these adolescents need the guidance and support of their family, their community, and national and global leaders. They also need governments and a world community that are committed to their health, development, education, and well-being.

In the following chapters, you will find factors that are associated with varying rates of adolescent pregnancy. These chapters will also be helpful in identifying the risks and consequences for adolescent mothers and their children. The authors of the country-specific chapter also make the point that adolescent pregnancy risks and the health burden vary widely by region, country, and within countries. Social policies, programs, and clinical practices that have been shown to reduce or increase rates of teen pregnancy are also highlighted and presented in the context of the individual country.

The following is the life experience of a teen mom who was one of my students in a master of social work program in 2013. Although not typical of the experience of most teen moms in the United States, her story is an example of the potential that is within each adolescent mother.

My Life Story, So Far

I was born and raised in Tulsa Oklahoma. I grew up in north Tulsa in the suburban acres neighborhood and attended Alcott Elementary. I had a

pretty good childhood but experienced a few disappointments as well. I definitely think those disappointments made me a stronger person and built my character. My mother worked pretty hard because she was a single parent. I never knew my father as a child and would often fantasize about what a great father he would have been if he were in my life. Most of these fantasies were prompted by me getting into trouble and resenting the punishment or consequences I had to face up to. I did have a stepfather though, who entered our lives when I was about 6-year-old. Somehow, I never really saw him as a father; he seemed more like a family friend. He was very nice, and he always told the most fascinating stories about his childhood. I enjoyed being around him, but he just seemed like an uncle or close family friend.

By the time I was 12, my mother and stepfather broke up, but it did not seem like a big deal to me because I never really got close to him. Shortly after their breakup, my mother and her twin sister decided to purchase a house together. So for the rest of my childhood, we lived with my aunt and her children. My aunt was a second mother to me. At times, I felt closer to her than to my own mother. Everyone always said I looked more like her too and she always let me get away with things that my mother would not stand for. Well, most of the time she did unless it came to household chores; if my chores were not done, I was basically grounded for the day.

My family was very close, and we always had family get-togethers and hosted dinner parties during the holidays or birthdays. But by the time I was about 14, I began to be more independent. I started working at the neighborhood Braum's, and by 15, I had a credit card in my name from Mervyn's department store that I used to purchase my own school clothes. By the time I was 16, I felt self-sufficient and did not ask my mom for much. I pretty much came and went as I pleased and did just what I wanted to do. My mom was never that much of a talker, so she never really sat me down and educated me about sex, pregnancy, STDs, or anything like that, mostly because her mother never had these kinds of conversations with her. The only thing I heard any of the women in my family say was "keep your legs closed." I knew what that meant, but since it was forbidden, it definitely made me curious about sex. When I was 16, I met my then boyfriend, now husband. We attended school together at Project 12 alternative school. I had gotten bored with school and dropped out of Edison High but later decided that it was not such a great idea to just drop out of school, so I enrolled in Project 12 and later earned my GED.

After dating for a couple of years and shortly after my 18th birthday, I found out that I was pregnant and I was happy about it. Most of my friends either had a baby or was pregnant. All I could think about was having the opportunity to get my own place and how having a baby would make it easier to do so. Before I gave birth to my son, my boyfriend got into trouble with the law and was sentenced to 3 years in prison. I quickly learned the struggles of being a single parent. One of the first things I realized was that without money or a job, I would have to live in project housing. I was not used to that because every home I lived in prior was owned, well-kept, and in a modest neighborhood. One of my first apartments was in the Fairmont Terrace Apartments, now infamously known as the apartments where a multiple homicide occurred. But even back in the mid-nineties, after I moved in, I heard all kinds of stories about people who had been found dead and murdered there. This was after I had witnessed the violent death of one of my best friends who was the victim of a drive by shooting. Needless to say, I was very scared at night and had a hard time living there with my baby boy.

Shortly after moving there, I decided very quickly that I did not want this life. I began to look into going to school and finding a way to improve my situation. I enrolled into Tulsa Junior College (now Tulsa Community College) for a math course. I did not have my own transportation so I would catch the bus or drive the family car to school whenever my mom was not using the car or if she was at work. I finished the course with a B, and I was very proud of myself. This gave me a boost of confidence to later pursue a college education.

By the time I was 19, I was beginning to make some life-changing decisions in my life. I had given up drugs and alcohol and started changing who I hung around. I began to realize that if I wanted a better life for my child and me, I would have to start making better decisions. I also told my boyfriend that he would have to make some changes too. After he was released from prison, he still was not quite ready to make any serious changes, so I decided to break up with him. I also took a trip to Albany, New York, to meet my father for the first time. I quickly learned that I had not missed much by not having him in my life and he still has never lived up to his role as a father in my life. Meeting him was also a relief and lifted the burden of never knowing who he was.

At the age of 20, I moved to Phoenix, Arizona, to live with my godparents. My godparents were very instrumental in my decision to seriously pursue my education and become a community servant. In 1995, my godparents started an outreach ministry called Keep the Peace World Ministries (KPWM). I served as a missionary and teacher during my 10 years with the organization. KPWM served a variety of individuals and families: the homeless, drug and alcohol addicts, ex-convicts, prostitutes, teens and elderly, rich and poor and just about any other population that can be thought of. We helped these individuals find housing and nutrition assistance, rehabilitation services, educational services, spiritual guidance to name a few. During that time, I learned so much about other religions, cultures, and other ways of living and about the struggles that people were going through on a day-to-day basis. I had no idea that I was doing case management and social work, but I knew that I loved it. I also learned a great deal about myself, my capacity to love, and forgive and minister to those less fortunate than me.

However, during those 10 years, I had many struggles of my own. I had been homeless, living in family shelters with my young son. I lived in poor neighborhoods; for one period, I lived in a duplex with no running water or electricity and had to plug in an extension cord from my duplex to my godparents duplex to have electricity. Thankfully, my son was able to stay in my godparents' duplex where he had access to everything he needed. I also had to fill up several 25 gallon buckets every evening to ensure that I would have water to flush my toilet throughout the day and overnight. I spent my days at school, and I spent my evenings and free time doing missionary work. It was a very difficult life, but I loved it because it brought me so much joy to be helping others and I was able to teach my son the value of education and service to the needy. I also had the love and support of my godparents and godsisters so it definitely made it worthwhile. By 2002, I had earned my associates degree and was able to find descent work and began saving my money. Later my godfamily and I saved up enough money to move to a nice neighborhood in Tempe, Arizona. We continued our ministry work and service to needy individuals and families through the church and gained lots of friends over the years.

At the age of 30, in 2005, I decided to move back home to Oklahoma. I missed my family and wanted my son to get to know his father's families and me as well. My boyfriend and I reconnected and started dating again. We had both grown up a great deal and found that we were still attracted to one another after all those years. Shortly after moving back, I decided that I wanted to pursue a degree in social services. I enrolled in school and earned a bachelor's degree in human services and management and graduated with a 3.8 GPA. I was so proud of myself and often reflected on where I had come from. However, I believe that most of the bad things that happened in my life were because of the choices I made. My then boyfriend and I are now married, and we had another baby boy. And, my oldest son and his girlfriend now have a child of their own. I am a grandmother now. My son works full-time and goes to school part-time at TCC. I am beginning to see my life come full circle.

After achieving some success, I began to think about going back to school to earn a master's degree in social work. So in the fall of 2012, I started the MSW program at the University of Oklahoma in Tulsa to begin my dream of becoming a social worker and I am confident

that I will succeed. I also plan to become a licensed clinical social worker so that I can help individuals not only on a material level but also on a therapeutic level as well.

I was a teenage mother and went through many struggles and overcame many obstacles; having those experiences has given me a passion to want to help other single teen mothers. My goal is to help them get on the path to education and motivate them to become self-sufficient. I believe that having an education is vital to being able to obtain gainful employment, which can lead to living a good life and breaking the cycle of poverty. This is the vision I have for the young mothers that I want to work with. Hopefully, in the future, I will be able to start a foundation or scholarship of my own that will be for single mothers who are pursuing their education. I want to inspire them and show them that no matter where you have come from and what you have been through, you can make it and you can make a difference.

Family Picture

Appendix A: Developed Countries

Countries and territories classified as the **developed** nations by the United Nations: Andorra; Australia; Austria; Belgium; Canada; Cyprus; the Czech Republic; Denmark; Estonia; Finland; France; Germany; Greece; Holy See; Hungary; Iceland; Ireland; Israel; Italy; Japan; Latvia; Liechtenstein; Lithuania; Luxembourg; Malta; Monaco; the Netherlands; New Zealand; Norway; Poland; Portugal; San Marino; Slovakia; Slovenia; Spain; Sweden; Switzerland; the United Kingdom; the United States (UNICEF 2011. The State of the World's Children 2011. NY: United Nations Children's Fund).

Appendix B: Developing Countries

Countries and territories classified as the **developing** nations by the United Nations: Afghanistan; Algeria; Angola; Antigua and Barbuda; Argentina; Armenia; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Botswana; Brazil; Brunei Darussalam; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; the Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; the Democratic Republic of the Congo; the Democratic People's Republic of Korea; Djibouti; Dominica; the Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Ethiopia; Fiji; Gabon; Gambia; Georgia; Ghana; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; India; Indonesia; Iran (the Islamic Republic of); Iraq; Israel; Jamaica; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; the Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libya; Madagascar; Malawi; Malaysia; Maldives; Mali; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Mongolia; Morocco; Mozambique; Myanmar; Namibia;

Nauru; Nepal; Nicaragua; Niger; Nigeria; Niue; Occupied Palestinian Territory; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; the Philippines; Qatar; the Republic of Korea; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Solomon Islands; Somalia; South Africa; South Sudan; Sri Lanka; Sudan; Suriname; Swaziland; the Syrian Arab Republic; Tajikistan; Thailand; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; the United Arab Emirates; the United Republic of Tanzania; Uruguay; Uzbekistan; Vanuatu; Venezuela (the Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe (UNICEF. 2011. The State of the World's Children 2011. NY: United Nations Children's Fund).

Appendix C: Least Developed Nations

Countries and territories classified as the least developed nations by the United Nations: Afghanistan; Angola; Bangladesh; Benin; Bhutan; Burkina Faso; Burundi; Cambodia; the Central African Republic; Chad; Comoros; the Democratic Republic of the Congo; Djibouti; Equatorial Guinea; Eritrea; Ethiopia; Gambia; Guinea; Guinea-Bissau; Haiti; Kiribati; the Lao People's Democratic Republic; Lesotho; Liberia; Madagascar; Malawi; Maldives; Mali; Mauritania; Mozambique; Myanmar; Nepal; Niger; Rwanda; Samoa; Sao Tome and Principe; Senegal; Sierra Leone; Solomon Islands; Somalia; Sudan; Timor-Leste; Togo; Tuvalu; Uganda; the United Republic of Tanzania; Vanuatu; Yemen; and Zambia (UNICEF. 2011. The State of the World's Children 2011. NY: United Nations Children's Fund).

Appendix D

Issues to cover in a sexual education curriculum for children and adolescents.

Reproductive Anatomy and Physiology
- Respect for all genders
- Intercourse, baby grows in uterus
- Puberty and body changes—no pregnancy before puberty
- Pregnancy and birth

Body Image
- Value of differences—male/female, shapes, sizes, colors, disabilities, etc.
- Pride in and appreciation of one's body
- Homosexuality and heterosexuality and appropriate labels (gay men and lesbians)
- Respect for all sexual orientations

Relationships
- Families

Different kinds of families

Role of families: taking care of each other, developing rules, loving each other
- Friendship

Components of friendship

Sharing, hurting, and forgiving feelings
- Love

Importance of showing and sharing love

Different ways to show love (family, friends, etc.)

Dating
- Definition of dating
- People who date: teenagers, unmarried adults, single parents

Marriage and Commitments
- Divorce; reasons and difficulties of divorce
- Raising children
- Adoption

Values
- Decision-making
- Getting help in making decisions

Communication
- Assertiveness
- Personal rights and telling people what you want
- Who to ask for help: parents, teacher, counselor, minister, a friends' parent

Body curiosity is normal
- Masturbation
- Boys and girls masturbate
- Private (not secret) activity

Shared Sexual Behavior
- Touching, hugging, kissing, sexual behavior

To show love and share pleasure
Human Sexual Response
Normal, healthy for people to enjoy
Contraception and Abortion
Wanted and unwanted pregnancies
STDs and HIV
Definition and causes of STIs
Ways of can and cannot get STIs
Sexual Abuse
Body rights
Good touch/bad touch
What to do if you feel abused or afraid—tell a trusted adult
Never the fault of the child
Both boys and girls can be abused
Reproductive and Genital Health
Keeping your genitals healthy—washing, doctor visits
Healthy and unhealthy behavior during pregnancy—drugs/smoking, etc.
Gender Roles
Sexuality and Religion
Religious opinions on sexuality
Diversity
Stereotypes
Discrimination—all people should be treated fair and equally
Sexuality and the Media
Truth versus fiction about sexuality on TV/movies/Internet
CommercialsAn important activity involves providing hands-on, realistic models of the male and female genitalia for children to touch, take apart, and examine. This may be a child's only chance to see adult genitalia up close before they become adults themselves.

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Biological Determinants and Influences Affecting Adolescent Pregnancy

Andrew L. Cherry

Keywords
Adolescent motherhood · Delinquency behavior genetics · Environmental mediation · Gene–environment interaction · Evolution · Menarche · Nature–nurture · Puberty · Reproductive strategy · Sexual debut

Starting from a Biological Perspective

The basic assumptions employed by professionals to define *adolescent pregnancy* give direction to research and authority to policy and interventions that form the services provided by the medical and helping professionals. Accordingly, because adolescent pregnancy is first of all a biological process, logically professional assumptions would start from a *biological* perspective. The biological reality is that adolescent girls and boys need sexual and reproductive health care and education designed to meet their needs given their physical and emotional development. The risk they face from genetic vulnerabilities and environmental exposures is too great to keep them ignorant about their sexual and reproductive development. One example of a service that is obvious from a biological perspective is based on data that show almost 1 in 8 girls reaches menarche while still in primary school. When designing programs to provide sexual and reproductive health information and health services for adolescent girls, if we first consider the biological variations in sexual development among primary school girls, we would provide them with the education and services girls need when reaching menarche. Yet, in many countries, adolescent sexuality and pregnancy are seen as a moral problem not as a biological process. Thus, in many countries and cultural groups, primary school girls are viewed as too young to receive sexual and reproductive services and, too often as a result, suffer from long-term adverse consequences.

Adolescent pregnancy is a natural phenomenon that is biologically available to virtually all adolescent girls. This biological imperative means that essentially all adolescent girls have the potential to become pregnant. Because of this reality, there is a bona fide need to provide maternal health education and care in the most comprehensive way possible.

From a biological perspective, the answer is to intervene medically and psychosocially to prevent a pregnancy from doing harm to the adolescent mother and her child. This includes providing services to address specific physical and psychosocial issues that are common among adolescent girls. Novelist Hilary Mantel

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described the phenomenon of adolescent pregnancy as: "Having sex and having babies is what young women are about. And their instincts are suppressed in the interests of society's timetable" (Davies 2010).

Far from being harmless, however, there is agreement among medical professionals that adolescent pregnancy and motherhood at a very young age are correlated with elevated health risks for young adolescent mothers and their children. For the most part, the harm is a result of the immaturity of the girl's body. Conversely, there is substantial disagreement that delaying childbearing until adulthood results in better outcomes. This conclusion is based on the preponderance of research that describes adolescent pregnancy as a problem. However, from a biological perspective, reproductive maturity and adequate resources result in the best pregnancy outcomes.

Many who question the research that describes adolescent pregnancy as a problem point out that starting one's research based on the assumption that adolescent pregnancy is a *problem* is likely to produce research describing adolescent pregnancy in terms of different *problems*. Given the basic assumption that adolescent pregnancy is a problem, it is no wonder that policies and interventions are designed to prevent adolescent pregnancy while neglecting sexual and reproductive health education and services.

When examining the medical, social, political, and public response to adolescent pregnancy in different countries around the world, it becomes apparent that the biological perspective (a culmination of physiological and anatomic processes) is not the dominant perspective and most often takes a backseat to political, cultural, religious, and vague moral interests (Furstenberg 2007). Next in this chapter, the biological evidence that can inform our understanding of adolescent sexuality and pregnancy is presented.

Biological Determinants

Maturation is the process of developing biological imperatives needed by living organisms to perpetuate their existence. The imperatives that must emerge during maturation have been summarized as survival, territorialism, competition, reproduction, and quality of life-seeking. The reproduction imperative, as a focus of adolescent pregnancy in modern society, has little to do with nature and almost all to do with culture. Which begs the question, those who do not fulfill an imperative are by definition described as maladaptive, while those that do fulfill an imperative are described as adaptive? By definition, adolescent pregnancy satisfies the reproductive imperative.

Adolescent pregnancy in modern society, however, is maladaptive not because of some endemic organic force but because of the preeminence of individual economic security over procreation. There is no support in a modern society for dependent, pregnant, and parenting adolescents. Nevertheless, research, since the 1990s, has clearly demonstrated that there are both evolutionary and genetic influences that affect a girl's early fertility and resultant sexual behaviors. Even behaviors that we had assumed were exclusively the result of environmental experiences that have been shown to be influenced by individual genetic makeup. The assumption is that there are genetic underpinnings of behavioral phenotypes. Studies using *behavior genetic designs* (i.e., identical twin studies and studies of the children of identical twins) in order to control for genetic influences have been conducted to rule out genetic influences. This line of research has not ruled out a genetic influence on adolescent sexual behavior. Instead, this research found considerable evidence that while the environment affects and influences a girl's sexual behavior, a girl's *genes* also affect and influence her sexual behavior. Including knowledge of this *gene–environment interplay* (D'Onofrio 2003; Jaffee and Price 2007) when designing health and education services could result in more adolescent-friendly and effective sexual and reproductive health services.

To come to the point, as specific genes are identified, we can begin to explore important and pressing questions about behavior. How do these genetic influences interact with environmental

factors to shape development and behavior? How do we interpret these findings? How do we ask new questions about these findings? How do we celebrate the knowledge? And how could we use or misuse this knowledge? These issues are pervasive in all areas of human research, and they are especially salient in human behavioral genetics.

Investigating Early Fertility

Behaviors related to menarche and fertility and particularly early fertility are prime candidates for investigating the importance of evolutionary and biological predisposition on adolescent sexual and reproductive behavior. Important to our understanding of adolescent pregnancy is this concept that the physiological and anatomic processes involved in puberty are affected by environmental exposure. In biological terms, puberty is a series of physiological and anatomic processes that occur during adolescence. Puberty is also the state of physiological development after which the adolescent is physically able to sexually reproduce. Grumbach and Styne (1998) defined puberty as an individual process of development driven by a gonadotropin-releasing hormone (often referred to as the growth hormone) in the hypothalamus. In addition to gonadotropin secretion, the gonadal steroids (often referred to as the sex steroid) combine and result in puberty.

Yet, the timing of normal puberty varies around the world and by some measures has changed over time. In the past, precocious puberty was defined as sexual development before the age of 8 in girls and age of 10 in boys. In 1999, these limits were revised to 7 years of age for Caucasian girls and 6 years of age for African-American girls. Precocious puberty is four to eight times more prevalent in girls than in boys.

Precocious puberty means having the premature signs of puberty such as the development of breasts, testes, pubic and underarm hair, body odor, menstrual bleeding, and increased growth. Among girls, the first signs of precocious puberty are the appearance of pubic hair and budding breasts. Menarche is highly correlated with the appearance of breast buds and is therefore considered to be an indicator of early onset of puberty.

In previous studies, differences in the timing of puberty have been explained in terms of variations in ethnicity, geographical, and socioeconomic conditions. These models, however, are not a good explanation for an increased incidence of sexual precocity observed in the United States since the 1980s. While ethnicity, geographical, and socioeconomic conditions cannot adequately explain the drop in the age of puberty in the United States, the onset of puberty as a possible sensitive and early marker of the interactions between environmental conditions (such as industrial and household chemicals) and genetic susceptibility is hypothesized as a possible explanation (Parent et al. 2003).

Sociosexuality: Genes and Environmental Interaction

Theories about sociosexual development tend to focus on the environmental influences (for the most part the parental effects) that shape individual sexual behavior. The causal connections between parental influence and child outcomes using typical family samples are limited, however, by the inability of this approach to account for all of the malleable conditions both environmental and genetic that could influence behavior, particularly sexual behavior.

So far, we know that social learning and environmental influences explain a great deal about individual behavior and preferences. What we have learned since the 1980s is that environment and learning explain a lot less about behavior than previously thought. What we do know, in reference to sexual behavior, which is of importance to our understanding of adolescent pregnancy, is that substantial variation in human sexual and reproductive behaviors is inherited. Explained by evolutionary theory,

genetics is predicted to be a major influence on sexual behavior because sexual behavior is the most proximal determinant of fertility, the evolutionary process by which genic reproduction is modified or maintained. Moreover, in some developmental processes, it is reasonable to expect that some genetic influences will be stronger in older children. As children mature and are free to express their genetic preferences in selecting their environment and associates, they will be more influenced by their genetic influences.

To test genetic theory, twin studies have been conducted and show that monozygotic (MZ) twin pairs (fertility-related phenotypes) can vary in early onset or late onset of maturation. Among the twin pairs, however, whether development is early or later—the age of onset of menarche and the age of first sex, the desired age of marriage, and the desired age to have children are virtually the same for each twin in the pair. These findings strongly support the hypothesis that genetic differences between individual girls account for their variation in sexual timing (Aragona 2006; Bailey et al. 2000; Dunne et al. 1997; Lyons et al. 2004; Martin et al. 1977; Rowe 2002; Waldron 2004). Additionally, among males, functional polymorphisms for dopamine receptor genes (*DRD4 48 bp VNTR*) are associated with earlier age at first sex, migratory behavior, and a greater frequency of multiracial ancestries (Miller et al. 1999). What the twin studies have demonstrated is that variation in social behavior partly reflects individual genetic differences and environmental influences. In modern society, however, the individual's genetic predisposition is also influencing the shape and form of the individual's environment. When individuals are free to select their social environment (friends, schools, occupations, organizations, and sexual partners) they are more incline to select social environments based on their genetic predisposition than individuals with little control over selecting their social environment (Scarr and McCartney 1983). This self-selection phenomenon in humans is obvious in numerous situations. The self-selection into a compatible profession, for instance, is virtually essential for success.

Children-of-twins and family comparison studies have added to our confidence in the *gene–environment interplay* explanation of adolescent pregnancy. This methodological design provides an additional rigorous test of the degree of genetic influence on a child's life trajectory. The children-of-twins design has been used to examine the influences of marital conflict (Harden et al. 2008), stepfathering (Mendle et al. 2006), harsh punishment (Lynch et al. 2006), smoking during pregnancy (D'Onofrio et al. 2003), marital dissolution (D'Onofrio et al. 2005, 2006), parental schizophrenia (Gottesman and Bertelsen 1989), and parental alcohol/drug problems (Jacob et al. 2003) on child adjustment.

As opposed to the *gene–environment interplay* construct, modeling theory explains that children acquire their mating strategy after observing their parents' relationship, which is an example of a specific behavior that would appear to be a case of social learning. Thus, if policy were based on modeling theory, a prevention strategy would be needed to shape the relationships of parents or at least to persuade a child that there are specific acceptable sociosexual behaviors.

If there is empirical support for this social learning hypothesis, researchers would find a strong shared environmental component among children from specific environments. The environment would have a statistically significant influence on the children's sexual behavior. This was not found to be the case.

In a number of studies, similar to the work by Bailey et al. (2000), a large, representative sample of volunteer twins showed that familial resemblance in sexual tendency appeared primarily due to genetic rather than similar environmental factors. This evidence is substantial. It makes the case for concluding that genetics has a profound influence on sexual behavior, and thus, these genetic influences must be incorporated into the design and development of reproductive and sexual policy and programming.

Adolescent Pregnancy and the Nature Versus Nurture Conundrum

The gaps in our knowledge about the different levels of influence from nature and nurture continue to create dissidence. Most reasonable people who have studied the issue agree that both nature and nurture shape our sexuality, however, to what degree is still in question.

Studies that support the gene–environment interplay have investigated how it affects menarche, a physical event thought to be purely biological. To make the point about the influence of the contributions of gene–environment interplay, body mass index (BMI) (body weight) and its role in causing variations in the age of the onset of menarche have been instructive. A study referred to as the FinnTwin16 study recruited twins (1,283 twin pairs) from consecutive birth cohorts from the national population registry, which included 100 % of all living twins in Finland. There were 468 MZ girls, 378 girls from like-sex dizygotic pairs, 434 girls from opposite-sex pairs, and 141 older female siblings of the twins.

Girls from opposite-sex dizygotic twin pairs had a significantly higher mean age at menarche (13.33 years) than like-sex dizygotic twin pairs (13.13 years). The MZ correlation for age at menarche was $r = 0.75$, the like-sex dizygotic correlation was $r = 0.31$, and for the opposite-sex twin pairs, the correlation was $r = 0.32$. A bivariate twin analysis of age at menarche and BMI indicated that 37 % of the variance in age at menarche can be attributed to additive genetic effects, 37 % to dominance effects, and 26 % to unique environmental effects. The correlation between additive genetic effects on age at menarche and BMI was $r = 0.57$, suggesting a sizable percentage of genetic effects on menarche and puberty (Kaprio 1995).

Subsequently, what is most striking about the genetic influence on early fertility is that it accounts for over 50 % of the variation in early fertility. This finding is especially important to providing sexual and reproductive services to young girls. It is especially troubling, however, because of the social and emotional cost borne by adolescent girls who become pregnant. Costs that where far too many girls and adolescents end in a negative life cycle for them and their children (Kohler et al. 2002).

Where sufficient BMI is needed for menarche to begin, obesity is strongly associated with when girls reached menarche at a significantly earlier age than girls within a normal weight range. The report by Bau et al. (2009) is representative of this line of research. In the Bau study, girls who were overweight started menarche at 12.5 years of age, while girls within a normal weight range started at age 12.9. Underweight girls were much later at 13.7 years of age. The body weight for all girls was similar irrespective of age and height (Bau et al. 2009).

Puberty, Age of Menarche, and the Genetic Influences

The worldwide median age of menarche is estimated to be 14 years of age. About 50 % of girls began menarche before age 14 and 50 % start after age 14. Most often in developed countries and modern urban areas, the age of onset of menarche is under 14 years of age. Among girls living in developing countries, the age of onset of menarche is over 14 years of age. There are also significant differences by geographical region, race, and ethnicity. The average age of menarche in the United States is about 12.5 years of age. In China, the age of menarche onset is 12.8 years. In Nigeria, the average age is 13.7 years (Ikaraoha 2005). In Sudan, it is 13.85 (Attallah et al. 1983). In Morocco, it is 13.66 (Montero 1999), and in Mozambique, it is 13.9 years of age (Padez 2003). Table 1 provides age of menarcheal t from a sample of counties from around the world.

In addition to the average age of menarche varying from country to country, the average age of menarche also has varied significantly over decades. To illustrate this variation over time, the average age of menarche among girls in the

Table 1 Global variation in mean estimates of age at menarche

Argentina	12.6	Philippines	13.6
Australia	13	Portugal	12.5
Canada	12.7	Russia	13
Chile	13	South Africa	12.5
Columbia	12.8	South Korea	13.9
Germany	12.8	Spain	12.30
India	14.3	Sweden	13.1
Indonesia	13	Switzerland	13
Ireland	13.5	Turkey	13.3
Japan	12.5	USA	12.5
Netherlands	13.2	Uganda	13.4
Nicaragua	14	United Kingdom	12.9
Nigeria	13.7	Vietnam	12.7

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United States was 13.5 years in 1900. The age slowly dropped but was very similar between the 1930s and the 1960s (mean age at menarche, 12.72–12.99 years). Then, in the 1970s, the mean age at menarche began to drop again. By the 1980s, the average age of menarche was significantly younger ($p < 0.001$) than in the previous 50 years (mean age at menarche, 12.34 years). Then again, if the data are correct and they seem to be, the historical data on age at menarche were about the same during the first millennium as it is today. In ancient Rome, the menarcheal age of onset was 12–14 years of age. In medieval Europe, it was 12–14 years of age, and in medieval Middle East, it was 12–13 years of age. Which begs the question, what was going on between medieval times and modern times that so radically decreased and then increased the menarcheal age in the twentieth century?

The variation in the age of onset of menarche is important to our understanding of adolescent pregnancy. Based on the previous research, we can say with confidence that the correlation between the age of menarche dropping in the 1970s and the increase in US adolescent pregnancy beginning in the 1970s was no accident. As the twin studies reveal, the younger the girl, when she starts menarche, the more fertile she will be. This is because sexual behavior is not just driven by modeling and decision making. Individual sexual behavior is also driven by instincts resulting from evolutionary development. *Why*, because sexual behavior is the most proximal determinant of genic reproduction and thus continued existence as an organism.

Urban Versus Rural Age at Menarche

Globally, the major differences in age of onset of menarche are not by country but by the distribution of wealth, most notably between urban and rural areas of the world. While the average age of onset is between 12 and 13 years of age, in rural areas, the age of onset is 14 years of age or slightly older. Starting menarche at age 17 is not unusual in many rural areas of poor countries. Studies of menarcheal age in urban and rural girls report that while there is a difference in age, the differences are the greatest in the less developed countries. Since 1940s, menarcheal age has decreased at a rate of 0.34 years per decade for rural girls, 0.73 years per decade for urban girls, and 0.46 years per decade for combined groups of both rural and urban. The decline in menarcheal age since the 1940s worldwide is attributed to the improving socioeconomic conditions worldwide (Cameron et al. 1991).

The most obvious explanation for the discernibly later average age of onset of menarche among girls living in rural areas (especially in developing countries) is poor nutrition. In most countries, a lack of resources available to rural communities predicts rural poverty and thus poor nutrition among the children. Other compounding factors, however, also contribute to the difference. In many rural cultures, boys are valued over girls. Boys are nurtured; girls receive less attention. Child marriage and girls marrying at a very young age is still a part of the culture. Formal female education is lacking or limited, especially in terms of sexual and reproductive health. Poorer nutrition and health among rural girls, when compared to their urban counterpart, slow their maturation process. Consequently, while the menarcheal age for both urban and rural girls declined over the decades because of improved nutrition, more resources were available to urban girls and that made all the difference. Among all girls, however, the timing of menarche is a combination of female biology, inherited genes, and environmental exposure.

In addition to the menarcheal age, there are other biological factors related to adolescent pregnancy risk such as hormone levels, genetic timing, and age of first sexual intercourse. These are important biological developments that can increase or decrease adolescent pregnancy risk. Yet, time and again, these biological factors been ignored in public policy and programming with wide-ranging consequences for adolescent girls. Not only is the social, emotional, and financial cost of this public policy failure borne by adolescent girls—it is a cost that too often results in a negative life trajectory for the girls and their children (Kohler et al. 2002).

The Belsky–Draper Hypothesis of Menarche

The global variation in menarcheal age between girls growing up in different economic environments (i.e., rural vs. urban) supports a hypothesis that, in general, girls who start menarche at a younger age have adequate resources or economic advantage over girls who start menarche later in their adolescents. This broad-spectrum theory, however, does not always explain the difference between girls in the same region where menarcheal age can vary by racial and ethnic group.

This was precisely the case in the United States in the 1970s and 1980s when a controversy erupted over how much younger African-American girls were compared to Caucasian girls who were becoming pregnant. This phenomenon seems to be contrary to global treads, which would predict that girls' with fewer resources would have a later menarcheal age (Chumlea 2003). Although a number of explanations were pushed forward, most agreed to some extent with Conservatist (although often with fewer resources) that African-American girls were younger when they became pregnant because of a breakdown in traditional Christian sexual morals among African Americans in the United States. Given the perceived sexualization of US society, and the claims-makers who framed it as a moral issue, there were few other explanations advanced enough to explain the differences.

In one exception to the preponderance of professional opinion, even though arguably it was also incorrect, Belsky et al. in (1991) reasoned that early maturity among African-American girls was a form of *conditional adaptation*. They hypothesized that there are also psychological resources, which impact the start of menarche. The Belsky–Draper hypothesis states that variations in menarche (which is a reproductive-strategy-oriented event) can be predicted by traditional and nonevolutionary events in the environment. Belsky and colleagues proposed that the early family environment (communicated nonverbally through the infant–parent attachment relationship) conveys to children the risks and uncertainties they are likely to encounter in their lifetimes. They conclude that the girl's sense of security during the period when the infant–parent attachment relationship develops would impact pubertal onset and thus predict an earlier or later menarche.

The hypothesis is based on the rationale that a lack of secure relationships in early life, typically associated with unsupportive family relationships, would speed up pubertal development among girls in similar family circumstances. Furthermore, these girls would develop earlier than girls living in a secure and supportive family. This construct of early pubertal development is based on the assumption that early sexual development gives the species an evolutionary advantage for their survival in a dangerous environment. This evolutionary strategy gives girls in these hazardous circumstances a biological advantage to offset the risk in their purpose to reproduce to sustain the species.

Because of the contradictory explanation for early menarcheal age, there have been a number of studies that have tried to test the Belsky–Draper hypothesis that there are psychological resources that affect the onset of menarcheal age. Moreover, because of the extraordinarily high likelihood of selection bias in sampling to test this type of complex hypothesis, quantitative findings have been mixed. Some supports the Belsky–Draper hypothesis, while others seem to disprove the hypothesis. Two studies specially carried out to test this hypothesis are representative of the issues related to menarcheal age and selection bias.

In 2002, Rowe reported a study of data from female twins collected by the *National Longitudinal Study of Adolescent Health* (Add Health) in an attempt to test the Belsky–Draper hypothesis. (See: http://www.cpc.unc.edu/projects/lifecourse/research_projects/add_health). The data were used to determine differences and similarities between age of menarche and age of first sexual intercourse among a national sample of female twins. In this sample, the average age at menarche was 17 years. While, the menarcheal age of these twin pairs was somewhat older than the average menarcheal age in the United States at the time, which could have influenced the findings; Rowe reported that the results indicated that age of menarche and age of first sexual intercourse were significantly influenced by genetic variation. Moreover, age of menarche was slightly more influenced by genetic heritability than age of first sexual intercourse. Nevertheless, the correlation between age of menarche and age of first sexual intercourse among the sets of MZ twins (identical twins) was $r = 0.72$. The level of correlation suggests that heredity more than environment accounts for individual differences in the variation in timing of the menarche. Or, does it? In this and other studies of identical twins, the sample sizes tended to be small. This precludes the use of covariance matrices in these biometric models to determine precise genetic effects. As a result, the possibility of selection bias even in identical twin studies continues to exist.

Sexualizing the Child

Child sexual abuse has long been known to result in a multitude of adverse effects for the victims. Among these are mental health problems, physical health problems, and risky sexual behaviors (Arata 2002; Breitenbecher 2001). In part, the harm to the child's life trajectory results from a phenomenon known as "revictimization." Among women in the United States who report being sexually abused as a child, they also report 2–3 times more sexual assaults in adolescence and adulthood than females without a history of child sexual abuse (Barnes et al. 2009). Even though the cause seems intuitive, the mechanism that explicates the link between childhood sexual abuse and later victimization is still enigmatic (Noll and Grych 2011).

In one example of many similar studies intended to investigate this observation, Vigil et al. (2005) used a life history theory to examine the relationship between child sexual abuse, childhood adversity, and patterns of reproductive development and behavior. They selected a sample of 623 women with an average age of 27 years. These women were a demographically diverse sample of American women from two US regions (rural and suburban), Missouri ($n = 418$) and the Albuquerque, New Mexico area ($n = 205$). Using a community survey approach, this sample of 623 women was

assessed for child sexual abuse, age of menarche, and social and family background.

The results of this study (given its obvious methodological flaws) showed that social and family environment had significantly less to do with the individual's age of menarche, first sexual intercourse, the desire to have children, first childbirth, and low self-valuation of physical attractiveness than having a history of child sexual abuse. These correlates within this group of abused women can be interpreted as meaning that childhood sexual abuse "in combination with other childhood circumstances" may "modify biological and behavioral patterns of individual maturation." While some of the findings related to behavior have been supported by similar research, the impact on the age of menarche is still left unanswered. Because of selection bias, there is still a question as to whether it is a combination of sexual abuse and other circumstances or whether the age of menarche is affected by other circumstances with a great influence on our the biology? For instance, we know that early biological maturation is significantly influenced by genetic inheritance. We also know that *early sexual maturation has been associated with child sexual abuse*. This study does not address these issues.

In a more recent study, Belsky and colleagues (2010), in an effort to support their original hypothesis, reported on a study where they used life history theory to test their hypothesis. Their study tested the evolutionary strategy of *early programming of human reproductive development*. This construct proposes a corollary of "early rearing experience, including that reflected in infant–parent attachment security, regulates psychological, behavioral, and reproductive development" (p. 1195).

In this study, Belsky and associates examined the annual physical examinations from 373 white females when they were between 9½ and 15½ years of age. They were enrolled in the National Institute of Child Health and Human Development Study of Early Child Care and Youth Development (2005). The test of the hypothesis was to determine whether self-reported age of menarche was different among girls who experienced infant attachment *insecurity* at 15 months of age as compared to girls who experienced infant attachment *security at the same age*. Belsky and colleagues report results that support their conditional adaptation hypothesis. Girls who experienced infant attachment *insecurity* reported an earlier age of menarche.

Again, however, a good dose of skepticism is called for in relation to these findings. There is obvious selection bias in the sample of women they examined. Although selection bias does not on its own disprove a hypothesis, it leaves open the question about the study being evidenced that the hypothesis has a great deal of utility. Given that earlier biological maturation is inherited and that a younger age at puberty tends to predict a younger age at first sexual intercourse, it is not unexpected that it tends to predict earlier parenthood. What the findings do not rule out is the real possibility that girls who experienced *attachment insecurity* also inherited a predisposition to earlier sexual maturation, which in part given social norms could have contributed to the girl's *attachment insecurity.*

From another perspective, the Belsky–Draper hypothesis does not explain professional observations over 50 years in the field of child protection, especially among children who have experienced a dramatic loss (typically of their mothering figure). In child protection cases, it is fairly common to see a delay in pubertal development. Although there have been no studies of this phenomenon, the delay in development can be quite profound and has been observed by most professional caring for abused and neglected child. It is common among severely abuse children to find a 15-year-old that has the maturity level of a 10- or 11-year-old. As antidotal evidence, it is a similar reaction to the human body delaying maturity because of a lack of adequate nutrition.

There are several serious flaws in the Belsky–Draper hypothesis. The most obvious is that the primary worldwide threat to adolescent fertility is inadequate nutrition not family-transmitted child insecurity. In such cases, the evolutionary

response to a lack of adequate nutrition is to fit the organism to the environment in ways that delay puberty and reduce reproductive success until adequate nutrition is available.

A similar evolutionary response might explain precocious puberty among African-American girls? A major evolutionary strategy for survival is to increase one's individual value, which increases the organism's chances of reproduction. For African-American girls, when the opportunity to increase social capital is limited and reproductive strategies are the only option available, teen pregnancy rates will be high; much like they were between in the 1950s and the 1970s in the United States.

Nevertheless, the Belsky–Draper hypothesis to predict the timing of menarche was a major breakthrough in the thinking about sexual development. It added to the biological and hormone hypotheses a psychological component. Studies of conditional adaption continue to reveal the malleability of the biology of life. In the case of menarche, however, the research shows that while menarche might be influenced by conditional adaptation and psychological influences, it has been shown to influence the age of menarcheal onset within a window of time, a range of age during childhood between 7 and 17 years of age.

Children of Twins Approach

There are many other examples of the environments acting as a trigger to initiate early or delayed maturation, but not enough. More studies using socially and contextually informed analyses of behaviors once thought to be shaped by moral standards are sorely needed. Without a body of genetic studies that point to behaviors as being formed by the differential forces of *nature and nurture*, the focus of reproductive and sexual health policy and services to prevent adolescent pregnancy will be based on the dominant philosophy rather than the best scientifically based knowledge.

There are also other examples where evolutionary theory did not explain early puberty. One such study examined the environment to see if stepfathering could trigger early maturation. These researchers thought that evolutionary theory predicted early maturation among girls growing up in households or in close proximity to unrelated adult males. In other words, they theorized that girls would start menarche earlier than their peers who were not around unrelated adult males. This was presented as an evolutionary strategy for families under stress. While earlier studies supported the relationship, Mendle et al. (2006) tested the possibility that the finding was a result of a nonrandom selection bias. They reasoned that the girl and stepfather shared a similar environment, and combined with genetic predisposition, these circumstances created a spurious relation between stepfathering and early menarche among nonrelated girls in the family.

To control for genetic differences and shared environmental experiences, the researchers use a children-of-twins design to examine the relationship between stepfathers and early menarcheal onset. The researchers found that cousins with or without stepfathers did not differ in age when menarche started. Furthermore, when the mother's age was controlled for, the onset of menarche associated with stepfathering in unrelated girls was eliminated. These findings strongly suggest that selection of the sample, not the stepfathering environment, accounts for the finding that stepfathering caused early menarche in unrelated girls (Mendle et al. 2006).

Menarche is an event experienced individually by each girl. In general, it is laden with personal, biological, and social significance for the girl, her family, and society. Menarcheal onset is also important for studying puberty in girls because of the wide variation in pubertal development across individuals. Menarcheal age is also an easily identifiable marker that can be used to compare the developmental status and relationship among same-age peers. Using menarche as a developmental marker, in

addition to the studies mentioned earlier, researchers have examined a number of different behaviors that could be related or affected by early puberty. In general, early physical development among girls rather than their moral beliefs or religious controls is correlated with less-than-desirable outcomes when compared to girls who begin puberty later in their adolescence. Body dissatisfaction and dissatisfaction with weight were linked to early menarche (Petroski et al. 2006), so was early menarche and risk of depression (Stice et al. 2001; Joinson et al. 2009) and eating disorders (Gaudineau et al. 2010). Early menarche, however, was not related to externalizing behavior (Carter 2011), mental health disorders (Rutter 2005), and alcohol and drug use (Al-Sahab et al. 2012).

Given the mixed findings related to early menarche and behavior, it is evident that a great deal of work is yet to be done. The gene–environment interplay, however, is unmistakable. Girls who mature earlier than their peers will experience some degree of pressure to engage in behaviors more appropriate based on their appearance rather than on their life experiences, coping skills, or cognitive abilities (Graber et al. 1997). All things considered, these research findings make it imperative that sexual and reproductive services, starting in elementary school, that are required by girls who mature early, be provided in a timely manner to prevent or modulate undesirable outcomes that result from early maturity.

Behavioral Genetic Analysis

There are few topics that can stimulate the level of acrimonious discourse that are found in discussions about adolescent sexuality. The debate and discussion was brought on by an increase in teenage pregnancies, the trend toward earlier puberty, and earlier initiation of sexual intercourse. These "disturbing" trends related to adolescent sexual activity were initially blamed on the outdated and nonfunctional sexual customs (Reiss 1990), and another sign of a catastrophic moral decline (Popenoe 1998). None of these issues have less real or concrete substance than the debate over the initiation of sexual intercourse among young and unmarried adolescents. Emotions around the circumstances that result in the initiation of sexual intercourse, particularly among young girls, can derail even the most pragmatic discussion. Nonetheless, as the evidence grows about the biological basis for many of our "moral" behaviors, there is substantial evidence that the initiation of sexual intercourse is a subtle, interaction between our genes and our environment (Dunne 1997; Rowe 2002).

Research on hormone levels and genes has shown that biological influences are intricate in the initiation of sexual intercourse. These investigators have found that androgen hormone levels (assessed by blood serum assays) and dopamine receptor genes are related to adolescent sexual arousal, sexual behavior, and age of first sexual intercourse (Miller et al. 1999). Furthermore, these biological influences explain more of the variance in the age of first sexual intercourse than psychosocial variables alone (Rodgers et al. 1999). Despite the emotional reaction and the moral outcry from the public over adolescent sexual behavior, professionals must accept the reality that biological influences play a more important role in adolescent sexual behavior than has been generally acknowledged even in the professional literature.

First Sexual Intercourse: Genes and Environment

A substantial body of research has studied the impact of early first sexual initiation on behavior. The epidemiological surveys consistently identify a number of detrimental outcomes among adolescents who report early first sexual debut. Among problems that have been reported are mental health issues (Harden et al. 2008) and delinquency (Arsenault et al. 2003). Both are suspect because in other studies, mental health disorders and antisocial behavior/delinquency have been identified as being related to genetic influences.

In this type of case, genetically informed studies can be used to separate genetic influences from environmental influences; for example, environmental influences that affect age at first sexual encounter can be separated from genetic influences. Starting with the theory that timing of the first sexual experience is related to both nature and nurture, twin studies were used to control for genetic influences that "pull apart" the genetic and environmental effects. In one type of design, MZ twins who differ in their age at first sexual encounter were compared. Using this design, differences in behavior between the twins cannot be caused by genetic influence. Consequently, differences in adjustment between twins who differ in their age at first sex also cannot be attributed to aspects of the familial environment that the twins share such as sociodemographic status of family, family structure, or family relationships (Dick et al. 2000).

Twin studies not only control for genetic selection, but also control for shared environmental influences that cannot or were not measured. Comparing identical twins provides a rigorous test of whether the relation between timing of first sex and delinquency is causal. If Identical Twin A has sex earlier than her Identical Twin B, and Twin A also shows high levels of delinquency than her identical twin sister, this association cannot be due to any genetic or environmental third variables that are shared by the identical twin sisters.

This is important because the number of previous studies using nongenetically informed samples has suggested that there was a relationship between timing of first sex and later delinquency. In one such study, which typifies a common problem in the research on adolescent sexuality, Armour and Haynie's (2007) using data on adolescents participating in three waves of the National Longitudinal Study of Adolescent Health ($N = 7{,}297$) conclude a causal relationship based on nonexperimental data. Based on their interpretation of their findings, adolescents who experience an early sexual debut are statistically more likely to participate in delinquent behavior a year later than peers who debut on time and adolescents who experience late sexual initiation.

In contrast, when Harden et al. (2008) examined the association using the same data set (the National Longitudinal Study of Adolescent Health) using a genetically informed samples of 534 same-sex twin pairs, their findings were quite different in terms of delinquency. After controlling for genetic and environmental confounding variables and using a quasi-experimental design, Harden and associates found that an earlier age at first sex debut predicted lower levels of delinquency in early adulthood not higher levels of delinquency.

What we can say with confidence is that identical twins have similar characteristics that are influenced by genes. For instance, the age of maturation is influenced by genetic predisposition. We also know that age of maturation increases the risk of early sexual initiation. Added to this condition is the knowledge that a large number of twins differ a great deal in their age at first intercourse; this difference allows for the control of genetic influences when studying the effect of early adolescent sexual initiation on their life trajectory.

What we can also say with confidence is that early adolescent sexual activity has been repeatedly linked to other detrimental outcomes that are the result of nonshared environmental factors, conditions among twins that are not shared. Most notably inconsistent and ineffective is contraceptive and condom use, which results in pregnancy and disease. Nonshared environmental factors were found in traditional religious cultures such as in the United States where adolescents are provided limited sexual health and reproductive education. Other Western industrialized countries report similar rates and patterns of teenage sexual activity but have drastically lower rates of teenage pregnancy. Based on genetically informed research and international comparison studies, it is clear that a more nuanced view of adolescent sexuality is needed when we assume that adolescent sexuality is neither inherently wrong nor globally damaging.

Discussion

There is little disagreement among scientists that our genes influence individual sexual development and behavior; the disagreement, however, is related to how much influence our genes actually have on our sexual behavior. We now know that genetic predisposition plays an important and prominent role in many areas of adolescent sexual development, knowledge that is providing useful information for policy makers and providers. Although the sociological models explain a great deal of the variation in sexual behavior, integrated models (biopsychosocial models) are more accurate and give a richer picture of the determinants of adolescent sexuality. At its most basic level, genetics determines the timing of puberty and sexual arousal. Early maturation is predictive of early sexual arousal and early sexual initiation.

Neither phenomena (the timing of puberty and early sexual arousal) are given due respect in policy or programming related to providing adolescent sexual and reproductive health. Given this basic reconceptualization of adolescent sexuality, which is informed by our understanding of genetics, fundamental change in the way adolescent sexuality is viewed and responded to, is in order.

There is no question that a great deal of work remains to be done before we will understand the mechanism and function of the genetic transfer of behavior. We know of its existence, but we do not know the process. What we can determine, that may be even more important, is what proportion of behaviors are shaped by genetic influences and what behaviors are shaped by environmental influences.

Understanding the role of genetics will allow us to focus on environmental influences that can be modified. For example, using this knowledge, we could (but would not want to) use poor nutrition to delay puberty. This would have what some perceive as a positive effect because it also delays sexual arousal and sexual initiation. We also do not want to treat an adolescent involved in an early sexual experience as a predelinquent. This response has been shown to be a self-fulfilling prophecy. Instead, a reconceptualized view of adolescent sexuality informed by our understanding of genetics will allow us to focus scarce resources in the areas of sexual and reproductive health where we can improve outcomes and trajectory for the adolescent and the children of adolescent mothers.

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Adolescent Pregnancy: Sexual and Reproductive Health

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Keywords

Adolescent motherhood · Abortion · Coerced sex · Contraception · Fistulae · Gender violence · HIV/STIs · Obstructed labor · Perinatal care · Postpartum care

Introduction

Addressing the sexual and reproductive health needs and problems of adolescents is a crucial element of the World Health Origination (WHO) Global Reproductive Health Strategy (World Health Organization 2004b). In many parts of the world, the sexual and reproductive health needs of adolescents are either poorly understood or not fully appreciated. Evidence is growing that this neglect can seriously jeopardize the health and future well-being of young people (World Health Organization 2003, 2006b, 2011g).

Sexual activity during adolescence (within or outside marriage) puts adolescents at risk of sexual and reproductive health problems if they do not have access to the needed information, education and services (United Nations 2005, 2011f, 2012c). These include early pregnancy (intended or otherwise), unsafe abortion, sexually transmitted infections (STIs) including human immunodeficiency virus (HIV), and sexual coercion and violence. In addition, in some cultures, girls face genital mutilation and its consequences (World Health Organization 2006c).

This chapter looks at the sexual and reproductive health issues related to adolescent pregnancy from the point of view of the continuum of care. The continuum of care is an approach promoted by WHO and in the context of reproductive, maternal, newborn, and child health (RMNCH); it includes integrated service delivery and community actions for mothers and children from pre-pregnancy to delivery, the

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immediate postnatal period, and childhood. In the context of adolescent pregnancy, the continuum of care means that provisions should be made to ensure access and quality services before the pregnancy (such as interventions to improve nutritional status and health to reduce the likelihood of health problems in the mother and baby), during the pregnancy (antenatal, intra- and immediate postnatal care, as well as safe abortion and post-abortion care), and after the delivery to ensure proper care for the adolescent mother and her baby.

Moreover, the continuum of care has a second dimension, which is linking the various levels of care at home, community, and health facilities. The care for pregnant adolescents, thus, is a joint responsibility of families, communities, and health care systems—through outpatient services, clinics, and other health facilities (Fig. 1), as well as other sectors (WHO Regional Office for Europe 2011b). It is a person-centered care that involves adolescents in its design, planning, and monitoring and understands holistically their physical, emotional, and social concerns.

A broader life-course perspective emphasizes that the health of adolescents is affected by early childhood development and the biological and social role changes that accompany puberty, shaped by social determinants of health that affect the uptake of health-related behaviors. The onset of these behaviors and states in adolescence affects the burden of disease in adults and the health and development of their children (Sawyer et al. 2012; Viner et al. 2012). The importance of tacking the social determinants of adolescent pregnancy, such as the cultural norms that support early marriage, the cultural context of sexuality education, social norms *vis-a-vis* coerced sex, etc. is of paramount importance.

With this framework in mind, in the first part of the chapter, we describe the global situation in sexual behaviors and use of contraception; pregnancy, childbirth, postpartum care, and health of newborns; access to safe abortions for pregnant girls; adolescent pregnancy and HIV/STIs; and adolescent pregnancy and gender-based violence. Further, the chapter describes actions that are required to prevent early pregnancy and poor reproductive health outcomes in adolescent girls. These actions, as the continuum of care requires, encompass actions by the families and communities, health sector, and other sectors. This part is based on a WHO systematic review developed in line with the WHO's Guidelines Review Committee (GRC)-recommended process. A guidelines development core group—consisting of representatives from different relevant WHO departments—was constituted. The core group worked together to list the main health and behavioral outcomes that were being aimed for as well as a series of questions relating to each outcome. This set of outcomes and corresponding questions was sent to a carefully selected multidisciplinary group of experts from around the world. The expert groups included researchers, advocates, policy makers, program managers, and staff from the United Nations and other development agencies. Group members were asked to rank the importance of the outcomes in reducing adolescent pregnancy and poor reproductive outcomes in adolescents, on a scale of 1–9. Outcome rates were deemed as *critical* if they scored 7–9 on average, *important but not critical* if they scored 4–6, and *not important* if they scored less than 4. Expert group members were also asked to provide feedback on the relevance of each question to the corresponding outcome and to the overall objective of the review, and in addition to suggest any needed revisions to the questions. Finally, they were invited to propose additional outcomes and questions. The responses were collated, reviewed by the core group, and based on this, a final set of outcomes and questions was agreed upon. This chapter is presenting evidence-based interventions for the selected outcomes which in broad categories are preventing early pregnancy and preventing poor sexual and reproductive health outcomes and includes health care systems as well as community actions. Finally, the chapter looks at the latest international developments in the global health agenda and analyzes the opportunities that these present to translate the recommendations in the WHO Guideline into actions.

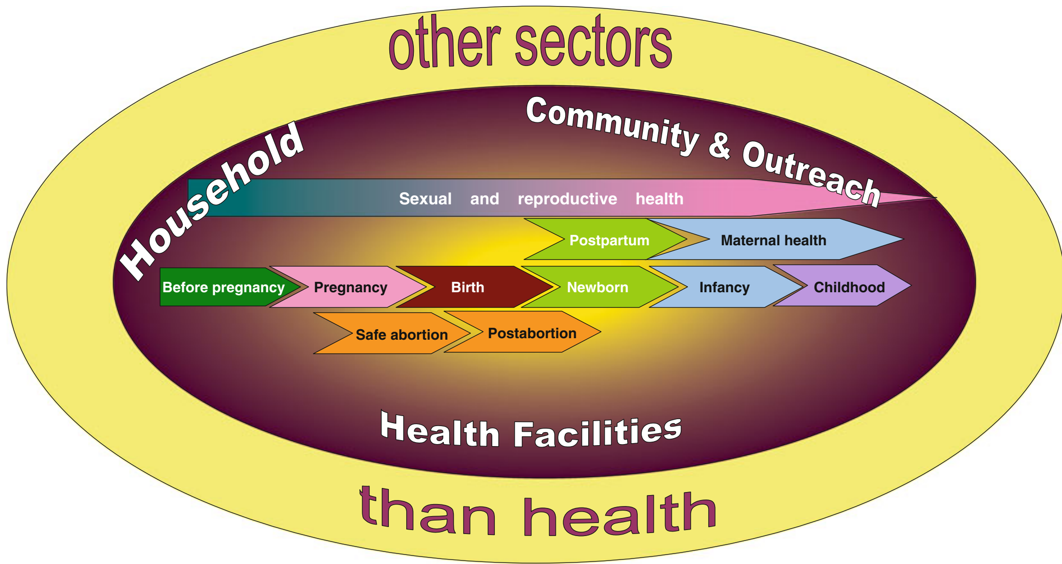

Fig. 1 The continuum of sexual and reproductive care for pregnant adolescents. *Source* Adapted from PMNCH fact sheet: RMNCH continuum of care http://www.who.int/pmnch/media/press_materials/fs/continuum_of_care/en/

Global Situation

Despite declines in average fertility rates, an estimated 14–16 million children are born to adolescent mothers aged 15–19 each year, representing 11 % of total births worldwide (Temin and Levine 2009; World Health Organization 2006b, 2012c). Even within the developing world, the incidence of adolescent pregnancy varies dramatically by region; while over 50 % of women in sub-Saharan Africa give birth before age 20, only 2 % of Chinese children are born to teenage mothers (Temin and Levine 2009; World Health Organization 2007).

Sexual Behaviors and Use of Contraceptives

Many of the births in adolescent girls are intended and take place within the context of early marriage, which is encouraged in some societies and remains common in developing countries. Approximately half of girls in sub-Saharan Africa are married by age 18, compared with 20–40 % in Latin America and 73 % of girls in Bangladesh (World Health Organization 2007). However, the status of being married does not guarantee access to family planning: 44 % of married girls aged 15–19 years in developing countries want to avoid pregnancy, but less than one in three of them use effective contraception (Singh et al. 2009). Thus, a substantial portion of teenage pregnancies are unintended and unwanted, ranging from 10 to 16 % in India and Pakistan to a high of 50 % or more in several African countries (World Health Organization 2007). In developed countries, fewer adolescents enter into marriage before the age of 18, which means that pregnancy and childbearing in this age group are occurring mostly outside of marriage or other formal unions (World Health Organization 2007).

Condom use is a key means of preventing negative reproductive health outcomes. Although data from sub-Saharan Africa and the developed world suggest that use of condoms by adolescents is increasing worldwide; the proportion of sexually active young people who report condom use is clearly too small to contain the spread of STIs (Bearinger et al. 2007). A survey among 15-year olds in 32 countries of the WHO European Region showed that on average

76 % of 15-year-old girls have used a condom at last intercourse and 26 % used the contraceptive pill; however, variations between countries ranges between 60 and 89 % for condom use and between 2 and 62 % for pill use (Baltag 2008; WHO Regional Office for Europe 2012). In the developing world, use of medical contraceptive methods is substantially lower among adolescent girls than in adult women (Bearinger et al. 2007). In sub-Saharan Africa, very small proportions of unmarried, sexually experienced girls aged 15–19 used medical contraceptive methods at most recent sex (from 4 % in Benin to 12.4 % in Mali). Current use of medical methods is slightly greater in unmarried, sexually experienced adolescent girls in Latin America and the Caribbean (from 16.1 % in the Dominican Republic to 41.3 % in Brazil) (Bearinger et al. 2007).

Young women under age 25 in developing regions are particularly vulnerable to unwanted pregnancies (Shah and Åhman 2012), and there is considerable regional variations in the extent to which adolescents plan to have babies. In the United States, almost three-quarters of pregnant 15–19-year olds said that their pregnancies were unplanned; in Latin America and the Caribbean, between a quarter and half of adolescent mothers said that their babies were unplanned, while in India, Indonesia, and Pakistan, only 10–16 % were unplanned (World Health Organization 2006b). The situation is not better in married adolescents: more than half of married adolescents in Ghana and Peru, and more than a third in Botswana, Kenya, Malawi, Zimbabwe, and Colombia reported unplanned or unwanted babies (World Health Organization 2006b).

Preconception Care

Preconception care is the provision of biomedical, behavioral, and social health interventions to women and couples before conception occurs, aimed at improving their health status, reducing risky sexual behaviors, and identifying individual and environmental factors that could contribute to poor maternal and child health outcomes. Its ultimate aim is to improve maternal and child health outcomes—both in the short and the long term (World Health Organization 2012a).

The USA-based Centers for Diseases Control, the Netherlands-based Erasmus University and the Health Council of the Netherlands, and the Pakistan-based Aga Khan University have published ample reviews of the evidence of preconception care interventions in contributing to a range of health and development outcomes (Bhutta et al. 2011; Center for Disease Control and Prevention 2006; Health Council of the Netherlands 2007; Jack et al. 2008).

These reviews have shown that to address a number of health problems—such as nutritional deficiencies and disorders, vaccine for preventable infections, environmental risks, screening for genetic disorders, early pregnancies, unwanted pregnancies, and pregnancies in rapid succession, female genital mutilation, intimate partner and sexual violence—effective interventions do exist (World Health Organization 2012a). A recent meeting of WHO and other international experts concluded that in both high- and low-income countries, preconception care should make a special effort to target adolescent girls who are especially vulnerable in many low- and middle-income settings; without special attention, their needs are likely to be neglected (World Health Organization 2012a).

Pregnancy, Childbirth, Postpartum Care, and Health of Newborns

About one in eight births in developing countries are to girls aged 15–19(United Nations 2009). Although adolescent birth rates are declining, the absolute number of births has declined less, owing to the increase in the adolescent population. Moreover, in many countries, the proportion of births (among women of all ages) that occur in adolescents has increased, because of the reduction of fertility in older women (World Health Organization 2012c). Women aged 15–24 in the Africa region account for 43 % of all births in the region. In Asia (excluding the

Eastern Asia sub-region) and in the Latin America/Caribbean region, young women aged 15–24 account for 49 and 47 % of births, respectively (Shah and Åhman 2012).

Maternal and Perinatal Mortality

Maternal mortality and morbidity account for 16 % of all disability-adjusted life years, the sum of years of potential life lost owing to premature mortality and the years of productive life lost owing to disability, among women aged 15–29 in developing countries (United Nations Commission on Population and Development 2012). Health risks for mother and baby are strongly associated with childbirth at an early age. Many of these risks are also associated with giving birth for the first time (primiparity). Since adolescent mothers are usually also first-time mothers, it is difficult to separate these risks. Adolescent mothers aged 15–19 are more likely than older mothers to die in childbirth, while very young mothers aged 14 and under are at highest risk (World Health Organization 2006b). A systematic analysis of population health data that investigated global patterns of mortality in young people has shown that maternal conditions were a leading cause of female deaths at 15 % (Patton et al. 2009).

Adolescents are more likely than older women to give birth to preterm and low birth weight (less than 2,500 g) or very low-weight (less than 1,500 g) babies, are at risk for malnourishment, poor development, or even death (World Health Organization 2004a, 2006b). Impaired fetal growth is more common in pregnancy in girls younger than 18 years and is a potent precursor of adult diabetes (Norris et al. 2012). The youngest age groups run the highest risk and lack of social support during pregnancy and are also associated with preterm labor (and associated risk of neonatal or perinatal mortality), increased risk of stillbirth, and infant and child mortality (World Health Organization 2006b). Furthermore, about 140 million girls and women worldwide are currently living with the consequences of female genital mutilation which is mostly carried out on young girls sometime between infancy and age 15. In Africa an estimated 101 million girls 10 years old and above have undergone FGM (World Health Organization 2013c). Babies born to women who have undergone female genital mutilation suffer a higher rate of neonatal death compared with babies born to women who have not undergone the procedure.

Anemia

Severe anemia is an important indirect cause of maternal mortality, and approximately half of adolescent girls in the developing world are anemic (World Health Organization 2006b). Nutritional deficiencies in folic acid or iron and infectious diseases, such as malaria and intestinal parasites, all contribute to adolescent anemia. Iron-deficient, anemic adolescent mothers are more likely to give birth to preterm or low-birth-weight babies. Specific transgenerational effects would be particularly severe in countries where both adolescent malnutrition and micronutrient deficiency are high and teenage pregnancy is common (Patton et al. 2009). For example, in India, about half of girls aged 15–19 are underweight and anemic, and a similar proportion are married before age 19 years (Norris et al. 2012).

Prolonged Labor, Obstructed Labor, and Fistulae

Teenage women are themselves more likely to face intrapartum complications such as obstructed and prolonged labor, vesico-vaginal fistulae, and infectious morbidity (Bhutta et al. 2011).

Prolonged obstructed labor, usually the result of a small pelvis, is more common in first-time mothers, smaller women, and girls below the age of 16 whose pelvis is immature (World Health Organization 2004a). Pregnant women experiencing prolonged or obstructed labor need emergency obstetric care which makes it difficult for adolescent mothers in poor, rural communities to seek timely emergency care. Labor therefore may

continue for days without intervention and result in obstetric fistula. Each year between 50 000 to 100 000 women worldwide are affected by obstetric fistula. It is estimated that more than 2 million young women live with untreated obstetric fistula in Asia and sub-Saharan Africa (World Health Organization 2010). In fistula patients from some countries the association with adolescent pregnancy is very high (World Health Organization 2006). Harmful traditional practices, such as female genital cutting or mutilation, also contribute to the risk of obstetric fistulae. Such cutting is usually carried out under unsanitary conditions, often by removing large amounts of vaginal or vulval tissue, thus causing the vaginal outlet and birth canal to become constricted by thick scar tissue. These practices, mostly carried out on very, increase the likelihood of gynaecological and obstetric complications, including prolonged labour and fistula. Although there are few reliable statistics available, these practices may increase the likelihood of such complications by up to seven times (World Health Organization 2006).

Puerperal Sepsis

Puerperal sepsis is one of the main causes of maternal mortality among adolescents (World Health Organization 2004a) and is common in mothers who experience complicated childbirth without access to hygienic health services and/or have had a long or obstructed labor.

Health Care of Adolescent Girls During Pregnancy, Delivery, and the Postpartum Period

Timely antenatal care, care in childbirth, and postnatal care are all critical for safe motherhood. For routine antenatal care, WHO recommends minimum four visits during the pregnancy (at 16 weeks, between 24 and 28 weeks, at 32 weeks, and at 36 weeks) with specific activities (scientifically proven to be effective) during each visit (World Health Organization 2002b). More frequent visits may be required if there are other intercurrent problems, such as HIV infection, severe anemia, and hypertension (World Health Organization 2010a). Data from the United Kingdom and the United States show that adolescents often do not receive optimum antenatal care (Lewis 2001; Partridge et al. 2012). However, studies that compare pregnancy-related care between adolescents and older women show mixed evidence. An analysis of Demographic and Health Survey data for 15 developing countries examined adolescents' use of antenatal care, delivery care, and infant immunization services compared with use by older women. The study found that in five of the 15 countries, women aged 18 or younger were less likely than women aged 19–23 to use either antenatal care or delivery care, or both. The association of age and health care use was largely limited to Bangladesh, India, Indonesia, Nicaragua, Peru, and Uganda. In Latin America, controlling for parity allowed differences between adolescents and older women to emerge. Except in Uganda, there were no differences in health care use by mother's age in the African countries (Reynolds et al. 2006). The latest data from Burundi and Ethiopia show that the coverage with antenatal care in surveyed adolescents is comparable with the coverage in women between 20 and 34 years old (Central Statistical Agency Ethiopia and ICF International 2011; Institut de Statistiques et d'Études Économiques du Burundi (ISTEEBU), Ministère de la Santé Publique et de la Lutte contre le Sida [Burundi] (MSPLS), and ICF International 2010). In the same time, fewer than half the pregnant adolescents in Chad, Ethiopia, Mali, Niger and Nigeria have received any antenatal care from a skilled provider (Kothari et al., 2012). Clearly, the situation is mixed and it seems that coverage with antenatal care alone although useful indicator does not capture the whole picture. It seems that looking more in depth into the content of the antenatal care and coverage with specific interventions might provide a better insight into the specifics of adolescence.

In addition to receiving adequate antenatal care, the WHO recommends assistance from a skilled birth attendant during delivery (World Health Organization 2002a). Information about the percentage of births to adolescents that are attended by skilled personnel is scarce. Some countries, like India and Bangladesh, show no significant difference in institutional deliveries and deliveries by skilled attendants between adolescents and older women (20–34 years of age) (World Health Organization 2007). In Chad, Ethiopia, Mali, Niger and Nigeria less than 50 per cent of adolescents delivered with the help of a skilled attendant (Kothari et al., 2012). A DHS analysis (Reynolds, et al., 2006) found that in some countries, including Brazil, Bangladesh, India and Indonesia, adolescents were less likely than older women to obtain skilled care during childbirth.

Postpartum Care

The majority of maternal deaths occur because of postpartum hemorrhage, and almost half of maternal deaths occur within one day of delivery and 70 % within a week (World Health Organization 2007). It is therefore very important to pay attention to immediate and later postpartum care. Information regarding postpartum care among adolescents is scarce. The proportion of adolescent mothers who received postpartum care within 2 months ranges from 16 % in Colombia to 55.7 % in Ghana and compares with the postpartum care received by older women (World Health Organization 2007).

Access to Safe Abortion for Pregnant Girls

Although many of adolescent pregnancies are intended, many still are not only unplanned but also unwanted, as seen by the estimated 2.2–4 million adolescent girls who obtain abortions each year. In many countries, 30–60 % of adolescent pregnancies end in abortion (World Health Organization 2004a). This figure is disproportionate considering that adolescent pregnancies make up just over 10 % of pregnancies worldwide.

In 2008, of the 43.8 million induced abortions globally (Sedgh et al. 2012), 21.6 million were estimated to be unsafe. Unsafe abortion is defined by the WHO as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (World Health Organization 2012b). Nearly, all unsafe abortions (98 %) occur in developing countries. Unsafe abortion accounts for 13 % of maternal deaths (Ahman and Shah 2011) and 20 % of the total mortality and disability burden due to pregnancy and childbirth (World Health Organization 2008). Almost all deaths and morbidity from unsafe abortion occur in countries where abortion is severely restricted by law and in practice. Every year, about 47,000 women die from complications of unsafe abortions (World Health Organization 2011d); an estimated 5 million women suffer temporary or permanent disability, including infertility (World Health Organization 2012b).The total number of unsafe abortions has increased from about 20 million in 2003 to 22 million in 2008 (World Health Organization 2012b); also there was a global increase in the proportion of abortions that are unsafe among all induced abortions—from 44 % in 1995 to 49 % in 2008; in developing countries, it stayed at around 55 % (Sedgh et al. 2012).

Because they are less likely to have access to legal and safe abortion, adolescents are especially vulnerable to unsafe abortion. In 2008, there were an estimated 3 million unsafe abortions in developing countries among girls aged 15–19 (World Health Organization 2011e). Forty-one percent of unsafe abortions in developing regions are among young women aged 15–24, 15 % among those aged 15–19, and 26 % among those aged 20–24. The differences in the distribution of unsafe abortion by age between regions are distinct. Of the 3.2 million, unsafe abortions are among young women 15–19 years old, and almost 50 % are in the

Africa region. Some 22 % of all unsafe abortions in Africa compared to 11 % of those in Asia (excluding Eastern Asia) and 16 % of those in Latin America and the Caribbean are among adolescents aged 15–19 (Shah et al. 2012).

Whether abortion is legally more restricted or available upon request, a woman's likelihood of having an unintended pregnancy and seeking induced abortion is about the same. However, legal restrictions, together with other barriers, mean many pregnant adolescents seek abortions from unskilled providers. The legal status of abortion has no effect on a woman's need for an abortion, but it considerably limits her access to a safe abortion. Where access to safe abortion is restricted, there is a greater likelihood that abortions are performed by unqualified persons in unhygienic circumstances (World Health Organization 2006b, 2012b). In Africa and Asia, about 13 % of maternal deaths are related to unsafe abortion, many of them in young single women (World Health Organization 2004c, 2006b). Of the 19 million illegal abortions each year, 2.2–4 million are among adolescents who tend to seek abortions later in pregnancy and have a tendency to delay seeking care in the event of complications (World Health Organization 2006b). The later the women in pregnancy undergo abortion, the greater the health risk.

Adolescent Pregnancy and HIV/STIs

Young people are at the center of the global HIV epidemic. Sub-Saharan Africa is home to almost two-thirds (61 %) of all youth living with HIV (3.28 million), 76 % of them being female. In parts of southeast and central Africa, 20–30 % of pregnant girls and women are infected with HIV, which is also spreading rapidly in Southeast Asia (World Health Organization 2006b). In Central and Eastern Europe, the Russian Federation and Ukraine have the fastest growing epidemics in the world, and young people account for a large proportion of the number of people living with HIV (Inter-Agency Task Team on HIV and Young People 2008). Furthermore, the global paediatric HIV epidemic is shifting into a new phase as children on antiretroviral therapy (ART) move into adolescence and adulthood. Their survival into adolescence and beyond represent one of the major successes in the battle against the disease that has claimed the lives of millions of children (Agwu AL, Fairlie L. 2013). However, the growing number of perinatally HIV-infected adolescents globally, and hence pregnant perinatally HIV-infected adolescent girls, poses challenges as they may fall through the cracks and suffer from a sense of abandonment as they move to adult HIV care and lose the familiar and dependable environment and staff of the paediatric HIV clinic (clinicians, social workers, nursing staff) and its support services (Mofenson LM, Cotton MF. 2013).

Given the level of risk of HIV/AIDS and the risk of teenage pregnancy in developing countries, it is clear that special attention should be paid to maternal health care services for pregnant HIV-positive adolescents. The factors that are influencing adolescent HIV-positive mothers' use of such services need to be well understood and interventions tailored. However, research on their access to and use of these services is scant, and pregnant adolescents remain a vulnerable subgroup, understudied and underserved, and at increased risk for HIV/STD (DiClemente et al. 2010). Emerging evidence indicates that the existing HIV/AIDS treatment, and care and support programs do not ask their adolescent clients about their sexual and reproductive health needs. This represents a missed opportunity for systematically identifying and addressing the reproductive health concerns of HIV-positive adolescent clients (Birungi et al. 2011). Data on prevention of mother-to-child HIV transmission in adolescent girls are also limited (North et al. 2006). Because of their age, teenage mothers may have to deal with disapproving health care providers; in addition, those living with HIV may face stigma and discrimination in health care settings (Birungi et al. 2011; Bond et al. 2002). Not surprisingly, in some settings, the use of Prevention of mother-to-child transmission of HIV (PMTCT) services

was less common than use of prenatal care services among HIV-positive female adolescents (Birungi et al. 2011). Factors found to influence adherence of pregnant adolescents to PMTCT recommendations included HIV and early premarital pregnancy stigma, fear of a positive test result, concerns over confidentiality, and poor treatment by health care providers (Varga and Brookes 2008). Adolescents seem to employ elaborate strategies to avoid HIV disclosure to labor and delivery staff, despite knowing this would mean no antiretroviral therapy for their newborn infants (Varga and Brookes 2008). A study that compared the percent testing for HIV and receiving the results in adolescents and older youth found no differences in these parameters; however, adolescents were less likely to say that a provider demonstrated condom use or that methods to prevent subsequent pregnancies were discussed (North et al. 2006).

An international comparison of levels and trends in STIs showed that overall, syphilis, gonorrhea, and chlamydia disproportionately affect adolescents and young people, with huge variations in the incidence among young people (Baltag 2008; Panchaud et al. 2000). *Chlamydia trachomatis* infection is one of the most common STIs among adolescents and is one of the most common causes of perinatal infection. Studies suggest that high-risk sexual behavior may continue in teen pregnancy and in the postpartum period, and routine prenatal and postpartum care with repeated prenatal chlamydial and other STD screening and counseling are indicated in this population (DiClemente et al. 2004, 2010; Ickovics et al. 2003; Niccolai et al. 2003).

Adolescent Pregnancy and Gender-Based Violence

Young women are at particular risk of unwanted sex, or sex in unwanted conditions, particularly when there are large age differences between them and their partners (World Health Organization 2012b); in turn, forced sexual initiation, intimate partner violence, and/or sexual violence appear to increase the risk of pregnancy in early adolescence (World Health Organization 2010b). Up to 50 % of sexual assault cases are committed against girls under age 16 (United Nations Commission on Population and Development 2012). Between 7 and 50 % of adolescent girls report that their first sexual experience was forced (Bott 2001; Jewkes et al. 2002; United Nations Commission on Population and Development 2012). Adolescent girls are more likely to be pressured into sexual activity at an older man's request or by force and often must rely on the man to prevent pregnancy. Although research on intimate partner violence among adults has dramatically expanded over the past 30 years; comparatively little is understood about partner violence among adolescents (WHO Regional Office for Europe 2011c). Women who are coerced into sex or who face abuse from partners are less likely to be in a position to use contraception and are therefore more exposed to unintended pregnancy than others (Jewkes et al. 2002). Conversely, women with unintended pregnancy are more likely to experience intimate partner violence (World Health Organization 2011c), which places adolescent girls at a relatively higher risk for the latter. In South Africa, it was found that pregnant adolescents were more than twice as likely to have a history of forced sexual initiation as non-pregnant adolescents (Jewkes et al. 2001). Similar findings in the United States have also been reported (Silverman et al. 2004).

The WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes in Adolescents in Developing Countries

The recommendations of the WHO guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries (World Health Organization 2011e), as well as the basis for these recommendations, are listed below by outcomes.

Prevent Early Pregnancy

To prevent early pregnancy, the WHO guidelines recommend actions to prevent marriage before the age of 18, to reduce pregnancy before age 20 (through sexuality education, education, economic and social support programs), to increase the use of contraception, and to reduce coerced sex.

Preventing Early Marriage

WHO's recommendations for preventing early marriage are informed by 21 studies, and project reports did not meet the criteria for grading as well as the collective judgment of the expert panel. The studies were conducted in countries, which included Afghanistan, Bangladesh, Egypt, Ethiopia, India, Kenya, Nepal, Senegal, and Yemen. In some of these studies and projects, the primary outcome was delaying the age of marriage, while in others, this outcome was examined secondary to outcomes such as school retention, knowledge and attitudes, or sexual behavior.

To prevent early marriage, WHO recommends actions by policy makers and by individuals, families, and communities.

Actions by Policy Makers

Prohibit early marriage In many countries, laws do not prohibit the marriage of girls before the age of 18. Even in countries where they do, these laws are not enforced. Consequently, child marriage occurs in many countries. Policy makers must put in place laws to prohibit the marriage of girls before the age of 18. In those countries where such laws are already in place, policy makers must ensure that they are enforced so that they make a difference in girls' lives.

Actions by Individuals, Families, and Communities

Keep girls in school Around the world, more girls are being enrolled in school than ever before. Educating girls has a positive effect on their health, the health of their children, and that of their communities. Additionally, girls in school are less likely to be married at an early age. Sadly, the school enrollment rate in girls drops sharply after 5 or 6 years of schooling in some countries. Policy makers must increase formal and non-formal educational opportunities for girls at both primary and secondary levels.

Influence cultural norms that support early marriage In some parts of world, girls are expected to marry and begin child bearing in their early or middle teenage years, well before they are physically or mentally ready to do so. Parents feel pressured by prevailing norms, traditions, and economic constraints to get their daughters married at an early age. In order to successfully delay marriage, community leaders must work with all stakeholders to challenge and change these norms. An empowered, informed girl needs a supportive family and community environment in order to fulfill her potential.

WHO's recommendations for research in this area are as follows:

1. To build evidence on the effect of interventions to prevent early pregnancy, including those that increase employment, school retention, education availability, and social supports.
2. To better understand how economic incentives and livelihood programs can work to delay the age of marriage among adolescents.
3. To develop better methods to assess the impact of education and school enrollment on the age of marriage.
4. To assess the feasibility of existing interventions to inform and empower adolescent girls, their families, and their communities to delay the age of marriage, and the potential of taking the interventions to scale.

Creating Understanding and Support for Preventing Early Pregnancy

WHO's recommendations for preventing early pregnancy are informed by two graded systematic reviews, three ungraded studies, as well as the collective experience and judgment of the expert panel. The studies in the systematic reviews included those conducted in developing countries (Mexico and Nigeria) as well as those conducted among poorer socioeconomic populations in developed countries. Collectively, the studies demonstrate reductions in early pregnancy among adolescents exposed to interventions that included sexuality education, cash transfer schemes, early childhood education and youth development, and life skills building. One study demonstrated a reduction in repeated pregnancies as a result of an intervention that included home visits for social support.

To create understanding and support for preventing early pregnancy, WHO recommends actions by policy makers and by individuals, families, and communities.

Actions by Policy Makers

Support Pregnancy Prevention Programs among Adolescents Early pregnancies occur because of a combination of social norms, traditions, and economic constraints. At the same time, there continues to be resistance to implementing sexuality education. Policy makers must give strong and visible support for efforts to prevent early pregnancy. Specifically, they must ensure that sexuality education programs, which are linked to contraceptive information and services, are in place.

Actions by Individuals, Family, and Communities

Educate girls (and boys) about sexuality Many adolescents become sexually active at an early age when they do not know how to avoid unwanted pregnancies and STIs. Contextual factors such as the pressure to conform to media stereotypes and the norms of their peers increase the likelihood of early and unprotected sexual activity. In order to prevent early pregnancy, curriculum-based sexuality education must be widely implemented. These programs must be carried out in a context in which adolescents can build their life skills and are supported to deal with thoughts, feelings, and experiences that accompany sexual and reproductive maturity. Sexuality education programs must be linked to contraceptive counseling and services.

Build Community Support for Preventing Early Pregnancy

In some places, premarital sexual activity is acknowledged. In others, it is not, and there is resistance to discussing meaningful ways of addressing it. Families and communities are key stakeholders and must be engaged and involved in efforts to prevent early pregnancies and STIs including HIV.

WHO's recommendations for research in this area are as follows:

1. To build evidence on the effect of interventions to prevent early pregnancy, including those that increase employment, school retention, education availability, and social supports.
2. To conduct research across sociocultural contexts to identify feasible, scalable interventions to reduce early pregnancy among adolescents.

Increasing the Use of Contraception

WHO's recommendations for increasing the use of contraception are informed by seven graded studies or systematic reviews, 26 ungraded studies, as well as the collective experience and judgment of the expert panel. The studies were conducted in countries including Bahamas, Belize, Brazil, Cameroon, Chile, China, India, Kenya, Madagascar, Mali, Mexico, Nepal, Nicaragua, Sierra Leone, South Africa, Tanzania, and Thailand. Some studies focused exclusively on condom use, while others sought to increase the use of hormonal contraceptives and emergency

contraceptives. Some studies examined the use of contraception as a primary outcome, while others examined their use as secondary to outcomes such as HIV prevention or knowledge and attitudes. Some studies focused exclusively on health care system actions (such as over-the-counter or clinic provision of contraceptives), while others focused on community and stakeholder engagement.

To increase contraceptive use (including condoms, hormonal contraceptives, and emergency contraceptives), WHO recommends actions by policy makers, individuals, families, and communities to change the health care system.

Actions by Policy Makers

Legislate access to contraceptive information and services In many places, laws and policies prevent the provision of contraceptives to adolescents, especially to unmarried ones and those below a certain age. Policy makers must intervene to reform laws and policies to enable adolescents to obtain contraceptive information and services, including emergency contraceptives.

A conditional recommendation is to reduce the cost of contraceptives to adolescents Financial constraints can restrict access to contraceptives to only those who have the financial means to purchase them. Policy makers should consider intervening to reduce the financial cost of contraceptives to adolescents, in order to increase their use.

Actions by Individuals, Families, and Communities

Educate adolescents about contraceptive use Adolescents in many places are not aware about where to obtain contraceptives and how to use them appropriately. Efforts to provide them with accurate information about contraceptives must be carried out in combination with sexuality education.

Build community support for contraceptive provision to adolescents There is continuing resistance to the provision of contraceptives to adolescents, especially those who are unmarried. Community members must be engaged, and their support must be obtained for the provision of contraceptives to adolescents.

Actions at the Level of the Health Care System

Enable adolescents to obtain contraceptive services In many places, adolescents do not seek health services such as contraceptive information and services because they are afraid of social stigma, of being judged, and being treated with disrespect by clinic staff. Health service delivery must be made more responsive and friendly to adolescents. Further, repeated pregnancies must be prevented by providing contraceptives to adolescents after they have a child or an abortion.

WHO's recommendations for research in this area are as follows:

1. To build evidence on interventions—formulating laws and policies, generating community support, improving the availability of over-the-counter hormonal contraceptives, and reducing the cost of contraceptives, to increase contraceptive use by adolescents.
2. To build evidence on ways of involving males in decisions about contraceptive use by couples and on transforming gender norms about the acceptability of contraceptive use (including condoms and hormonal contraceptives).

Reducing Coerced Sex

WHO's recommendations for reducing coerced sex are informed by two graded studies, six ungraded studies or reports, and the collective experience and judgment of the expert panel. The studies and reviews were conducted in countries including Kenya, Zimbabwe, Botswana, India,

South Africa, and Tanzania. The reports were of reviews of national laws. The studies involved actions across multiple sectors to influence knowledge and attitudes about coerced sex.

To reduce coerced sex, WHO recommends actions by policy makers and actions to influence individual and community norms on gender-based violence and coerced sex.

Actions by Policy Makers

Prohibit coerced sex In many places, law enforcement officials do not actively pursue perpetrators of coerced sex. Further, the fear of bringing shame and stigma upon themselves makes it very hard for victims to press for justice. Policy makers must formulate and—even more importantly—enforce laws that prohibit coerced sex and punish its perpetrators. These laws should be enforced in a way that victims and their families feel safe and supported in approaching the authorities and seeking justice.

Actions by Individuals, Families, and Communities

Empower girls to resist coerced sex In many places, girls feel powerless to refuse unwanted sex and to resist coerced sex. Girls must be protected from harassment and coercion. They must be empowered to protect themselves and to ask for and obtain effective assistance when they feel unable to handle a situation by themselves. Programs that build the self-esteem of adolescent girls, develop their life skills, and improve their links to social networks and social supports can help them refuse unwanted sex, resist coerced sex, and work with authorities to hold perpetrators accountable for their actions.

Influence Social Norms that Condone Coerced Sex Prevailing societal norms condone violence and sexual coercion in many parts of the world. Efforts to empower adolescents are important, but they are not enough. They must be combined with efforts to challenge and change the community norms that condone coerced sex. Communities and societies must be mobilized to make them fiercely intolerant of these violations of rights.

Engage men and boys to critically assess gender norms In many places, gender-based violence and coercion are accepted as the norm. Men and boys must be actively supported to look critically at and to question prevailing gender norms and stereotypes and the negative effects they have on women, girls, families, and communities. This could persuade them to change their attitudes and to refrain from violence and coercive behaviors.

WHO's recommendations for research in this area are as follows:

1. To build evidence on the effectiveness of laws and policies aimed at preventing sexual coercion.
2. To assess how these laws and policies are formulated, enforced, and monitored in order to understand how best to prevent the coercion of adolescent girls.

Prevent Poor Reproductive Outcomes in Adolescents

To prevent poor reproductive outcomes in adolescents, the WHO guidelines recommend actions to prevent unsafe abortion and mortality for unsafe abortion when it occurs and to increase access to skilled antenatal, delivery, and postnatal care.

Reducing Unsafe Abortion

WHO's recommendations for reducing unsafe abortions are informed by the collective experience and judgment of the expert panel. There were no studies that could be used to provide evidence to inform the panel's decisions.

To reduce unsafe abortion and mortality resulting from it, WHO recommends actions by policy makers, individuals, families, and communities and at the level of the health care system.

Actions by Policy Makers

Enable access to safe abortion and post-abortion services Policy makers must support efforts to inform adolescents of the dangers of unsafe abortion and to improve their access to safe abortion services, where legal. They must also improve adolescent access to appropriate post-abortion care, regardless of whether the abortion itself was legal. Adolescents who have had abortions must be offered post-abortion contraceptive information and services.

Actions by Individuals, Families, and Communities

Inform adolescents about the dangers of unsafe abortion and where they can obtain safe abortion services When faced with an unwanted pregnancy, adolescents in many places turn to illegal and unsafe abortions because they are not aware of its dangers and are unable or unwilling to seek help from health workers. All adolescents must be well informed about the dangers of unsafe abortion. In countries where abortion services are legally available, they must also be informed about where and how they can obtain these services.

Increase community awareness of the dangers of unsafe abortion There is very little public awareness of the scale and tragic consequences of withholding legal and safe abortion services to those adolescents who need them. Families and community members must be made aware of this as a means of building their support for policies to enable adolescents to access abortion and post-abortion services.

Actions at the Level of the Health Care System

Identify and remove barriers to safe abortion services Even in places where laws permit adolescents to obtain safe abortion services, they are unable or unwilling to do because of unfriendly health workers and clinic policies and procedures. Managers and health service providers must identify and overcome these barriers so that adolescents can obtain safe abortion services, post-abortion care, and post-abortion contraceptive information and services.

WHO's recommendations for research in this area are as follows:

1. To build evidence on the impact of laws and policies that enable adolescents to obtain safe abortion and post-abortion services.
2. To identify and assess interventions that reduce barriers to the provision of safe, legal abortion services in multiple sociocultural contexts.

Increasing Use of Skilled Antenatal, Childbirth, and Postpartum Care

WHO's recommendations for increasing the use of skilled antenatal, childbirth, and postpartum care are informed by 1 graded study, 1 ungraded study, existing WHO guidelines, and the collective experience and judgment of the expert panel. The studies were conducted in Chile and India. One intervention was a home visit program for adolescent mothers. Another intervention was a cash transfer system that was contingent upon health facility births.

To increase the use of skilled antenatal, childbirth, and postpartum care, WHO recommends action by policy makers, individuals, families, and communities and at the level of the health care system.

Action by Policy Makers

Expand access to skilled antenatal, childbirth, and postnatal care Policy makers must intervene to expand the access of all women, including pregnant adolescents to skilled antenatal care, childbirth care, and postnatal care.

Expand access to emergency obstetric care Basic and comprehensive emergency obstetric care is life-saving interventions. Policy makers

must intervene to expand their access to all women, including pregnant adolescents.

Actions by Individuals, Families, and Communities

Inform adolescents and community members about the importance of skilled antenatal and childbirth care Lack of information is a significant barrier to seeking services. It is important to disseminate accurate information about the risks of not utilizing skilled care for mother and baby, and where to obtain care.

Actions at the Level of the Health Care System

Ensure that adolescents and their families and communities are well prepared for birth and birth-related emergencies Pregnant adolescents must get the support they need to be well prepared for birth and birth-related emergencies. This includes creating a birthing plan that addresses complications and emergencies during childbirth. Birth and emergency preparedness must be an integral part of antenatal care for all pregnant adolescents and should be implemented in households, communities, and health facilities.

Be sensitive and responsive to the needs of young mothers and mothers-to-be Adolescent girls must receive skilled—and sensitive—antenatal and childbirth care. If complications arise, they must receive emergency obstetric care.

WHO's recommendations for research in this area are as follows:

1. To build evidence to identify and eliminate barriers that prevent the access to and use of skilled antenatal, childbirth, and postnatal care among adolescents.
2. To build evidence on interventions that inform adolescents and stakeholders about the importance of skilled antenatal and childbirth care.

Identify interventions to tailor the way in which antenatal, childbirth, and postnatal services are provided to adolescents, to expand the availability of emergency obstetric care, and to improve birth and emergency preparedness for adolescents.

Table 1 summarizes the interventions recommended by WHO guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries.

Summary of Interventions Recommended by WHO

The WHO guideline on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries did not investigate outcomes related to adolescent pregnancy and HIV/STIs specifically. Other WHO guidelines and strategies describe the health sector response to HIV epidemics in order to achieve universal access to HIV prevention, diagnosis, treatment, care, and support (WHO Regional Office for Europe 2011a; World Health Organization 2006a, 2010a, 2011b). For instance, the global health sector strategy on HIV/AIDS 2011–2015 (World Health Organization 2011b) identifies the strategic directions to guide national responses and outline recommended country actions, while the use of ARV drugs for HIV treatment and prevention is addressed in WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. The issues are addressed across all age groups and populations including adolescents, and are based on the broad continuum of HIV care (World Health Organization 2013b). For the first time the specific needs of adolescents both for those living with HIV as well as those who are at risk of infection are addressed in WHO's recommendations HIV and adolescents: *Guidance for HIV testing and counselling and care for adolescents living with HIV*. The guidelines suggest ways in which health services can improve the quality of care and social support for adolescents. It is

Table 1 Summary of interventions recommended by WHO guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries

	Actions by policy makers	Actions by individuals, families, and communities	Actions at the level of the health system
Prevent early pregnancy			
Preventing early marriage	Prohibit early marriage	Keep girls in school	
		Influence cultural norms that support early marriage	
Creating understanding and support for preventing early pregnancy	Support pregnancy prevention programs among adolescents	Educate girls (and boys) about sexuality	
		Build community support for preventing early pregnancy	
Increasing the use of contraception	Legislate access to contraceptive information and services	Educate adolescents about contraceptive use	Enable adolescents to obtain contraceptive services
	Reduce the cost of contraceptives to adolescents	Build community support for contraceptive provision to adolescents	
Reducing coerced sex	Prohibit coerced sex	Empower girls to resist coerced sex	
		Influence social norms that condone coerced sex	
		Engage men and boys to critically assess gender norms	
Prevent poor reproductive outcomes in adolescents			
Reducing unsafe abortion	Enable access to safe abortion and post-abortion services	Inform adolescents about the dangers of unsafe abortion and where they can obtain safe abortion services	Identify and remove barriers to safe abortion services
		Increase community awareness of the dangers of unsafe abortion	
Increasing use of skilled antenatal, childbirth, and postpartum care	Expand access to skilled antenatal, childbirth, and postnatal care	Inform adolescents and community members about the importance of skilled antenatal and childbirth care	Ensure that adolescents and their families and communities are well prepared for birth and birth-related emergencies
	Expand access to emergency obstetric care		Be sensitive and responsive to the needs of young mothers-to-be and mothers

recommended that governments review their laws to make it easier for adolescents to obtain HIV testing and care without needing consent from their parents. While adolescents should be encouraged to involve their families in health decisions, WHO recognizes that this is not always possible (World Health Organization 2013a). In an European Context, actions from the *whole-of-society* perspective are presented in Table 2.

Actions to Prevent and Manage HIV/AIDS and STIs Among Adolescent Boys and Girls (WHO Regional Office for Europe 2011a)

Translating the WHO Recommendations into Action on the Ground

There are good reasons for optimism that the WHO guidelines will contribute to strengthening national policies and strategies, and their concerted application.

Firstly, there is widespread recognition of the importance of preventing early pregnancy and pregnancy-related mortality and morbidity in adolescents. The Millennium Development Goals report published by United Nations in 2011 reiterates the point that "Reaching adolescents is critical to improving maternal health and achieving other Millennium Development Goals" (United Nations 2011).

Secondly, there is now a global strategy to prevent maternal and childhood mortality, within which activities to prevent early pregnancy and pregnancy-related mortality and morbidity are included. The development of the Global Strategy for Women's and Children's Health was led by the Secretary General of the United Nations. The strategy charts out what needs to be done and what contributions different stakeholders could make (United Nations 2010). More than 250 organizations have made commitments to advance the Global Strategy for Women's and Children's Health. Over a quarter (26%) of these commitments relate to adolescent health. Adolescent sexual and reproductive health policies, health services sensitive to adolescent needs, reducing early and forced marriage, reducing violence against girls are major areas where commitments are made (World Health Organization 2013d). To jointly implement this strategy, UNFPA, UNICEF, WHO, World Bank, and UNAIDS have joined forces in the context of the Health 4+ collaborative initiative to support countries with the highest rates of maternal and newborn mortality, and to accelerate progress in saving the lives and improving the health of women and their newborns. The initiative focuses on 60 countries with the highest burden and is supporting them to reduce the maternal mortality ratio by 75 % and to achieve universal access to reproductive health—the two targets under MDG 5 (WHO, UNICEF, UNFPA, World Bank, and UNAIDS 2010). A recent review of Strategy' implementation highlighted that adolescents have been a neglected dimension, and the independent expert review group recommended that an adolescent indicator should be included in all monitoring mechanisms for women's and children's health, and young people should be meaningfully involved on all policymaking bodies affecting women and children (World Health Organization 2013d).

Thirdly, funds to step up country-level work to reduce maternal mortality, and infant and childhood mortality are increasingly being made available. The UK is one of a growing number of high-income countries, which has published a strategy and set aside a substantial body of funds to support work in selected countries. The UK government's strategy document provides the rationale for addressing adolescents in relation to its twin priorities—preventing unintended pregnancies and ensuring that pregnancies and childbirth are safe, lists evidence-based strategies, and contains an explicit focus on adolescents in the section on measuring results (Department for International Development/UK Aid 2012). There is more happy news. On July 11, 2012, the UK government and the Bill and Melinda Gates Foundation with UNFPA and other partners hosted a groundbreaking summit to mobilize global policy, financing, commodity, and service delivery commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information and services and supplies without coercion or discrimination, by 2020. The official press release of the UK government and the Bill and Melinda Gates Foundation said that "The Summit has raised the resources to deliver contraceptives to an additional 120 million women that is estimated to

Table 2 Actions to prevent and manage HIV/AIDS and STIs among adolescent boys and girls

Cross sector actions		Family and community	Health system	Health services
Health in all policies	School setting			
Ensure that legal policy and regulatory framework supports the rights of adolescents to age-appropriate information, confidentiality, and privacy, and reinforce the principle of evolving capacities of the child in the existing policies and procedures for autonomous decision and informed consent	Implement comprehensive sex and STIs/HIV education programs that incorporate characteristics of effective programs and take into account the social and cultural influences on young people sexual behaviors	Implement dedicated (community-based or center for young people) services for MARA, including demand and harm reduction initiatives	Ensure that strategic information on the STIs/HIV epidemic among young people and its social drivers is available and informs programmatic and policy decision-making	Provide services that reflect characteristics of youth-friendly health services and are linked to activities to increase the use of services
Enforce laws and policies that directly address gender inequality and protect most-at-risk adolescents (MARA), decriminalize the behaviors that place them most at risk, and ensure that MARA have access to the services they need	Complement SRH education with selected social and health services either directly or through linkages to the community	Implement culturally appropriate interventions for young migrants, related training for health and community workers, and greater involvement of migrant communities in service delivery	Implement interventions to control HIV that are adapted to the country's epidemiological situation: interventions to control HIV among injecting drug users, including harm reduction programs; measures to prevent heterosexual transmission targeted at those with high-risk partners; interventions to control HIV among men who have sex with men	Ensure that local procedures protect and support young people in their decisions about disclosure of their HIV status
Implement interventions for HIV prevention, treatment, and care that reach migrant populations	Keep girls in schools and make schools free of sexual violence	Implement social support programs for YPLHIV, caregivers, and orphans, which engage men and transform caregiving roles	Implement interventions for HIV prevention, treatment, and care that reach migrant populations	Implement standardized approaches to the assessment and management of sexually abused children and adolescents, performed by a trained clinician following locally defined procedures and guidelines

(continued)

Table 2 (continued)

Cross sector actions		Family and community	Health system	Health services
Health in all policies	School setting			
Put in place policies to protect young people living with HIV (YPLHIV) from stigma, discrimination, and to support them in making decisions about disclosure of their HIV status	Provide access to alternative education approaches for YPLHIV, including flexible instruction hours, acceleration and catch-up programs, home-based care and education	Implement interventions targeting youth and community as a whole to increase use of existing services, mitigate the impact of HIV-related stigma and discrimination, and change gender norms that affect the risk of HIV infection	Implement gender-sensitive and appropriately adapted to young people needs STIs/HIV prevention and control interventions, including information and counseling, condom use, harm reduction, HIV testing and counseling, treatment, care and support services, and adolescent specific comprehensive approach to STIs case management	Make available syphilis screening of high-risk adolescent girls and young women, e.g., in antenatal and post-abortion clinics
Enforce laws and policies that protect women and girls against sexual violence, disinheritance, and gender discrimination of all kinds, including harmful traditional practices and sexual violence in and outside of marriage		Implement sex and STIs/HIV education programs with multiple components that are based on local needs, send clear, consistent messages about appropriate sexual behavior, and take into account the social and cultural influences on young people sexual behaviors	Strengthen referral within and outside the health system, coordination and partnerships between health, social and child protection services, to provide effective support to MARA and YPLHIV, including facilities to establish support groups for YPLHIV	Ensure that facilities have procedures to involve YPLHIV in service provision and that they provide age, developmentally and educationally appropriate information on care, treatment, support, and prevention for YPLHIV
Design and implement sex and STIs/HIV education programs that incorporate characteristics of effective programs and take into account the social and cultural influences on young people sexual behaviors		Implement parenting programs with certain characteristics to improve adolescents' SRH	Improve accessibility of health care facilities and train staff to be able to deal with young people on the basis of their specific situations and needs, including the needs of young migrants	Use culturally appropriate materials for young migrants population and increase efforts to inform migrant communities about available services

(continued)

Table 2 (continued)

Cross sector actions		Family and community	Health system	Health services
Health in all policies	School setting			
Expand social marketing projects to prevent HIV that are tailored to the needs of the young people and designed with their involvement		Implement community-based (on-site) STI case management, i.e., by integration of STI case management into existing community-based projects directed at young people	Promote linkages and convergence of STIs/HIV prevention interventions, including HIV counseling and testing, with sexual and reproductive health services, tuberculosis services, and PMTCT	
Ensure that social mobilization campaigns against gender inequality and HIV-related stigma and discrimination involve YPLHIV		Promote campaigns and community dialog to change harmful gender norms, engage men and boys, and eliminate violence against women and girls	Consider the benefits, acceptability, and feasibility of introducing HPV vaccination programs	
Put in workplace HIV policies and interventions with emphasis on prevention and non-discrimination		Consider male circumcision by well-trained health professionals in properly equipped settings for HIV prevention in countries and regions with heterosexual epidemics, high HIV, and low male circumcision prevalence	Ensure that financial considerations are not a limiting factor for YP in accessing services, appropriate medicines, and technology	
Ensure girls protection from foregoing education because of caregiving to HIV-infected parents or siblings				
Develop livelihood and vocational skills programs to increase employment opportunities				

Source Adapted from WHO Regional Office for Europe. (2011a). Evidence for gender-responsive actions for the prevention and management of HIV/AIDS and STIs. Young people's health as a whole-of-society response. Copenhagen, WHO Regional Office for Europe

cost $4.3 billion. More than 20 developing countries made bold commitments to address the policy, financing and delivery barriers to women accessing contraceptive information, services and supplies. Donors made new financial commitments to support these plans amounting to $2.6 billion—exceeding the Summit's financial goal." More importantly, it drew attention to the importance of addressing girls: "Contraceptive use also leads to more education and greater opportunities for girls, helping to end the cycle of poverty for them and their families. Up to a quarter of girls in Sub-Saharan Africa drop out of school due to unintended pregnancies, stifling their potential to improve their lives and their children's lives." (UK aid and Bill and Melinda Gates Foundation 2012.)

Finally, there is strong commitment at the highest level in Ministries of Health and in governments to address adolescent pregnancy. At the sixty-fifth session of the World Health Assembly in Geneva, WHO's report titled Early Marriage and Adolescent and Youth Pregnancies was universally welcomed (World Health Organization 2011a). Equally, in the context of the implementation of the Global Strategy for Women's and Children's Health, more commitments are made on adolescents' access to contraception such as development of adolescent sexual health policies (Benin), development of a comprehensive sexual and reproductive health programme (Malawi), and community mobilisation to increase involvement of young people in family planning (Senegal) (World Health organization 2013d).

That early marriage is illegal in most places where it occurs, that it is a violation of the rights of girls, and that it has detrimental health and social consequences on adolescent girls and their families and communities were reiterated by all speakers. Several of them went on to describe activities that their countries were involved in to prevent early marriage and the consequences of early and unprotected sexual activity. The Gambian representative was one of many speakers who said that her government was committed to implementing the recommendations made in WHO's Guidelines. She said that her government was committed to challenging and changing community norms that supported early marriage, to enrolling and retaining girls in schools, and to reducing the negative health outcomes of pregnancy by providing the needed health care services. This augurs well for the future.

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Adolescent Pregnancy and Mental Health

Mary E. Dillon

Keywords
Mental health · Antenatal depression · Rapid repeat pregnancy · Low birth weight · Postpartum depression · Bipolar disorder · Nature–nurture · Puberty · Psychosocial problems · Menarche

Introduction

This chapter is a survey of what we know about mental health issues and adolescent pregnancy. Literature and studies from different countries and cultures are presented to inform and help disentangle the influence of adolescent pregnancy on mental health and the influence of mental health on adolescent pregnancy. We know that culture and environment has an influence on behavior and one's life trajectory. We also know that genetics has an influence and we know there is interplay among these factors that produce a nature and nurture balance. We are also aware that other conditions, such as mental illness can dominate or at minimum complicate the nature and nurture balance. In the process of addressing these mental health issues, the incidence and rate of observed mental health disorders among pregnant adolescents will be covered. Then, the impact of depression and other mental health disorders, the adolescent mother's age, rapid repeat pregnancy, and other uniquely adolescent characteristics such as risk-taking behavior and substance use and misuse will be discussed in relationship to the differential effect on the development and life trajectory of children of adolescent mothers with a mental disorder.

Until late in the twentieth century, there was scant literature and almost no research on mental health issues among pregnant and parenting adolescents. Because adolescent pregnancy (or more often the real concern, unwed pregnancy) was perceived of as a *problem behavior,* the response from the community was to fix the *problem*. By the 1950s in the United States, traditional approaches used to prevent unwed adolescent pregnancy were failing or no longer practical. Close supervision of girls when they were in the company of boys and 'marriage' if the girl became pregnant were strategies used in the past that do not work well in a modern and rapidly changing society. When the high rate of adolescent pregnancy could not be easily fixed (for the most part an international trend) during the 1970s claims-makers declared that teen pregnancy was at epidemic levels; it was a crisis in the US practitioners and researchers took up the challenge and began to ask questions about

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adolescent pregnancy as a phenomenon that was a behavioral problem, but a problem that could be studied and understood. Using a problem-oriented paradigm, the community of researchers and practitioners began exploring the causes and consequences of adolescent pregnancy. Among these causes and consequences were mental health issues.

Before the 1990s, the demographic characteristics and the number of pregnant and parenting adolescents were being tracked and followed worldwide; but there were few studies of mental health disorders and service needs that differentiated adolescents from adult pregnant females. This does not seem too odd, considering the fact that there was and still is a great deal of variation in the definition of a female, who is of childbearing age. In the mind of many, once a girl becomes pregnant she is no longer a child but a mother who needs to learn to be a 'good mother.' The question is, however, how do you convince the pregnant and mothering adolescent that she is no longer a child herself?

Since the turn of the twenty-first century, the professional literature on the mental health of pregnant adolescents has grown substantially. These studies support the claim that adolescent pregnancy and parenthood can change mental health status, mental health over time, and the developmental outcomes of both the mother and her child (Biello et al. 2010). Other studies have established that mental health disorders can be an antecedent to adolescent pregnancy. Mental health issues such as depression (Woodward et al. 2001), anxiety (Quinlivan et al. 2004), aggression (Gest et al. 1999), childhood trauma (Carpenter et al. 2001), and child abuse—both physical and sexual (Herrenkohl et al. 1998), have been associated with adolescent pregnancy. Given these and other studies focused on pregnant adolescent girls with observed mental health issues, there is a growing body of research describing an adolescent spectrum of mental health issues that unique to pregnant adolescents (Kessler et al. 1997).

It has been long recognized that adolescence is often a period of transitory mental health stability. We are not referring to a mental illness but a developmental stage that is emotionally a watershed between childhood and adulthood. As a result, we expect an overall improvement in adolescent emotional health over time, and this occurrence has consistently been supported by research that suggests the mental health of adolescents improve as they transition into adulthood (Wickrama et al. 2009). Adolescence is also a developmental period when mental health disorders begin to effect behavior and one's thought processes. It is a period when mental illness develops and begins to change the trajectory of the life course of those affected.

Conventional wisdom suggests that pregnancy is a time of emotional well-being, and for most women, which includes adolescents, it is. For a substantial percentage of women (about 25 %), however, mental health problems such as depression, mood disorders, and anxiety become clinically significant. Certainly, the symptoms would be expected to be more frequent among women and adolescent girls who have a history of a psychiatric disorder or who are in the course of developing a mental health disorder. Even more confounding, studies since the 1970s concerning psychotropic medication during pregnancy have not sufficiently answered questions about the safety of prenatal exposure to psychotropic medications, nor the use of psychotropic medications by adolescents under any circumstances. Furthermore, among adolescent girls who are being treated for a serious mental health disorder with psychotropic medication, it is a common practice for the expectant adolescent mother (like adult pregnant women) to discontinue all pharmacologic treatment, particularly medications typically used to treat severe mental illness. Stopping a medication, that is successfully treating a mental disorder, may result in a slow process where the adolescent decompensates both behaviorally and mentally. In a pregnant adolescent mother, this process puts her and her child's welfare at risk. To reduce the increased risk caused by an untreated adolescent mental illness, at minimum an intervention program would need to include case coordination and management of social and financial services, mental health services, parenting education, and academic educational services.

Adolescent Pregnancy and General Health Problems

The impact of pregnancy as a condition that affects the general health and well-being of women has been given little attention. As for the nulliparous adolescent, there has been even less consideration of the affects of common pregnancy on their general health. What we think we know is that the younger the female, the more she reports common pregnancy symptoms having a marked impact on her physical and mental health during pregnancy, for example, Gartland et al. (2010) found that almost 70 % of pregnant women experienced three or more physical symptoms. The most common physical complaints were exhaustion (87 %), nausea (64 %), back pain (46 %), constipation (44 %), and severe headaches or migraines (30 %). These physical symptoms can bring on mental health crises or complicate them in adolescents who are not prepared or aware of these physical problems related to pregnancy. As well, there is ample evidence that mental health problems seriously complicate gestation, birth, and child rearing. For example, the mother's age at her first birth has consistently correlated with a mother's elevated risk for depression, anxiety disorders, and other serious mental health problems (Hoffman et al. 1993; Moore et al. 1993; Lee and Gramotnev 2006; Biello et al. 2010). Additionally, there is also ample evidence to show that negative socioeconomic circumstances are associated with the variations in the rates of adolescent pregnancy and the incident of adolescent mental health disorders. It is understood by almost everyone, including most adolescent girls that adverse economic circumstances and privation befall the adolescent when she gives birth and attempts to raise her child. Above and beyond the effect of pregnancy and privation on the life of an adolescent mother and her child, the reality is that the majority of pregnant adolescent moms are from disadvantaged communities and families and giving birth typically reduces their chances for a better life for themselves and their child(ren). The birth often limits the adolescent mother's educational attainment, restricts her economic opportunities, and too often results in an unstable relationship with the child's father (Coley and Chase-Lansdale 1998; Geronimus and Korenman 1992; Lee and Gramotnev 2006; Paranjothy et al. 2009; Taylor 2009). These outcomes, whether the fault of the adolescent or society, have long-lasting effects on the adolescent mother and her children and are an additional source of depression and anxiety.

Predisposition for a Mental Health Disorder

Then, there are the pregnant and parenting adolescents who have a predisposition for depression, anxiety related to stress, somatoform disorders, mood disturbances, and psychotic disorders that commonly emerge and are identified during adolescence (Evans et al. 2001; Andersson et al. 2003). These disorders need to be treated in adolescents because they are also predictive of postpartum depression (O'Hara and Swain 1996; Austin and Leader 2000; Heron et al. 2004), premature delivery (Dayan et al. 2002; Dole et al. 2003; Orr et al. 2002), and low birth weight (Patel and Prince 2006; Rahman et al. 2007). In other research, psychological distress has been shown to suppress the immune system and leave the mother susceptible to infections (Halbreich 2005). Complicating a depressive disorder, adolescents who report being depressed are more likely to smoke and abuse drugs (Tzilos et al. 2012). Among adult mothers in general and adolescent mothers in particular, drug-taking behaviors increase the risk of premature deliveries and low-birth-weight babies.

Diminished Resources and Low-Birth-Weight Babies

The consequences of a low birth weight for the neonate are initially manifested as health problems. This is notable because adolescent mothers

tend to give birth to a higher rate of low-birth-weight babies than young adult women. As a rule, a community with a substantial percentage of low-weight births among its residents is also a community with limited resources. A high percentage of low-weight births equate poverty. It is one of those phenomena that transcend race, ethnicity, and culture (Paige et al. 2007). To test the concept, take any community from around the world where there is information on birth weight, and stick flag-pins in the address of the mothers of the low-birth-weight babies. The flags of the mothers of the low-birth-weight newborns will define the community where residents are impoverished and have little access to community resources such as healthcare.

In fact, some credible research has shown that the age of the mother is not as important as environmental and health-related factors. The use of alcohol and drugs during pregnancy will have more of an impact on the child's outcome than the mother's age. As well, when researchers controlled for socioeconomic status, the rate of low-birth-weight and premature babies born to adolescent mothers, as it turns out, is no different than older mothers (Goldenberg and Klerman 1995). The lack of access to prenatal care, another condition related to socioeconomic status, has also been shown to be associated with greater percentages of low-birth-weight infants Laditka et al. (2005).

In the United States, the typical pregnant adolescent is very likely to be from a minority racial or ethnic group that historically has been disadvantaged in the United States. Typically, she is a girl of color (Mathews et al. 2009). She and her family have few resources and live in a community with little social capital. Add to this, bureaucratic procedures that create confusion and obstacles in relationship to financial and medical assistance (particularly prenatal services) results in a delay in starting prenatal care; often resulting in a low-birth-weight or premature birth (Kinsman and Slap 1992).

Impact of Mental Health Disorders on Adolescent Pregnancy

The impact of adolescent parenthood on mental health has also been shown to affect the adolescent mother more than the adolescent father when compared to their non-parenting adolescent peers. In a six-year follow-up study of adolescents in the United States, Biello et al. (2010) compared changes in the mental health of parenting adolescents and non-parenting adolescents. They found that mental health improved for all teenagers over the six years; however, the mental health of adolescent fathers showed far more improvement and a faster rate of improvement than non-parenting adolescent males. They also found that adolescent mothers improved at a slower rate than non-parenting teenage females. Consequently, they concluded that mental health issues among adolescent mothers need to be considered and that these mental health issues have important implications for both adolescent mothers and their children. They suggest interventions should be developed to promote and ensure mental health among adolescent mothers.

The researches on the impact of a mental health disorders on pregnancy and parenting are not isolated to the developed countries (e.g., *Australia*: Gartland et al. 2010; *United Kingdom:* Winship 2009; *United States:* Crittenden et al. 2009). Although relatively small in number, studies consistently find mental health disorders affect pregnancy in countries where poverty and culture restricts sexual reproductive health education and practice (e.g., *Brazil:* Faisal-Cury et al. 2009; *Thailand*: Wingwontham et al. 2008; *South Africa*: Meintjes et al. 2010). These findings are neither surprising nor unexpected. The incident of endogenous mental health disorders such as depression, anxiety, mania, and schizophrenia while varying in name and expression (depending on culture and social context) is found in all human groups of pregnant adolescent and adult females. Poverty, general stress, stress related to

pregnancy, lack of medical care, and cultural norms, however, disproportionately burden pregnant and parenting adolescents with a propensity for a mental health problem. Even the most common symptoms of pregnancy have an obvious effect on the mother's physical and mental health, especially in early pregnancy, and especially among adolescent mothers (Winship 2009).

Depression and Adolescent Sexual Risk Behavior

Both endogenous and situational depression has been widely studied and found to be predictive of sexual risk behavior and problematic behavior during pregnancy especially for disadvantaged women. Depression among adolescents has shown similar affects. Lehrer et al. (2006) compared baseline depressive symptoms and sexual risk behaviors in a national sample of male and female middle and high school students in the United States over a one-year period. They examined the effect of 'religiosity,' 'same-sex attraction,' 'sexual intercourse before the age of ten,' and 'sexual risk behavior.' They found that boys and girls with high depressive symptom levels were significantly more likely than those with low depressive symptom levels to participate in risky sexual behaviors. Among boys, high levels of depression were specifically predictive of nonuse of a condom when they last had sex, and they had used alcohol or other drugs. Among girls, high levels of depression were significantly correlated with substance use, condom nonuse, and birth control nonuse with their last three sexual partners. Sexual risk behaviors among adolescents are consistently found to be associated with STDS, HIV/AIDS, and pregnancy.

Antenatal

During pregnancy *antenatal depression*, especially among low-income adolescent girls should be an expectation. In the general population of expectant mothers, research has been perplexing. Consequently, the reported prevalence of antenatal and postpartum depression varies widely from 10 to 50 %. Among disadvantaged women (i.e., low-income and women lacking average resources), the prevalence of *antenatal depression* is considerably elevated with rates of pregnancy-related depression reported to be as high as 40 % (Freeman 2007; Luke et al. 2009). Among pregnant adolescents, rates of pregnancy-related depression have been reported to be as high as 46 % (Holzman et al. 2006).

Antenatal depression is less common and is not as widely known as postpartum depression; nevertheless, if untreated, it can be just as harmful to both the mother and her unborn child. Cohen et al. (2006) reported that among a sample of pregnant women with a history of major depression, 43 % experienced a major depressive episode during pregnancy. Depressive episodes during pregnancy were even higher (68 %) among women who discontinued antidepressant medication when they realized they were pregnant. This is a concern because, although in practice, risk/benefit assessments commonly overlook or minimize the risks associated with untreated maternal depression (Logsdon et al. 2010).

In one study of 155 women (representing 87 % of a random sample of antenatal patients in two general practices in South London), 65 % of their children with depression were initially exposed in their mother's antenatal period. The researchers found that the children of women who experienced antenatal depression were almost five times as likely to experience depression themselves as children whose mother did not experience antenatal depression. Quite the reverse, however, occurred when the child's initial exposure to maternal depression happened during other developmental periods in the child's life. In these cases, maternal depression was not associated with adolescent offspring depression (Pawlby et al. 2009).

Antenatal depression can reach clinical significance during any trimester. Like other types of depression, it can last for weeks or months and may last through the entire pregnancy or

until after the baby is born. Antenatal depression has been described as feelings of being overwhelmed and is often associated with high stress levels. Women who report an antenatal depression spectrum disorder may describe a lack of connection to their unborn child. They may disassociate and may feel a lack of a bond with their baby even after the baby begins to move and kick. They will also report behavior observed among people who are clinically depressed. Unimportant events may cause her to tear up, become anxious, and annoyed (Pawlby et al. 2009). Given the physical and emotional consequences of adolescent pregnancy, antenatal depression must be considered a serious risk to the mother and child's health.

Treating Antenatal Depression with Antidepressant Medications

Determining the risks and benefits of treating antenatal depression with antidepressant medications is difficult. The selection of a treatment should be based on the severity of symptoms, the mother's history of depression, and her past response to antidepressant medication. Although the risks of antidepressant exposure for the fetus are still uncertain, some studies have found that there is a potential risk of cardiac teratogenicity with paroxetine (Paxil); persistent pulmonary hypertension of the neonate's SSRIs; and birth (under 37 weeks) associated with antidepressants medications as a class of drugs (Dole et al. 2003; Freeman 2007). In spite of the risk, research suggests that for women who experience moderate to severe depression or who have a history of recurrent major depression, antidepressants should be considered in conjunction with non-pharmacological treatment.

In adolescents with mild antenatal depression, non-pharmacological approaches should be the first choice for treatment. More specifically, mild depression can often be mitigated with exercise. Gynecologists recommend 30 min of exercise a day during pregnancy (Artal and O'Toole 2003). Likewise, exercise can be helpful in preventing and reducing postpartum depression . Although still inconclusive, omega-3 fatty acids may be helpful as an adjunct with other treatments for antenatal depression. The two fatty acids—docosahexanoic acid (DHA) and eicosapentanoic acid (EPA)—are found naturally in fish oil, flaxseed, and walnuts and they tend to be well tolerated in pregnant and postpartum women (Michel et al. 2011). The evidence available provides some small support for a benefit from omega-3 fatty acids to individuals with a diagnosed depressive illness but no evidence of any benefit to individuals who experience mild depression but whose depression does not meet clinical significance for a depressive disorder (Appleton et al. 2011). Psychosocial and psychological interventions have also been shown to help reduce antenatal depression and can often prevent postpartum depression among pregnant women at risk for depression (Suri et al. 2007).

Adolescent Mothers and Postpartum Depression

In the not-too-distant past, postpartum depression was considered to be rare. Postpartum depression is 'a mood disorder that can begin any time during the first year after delivery' (Beck and Gable 2001, p. 243). In the second decade of the twenty-first century, many consider postpartum depression among adolescents to be rare. This is not the case. Conversely, research on the experience of adolescent mothers has shown the rates of depressive symptoms in the postpartum period to be higher than expected. A number of studies have found rates as high as one half of adolescent mothers experience symptoms of depression during the postpartum period (Cantilino et al. 2007). Identifying postpartum depression is important considering the potential for long-term damage to the development of both the mother and baby (Field et al. 2005; Riley et al. 2009). Adolescent mothers report feeling abandoned and rejected by their partners, peers, and their family. These young mothers often describe feeling scared, feeling different, and feeling changed by the

reality of being a mother. In this emotional state of chaos, they are often at a loss to explain the experience or understand it (Eshbaugh 2006).

Symptoms of depression in adolescents during the postpartum year, as it turns out are quite common (Reid and Meadows-Oliver 2007). Logsdon (2008), Logsdon et al. (2005) studied postpartum depression among adolescent mothers and collected data from them on two different occasions during the postpartum year. They assessed the adolescent mothers for depression at 4–6 weeks postpartum and they assessed for depression again at 12 months postpartum.

What they found was both surprising and concerning. In terms of the numbers, 47 % of adolescent mothers were found to have clinically significant symptoms of depression. Moreover, the symptoms continued into the 12th month of the postpartum year. Although the percentage of girls experiencing postpartum depression was high, the issue is providing services to prevent and treat the depression. This percentage gives us a rough estimate of the need. What is disturbing, however, is that in this study, none of the girls who tested positive for depression asked for or receive treatment for depression. Untreated postpartum depression as stated above has the potential for long-term harm to both the mother and baby (Zlotnick et al. 2006).

In an effort to understand the barriers that impede adolescent mother's access to mental health treatment, Logsdon et al. (2009a) in their study found that there are personal and service barriers that adolescent mothers must deal with to receive mental health treatment. Personal barriers include lack of knowledge of depressive symptoms and depression treatment, and life challenges that interfere with attention to mental illness. Health service barriers include provider requirement that parental permission must be given to receive treatment, and in some cases, a parent must be present before services can be provided. In other cases, treatment cannot be accessed because of a lack of insurance coverage (National Academy of Sciences 2008).

Another issue related to seeking treatment for postpartum depression is an adolescent mother's intentions. The question is, why do some adolescent mothers seek treatment for postpartum depression and others do not. For the most part, their intentions are based on subjective norms (Logsdon et al. 2009b). Norms critical to seeking treatment are the adolescent mother's personal experiences with mental health treatment, and I would add her family's history of depression particularly, among first-degree relatives (i.e., parents, offspring, and full-siblings) and second-degree relatives (i.e., grandparents, half-siblings, and grandchildren).

Studies in developed countries typically report between 10 and 15 % of new mothers were affected by a major episode of postpartum depression. Mothers who suffer from postpartum depression may endure difficulties regarding their ability to cope with life events, as well as negative clinical implications for maternal-infant attachment. In a recent Canadian study, the prevalence of minor postpartum depression in all mothers was detected in 8.46 % of mothers. The prevalence of major postpartum depression was found in an additional 8.69 % of mothers. In that study, a number of conditions that contributed to postpartum depression were identified. The mother's stress level during pregnancy was a strong predictor of postpartum depression. The availability of support after pregnancy was also important. And, as has been shown in many studies, a prior diagnosis of depression, or a history of depression were significantly associated with the development of postpartum depression (Lanes et al. 2011).

In another small study in the United States, the psychosocial factors associated with postpartum depression were examined. The study was an attempt to help determine factors that increase the likelihood of the mother experiencing a postpartum depression. The sample was small. The 61 mothers were White, African-American, and Hispanic from a rural North Carolina community. The mothers were low-income and Medicaid recipients. In this study, mothers who reported problems with a mood disorder before or during pregnancy (especially adolescents reporting depression and anxiety) were significantly more likely to report postpartum depression ($p = 0.035$). Additionally,

the percentage of adolescent mothers who displayed minor depressive symptoms was slightly over 17 %. This tends to be fairly typical for adolescent mothers. In total, in this group of girls, almost 33 % of adolescent mothers were experiencing some level of major or minor depression when the survey was conducted (Hutto et al. 2011). Of course, these findings are not a surprise for those working in adolescent mental health. What is not widely known is that a substantial percentage of girls and young women who become pregnant will also experience mild to major symptoms of other mental health disorder. When at least a third of all adolescents who become pregnant also suffer from mental health disorders, both health policy makers and service providers should be using best practices for treating adolescent mental health and design specific treatment programs for adolescent mothers.

Postpartum Depression Among Latina Adolescents Mothers

Perry et al. (2011) adds to the knowledge about the applicability of this phenomenon among a group of 217 Latina mothers. These mothers were participating in a prenatal depression prevention program. In addition, to testing interventions to modulate postpartum depression among these adolescent mothers, a number of variables were examined to determine the impact of the mother's postpartum depression on their child's attachment to them. Attachment was measured using the Maternal Postnatal Attachment Scale. This scale was administered every 6–8 weeks after the child's birth. Predictor variables, thought to affect early attachment were depressive symptoms during pregnancy, pregnancy intention, feelings about the pregnancy.

Perry et al. (2011) (along with a few other researchers and practitioners who have studied the effects of depression on early attachment) are suggesting is that depression in the mother can profoundly affect the development of a bond between the child and mother. This suggests that if a mother presents with depressive symptoms, the attachment between the child and mother needs to be assessed. If the expected bond between the child and the mother or the mother and the child is not developing as expected, clinical intervention is indicated.

Substance Abuse and Adolescent Pregnancy

Teenage experimentation with alcohol and other drugs is legendary in most European countries and in the Americas where it plays a major role in the social life of a large segment of the population. In other countries where there is not a tradition of alcohol use, drug experimentation specifically with alcohol is less common. Nevertheless, given the vast changes in social media, and the popularity of Western culture, even adolescents from different social traditions would know that other young people use alcohol and other drugs as a way of escaping their dissatisfaction with life as an adolescent.

In human development, adolescence is a transitional period between childhood and adulthood. It is also a period of development where a great deal of experimentation takes place, especially in terms of prominent major social and moral behaviors that are the restricted purview of adults. This seems to be especially true when it comes to alcohol and other drugs of abuse. Although some would argue that the social and legal restrictions placed on alcohol use, drug use, and cigarette smoking tend to make these drugs and attractive nuisance, nevertheless the numbers of adolescents involved in substance use and the potential damage from experimentation and use make this behavior especially risky for the fetus. The truth is that adolescents die from experimenting with alcohol and other drugs. This is a double tragedy when a pregnant adolescent dies from a drug overdose or a drug-related event.

In the United States for instance, in a study of youth risk behaviors (2009), researchers found that 72.5 % of high school students had at least one drink during their lifetime and about 42 % had at least one drink in the last 30 days. It was

also reported that 46.3 % of students had tried smoking cigarettes and approximately 20 % had smoked a cigarette in the last 30 days. Marijuana experimentation (37 %) was slightly lower than cigarette experimentation over the lifetime of the students but marijuana use in the last 30 days was slightly higher (21 %) than cigarette smoking for these high school students. What is pertinent to a discussion of adolescent mental health and mental health of children born to adolescent mothers is that in the same survey, 46 % of the students reported sexual intercourse during their lifetime (Eaton et al. 2010).

When alcohol use, drug use, and cigarette smoking are widespread within the adolescent population, such as in Australia, Canada, United Kingdom, United States, and other adolescent populations influenced by Western culture, this is an indication of a major public health challenge. Based on this assumption, Barnes et al. (2007) examined adolescent substance misuse and pregnancy in the United Kingdom. Their study followed the release of demographic data that reported a doubling of maternal deaths (which included suicide) among young substance misusers.

The increase in adolescent maternal death both in the United Kingdom and the United States is not a new trend as much as it is a corollary with the general increase in substance use and abuse among female adolescents. The turn of the twenty-first century saw a new historical landmark in the annals of adolescent drug experimentation. For the first time, girls were experimenting and using alcohol and other drugs in larger numbers than their male counterparts. This increase in the percentage of girls experimenting and using substances was not just a local phenomenon; it was not simply a regional phenomenon, as it turns out, it was an international phenomenon. The rates vary but since the year 2000, in countries where data are available, the rate of female adolescent drug use tends to be as high as 25–30 % with some countries reporting slightly higher or slightly lower percentages (Office for National Statistics (ONS) 2003; Australian Institute of Health and Welfare 2004; Phipps et al. 2008). This rate of substance use has been fairly consistent since the mid-1990s. Common antecedents associated with adolescent substance misuse during pregnancy include coming from a dysfunctional family, maternal depression, exposure to violence, verbal and physical abuse, and familial substance misuse. In spite of the cause or motivation, alcohol use, drug use, and cigarette smoking have been shown to be deleterious to the fetus (Whitbeck and Crawford 2009).

Prevention of substance misuse is undeniably the best approach for reducing the problems caused by substance misuse. Regrettably however, it is not always the most effective approach. Given the reality that many adolescent girls began using drugs in some form when they are very young, a harm reduction approach would be more effective.

Delaying Childbearing Among Adolescents

Pregnancy as a condition that affects the general health and well-being of women is widely understood. Medically, a pregnancy can be uneventful or dramatic and even profound. For the nulliparous adolescents, the risk of medical complications is greater for younger girls and less so for older girls. What little we do known suggests that the younger the female, the more she reports that common pregnancy symptoms have a marked impact on her physical and mental health during pregnancy.

The primary social issues and many of the health issues are related to the adolescent's age. The younger the age of a first-time mother, the more likely her child will experience poor pregnancy outcomes such as low birth weight, birth defects, premature birth, and the pregnancy may precipitate or aggravate the mother's mental health problems. Conversely, nulliparous pregnancies that occur in a mother's late teens or in her early adulthood result in better outcomes for both the mother and the child. On a positive note, the improvement in outcome among older adolescents has been shown to be quite dramatic. In a study out of Australia, Gartland et al. (2010)

reported that *maternal age*, *employment, relationship status*, *and highest level of education* had the most effect on physical health while *maternal age*, *gestational age*, *employment*, and *cigarette smoking* had the greatest impact on mental health. Statistically, they were able to show that a 10-year increase in maternal age was associated with a 1.2 times decrease in physical health problems. In many ways, more important to the mother and child's mental health, the statistical analysis showed a 2.4 times decrease in mental health problems. This suggests that reported health and mental health problems are likely higher among younger expectant mothers and lower among older expectant mothers.

Another way that age of the adolescent mother plays an important role in her and her child's health is related to her decision to initiate prenatal care. Adequate prenatal care is essential to the future health and mental health of the child. In the United States, between the years 1986 and 1991, Medicaid eligibility was extended to additional groups, one of which was pregnant adolescents. While Medicaid has reduced some of the economic disadvantage for adolescent mothers and their children, it has most notably and demonstratively improved the physical and mental health of the mother and her child (Hueston et al. 2008).

Medicaid eligibility, funding made available to access prenatal care, has made a significant difference in the number of pregnant adolescents who initiate prenatal care. Research verified a trend toward starting prenatal care earlier among adolescents and preteens in the United States between 1978 and 2003 (Hessol et al. 2004). The improvements, although notable, have not reached all adolescents. In 2003, the last data available, 9 % of young adolescents and 16 % of preteens who became pregnant, were still not initiating prenatal care in the first or second trimester. Even though these percentages show a significant increase among pregnant adolescents who initiate prenatal care in the first and second trimester, up from 65 % to 90 %, the efforts to provide prenatal care early in the pregnancy for all pregnant adolescents needs to focus on young adolescents and preteens. Girls in this age group who become pregnant for many reasons continue to be a challenge for service providers.

Several of the reasons for a delay in initiating prenatal care have been identified. One reason is that a relevant proportion of adolescents, particularly young adolescents and preteens, is unfamiliar with available services and does not realize the importance of prenatal care. In other cases, the delay can be attributed to the younger girls trying to conceal their pregnancy.

Regardless of the reasons for not seeking prenatal care, a lack of prenatal care is associated with low-birth-weight infants, premature delivery, and poor pregnancy outcomes. Although pregnancy outcome is more associated with the mother's access to resources and her environment, early prenatal visits can identify many of these risks (Herbst et al. 2003). For instance, research in the United States and elsewhere has established that women who delay prenatal care are often impoverished, are involved in unstable relationships, are involved in substance misuse, and are the victims of domestic violence (Bloom et al. 2004; Brady et al. 2003). Many of these risks to the neonate that result in low birth weight such as inadequate nutrition, exposure to infection, the mother's use of drugs, and other risks can be addressed during prenatal care to reduce the likelihood of a low-birth-weight delivery (Ricketts et al. 2005).

Conditions that Affect Age at First Birth

There is good evidence to support programs and public policy that focus on delaying first birth, especially for preteens and young adolescents. Research has shown time and again that everything being equal, the older the adolescent, the better she and her child will do before and after the birth. Similar outcomes are reported in countries and cultures from around the world. Cultural sanctions aside, the commonalities that pregnant adolescents share almost worldwide are a lack of financial support, a lack of emotional support, and health and mental health services for themselves and their child. Many social scientists would point out that these

problems are not a part of the natural order of pregnancy. They are sanctions and obstacles that result in large part because of the adolescent mother's age.

Added to the social problems, there is an increased risk of physical problems associated with age of the mother. The younger the adolescent mother, the greater the risk of complications during pregnancy and at delivery. Because the physiological problems and the social problems are time sensitive, interventions that work in a positive way to delay pregnancy would help the potential mother in both domains.

There is also a great deal of evidence to suggest that better drug education, drug prevention, and drug treatment services can reduce unintended pregnancies. Mental health services will also play a role in reducing unwanted and unintended pregnancies. Providing mental health services to adolescent girls who are experiencing or developing a mental health disorder such as bipolar would also go a long way to mitigating the tendency to act out sexually.

As well, there is substantial evidence that a woman's age at first birth varies across countries and regions. This suggests that the age of the nulliparous mother can be and is influenced by different circumstances and surroundings, particularly in countries where Western culture prevails. For instance, in Australia and Canada, over 50 % of births are to women who are 29 years old and older (Riley et al. 2005; Statistics Canada 2006). Other studies, one in the United Kingdom reported the average age of women at first birth was 28 years of age (UK National Statistics 2008). In the United States, the average age of women at first birth is 25 (Mathews et al. 2009). Both in Japan and Sweden, the average age for first-time mothers is 29.2 and 29.4, respectively. In part, this change has been the result of the decrease in adolescent pregnancies and the increase in the number of first-time mothers who were 35 years of age and older when they became pregnant.

The change in the age of first-time mothers has not occurred just in different countries around the world, for example, in the United States, the changes have also varied from state to state. Mathews et al. (2009) reported that between 1970 and 2006, the average age of mothers at first birth had increased over five years in Massachusetts, New Hampshire, and Washington, D. C. While in other states with less opportunity for adolescent girls, such as Mississippi, New Mexico, and Oklahoma, these states saw a modest increase in the age of mothers at first birth of 2.5 years.

In 1970, the state of Arkansas had the youngest first-time mothers, 20.2 years of age. In the same year, Connecticut, Massachusetts, and New York had the oldest first-time mothers, 22.5 years of age. By 2006, a dramatic change had taken place. The state of Mississippi had the lowest average age for first-time mothers at 22.6 years of age. Massachusetts continued to have the highest average age for first-time mothers at 27.7 years of age. The age of first-time mothers also varied in the United States by race and ethnicity. The youngest first-time mothers were African-American with an average age of 22.7 years. Hispanic first-time mothers were slightly older, 23.1 years. The oldest first-time mothers were found among non-Hispanic white mothers. They were on average 26 years old.

This increase in age of mothers who gave birth for the first time can be observed among all ethnic and racial groups in the United States. The oldest average age for first-time mothers was found among Asian and Pacific Islanders. These women were on average 28.5 years old when they gave birth for the first time. The youngest average age for first-time mothers was found among American Indians and Alaska natives. On average, they were 22 years old when giving birth for the first time.

Because age is such a determinant in pregnancy outcome, public health programming, with the goal of delaying adolescent pregnancy until the mother is in her late adolescence or early adulthood would have many benefits. We know that opportunity and future prospects have a great deal of influence over an adolescent or young woman's decision to become pregnant. Education about the advantages of waiting until one is mature before becoming pregnant and providing opportunity that allows the adolescent

to maximize her value without becoming pregnant would increase the age of first-time mothers.

The Risk of Rapid Repeat Adolescent Pregnancies

The logic of extending the time between the first and second child of an adolescent mother not only makes sense but the concept is supported by a growing body of research focused on repeat pregnancies among adolescent mothers. Repeat pregnancy is defined as two births to the same mother within 24 months (Mott 1986; Rigsby et al. 1998). Repeat pregnancies are more likely among girls who live in disadvantaged communities.

Adolescent mothers, especially very young mothers who live in poverty, are at the highest risk level among adolescent mothers for a rapid repeat pregnancy. These very young mothers more often than older mothers, even in the same impoverished community, suffer the consequences of closely spaced pregnancies (Klerman et al. 1998). As mentioned before, very young mothers are less likely to initiate adequate prenatal care for their first child and they are less likely to initiate adequate prenatal care for their second child (Wiemann et al. 1997). Thus, the very young adolescent mother and her child are at greater risk for adverse health outcomes.

In addition to environmental and contextual conditions that increase the risk of a rapid repeat pregnancy among adolescent mothers, a mental disorder or the onset of a mental disorder will also increase the risk of a rapid repeat pregnancy among adolescent mothers. As mentioned earlier in this chapter, there is ample evidence to conclude that a mental health disorder can be an antecedent to adolescent pregnancy (Quinlivan et al. 2004). Taking into consideration that a mental disorder increases the risk of adolescent pregnancy; reason would support the conclusion that a mental health disorder would also play an important role in a rapid repeat pregnancy (Crittenden et al. 2009).

Supporting these conclusions, researchers concerned with risky sexual behavior among adolescent mothers point out that a history of suicidal ideation and attempts and clinically significant psychiatric symptoms are more prominent among adolescent mothers who gave birth the second time within 24 months of her first birth than teenage mothers who did not give birth a second time within 24 months. Depression and anxiety during an adolescent's postpartum period is a warning sign that she is at increased risk of a rapid repeat pregnancy.

Adolescents who have a rapid repeat pregnancy have been studied in the United States since the late 1990s, for good reason. The United States has the highest adolescent pregnancy rate among developed nations, and between 20 and 30 % of those adolescent mothers deliver a second child within 24 months (Schelar et al. 2007). As concerning as rapid repeat pregnancies are, several studies have suggested that the younger the adolescent (11-16 years), the more she is at risk of a rapid repeat pregnancy.

Urban and minority youth have been the primary focus of research on rapid repeat pregnancies in the United States. The findings have been fairly consistent. African-American and Hispanic adolescents are more likely to become pregnant and give birth than their white counterparts. These urban, minority adolescent mothers, as well, are more likely to live in poverty and live in high crime communities. These environments tend to limit the adolescent mother's access to healthcare, education, and employment opportunities. These types of environmental conditions have been clearly shown to impact the health and mental health of a young mother and her child (McLoyd 1998).

Social Predictors of Rapid Repeat Pregnancies

The sociodemographic and contextual variables or conditions that predict a rapid repeat pregnancy, as it turns out, are the same situations and conditions that are associated with adolescent

pregnancy in the first place. The family plays an important role in increasing or decreasing the risk of a rapid repeat adolescent pregnancy. Adolescent girls with poor or inadequate family involvement (Rigsby et al. 1998), poorly educated parents (Kalmuss and Namerow 1994), families that experience economic hardship (Furstenberg et al. 1987a, b) and mothers who had their first child during adolescence are at increased risk of a rapid repeat adolescent pregnancy (Atkin and Alatorre-Rico 1992). Girls that participate in at risk behaviors also had a higher risk for a rapid repeat pregnancy. Low educational achievement and aspiration (Bennett et al. 2006), delinquent behavior (Hope et al. 2003), use of alcohol and other drugs (Crosby et al. 2002), and resistance or failure to use effective contraception increases the risk of adolescent rapid repeat pregnancy (Garbers et al. 2010). Finally, adolescents who have their first child at a very young age (Gillmore et al. 1997), marrying during adolescence (Koenig, and Zelnik 1982), intended to become pregnant, and were disappointed or dissatisfied with the birth outcome of her first child (i.e., abortion, miscarriage, stillbirth) (Coard et al. 2000; Rosengard 2009) have been significantly associated with the rapid repeat adolescent pregnancies.

One of the most interesting variables associated with rapid repeat adolescent pregnancy is aggressive behavior. In their study, Miller-Johnson and colleagues (1999) found that girls who presented with persistently aggressive behavior in the third to fifth grades were at an increased risk of becoming pregnant. They reported that girls with stable patterns of aggressive behavior were younger when they gave birth for the first time and had twice the number of children than non-aggressive girls. In another study, adolescent girls who had rapid repeat pregnancies reported less confidence in their ability to negotiate with others without using physical force. These girls also agree more often than non-repeaters that a person had to use physical force to gain the respect of others. In another study, Raneri and Wiemann (2007) found interpersonal violence experienced by adolescent mothers increased the risk for a rapid repeat adolescent pregnancy. To some degree, this is related to competent self-regulation. Adolescence is a developmental phase where self-regulation is being acquired. As a result, adolescents tend to respond to the present and have difficulty considering the long-term consequences of their risk-taking behavior or even identifying risk-taking behavior (Cauffman and Steinberg 2000). Clearly, the research shows that there are more indicators of mental health problems and traumatic experiences during the prenatal and postpartum periods among adolescent mothers who have a rapid repeat pregnancy than among adolescent mothers who do not have a rapid repeat pregnancy (Patchen et al. 2009). With this knowledge, interventions that reduce the risk of a repeat pregnancy can be designed.

Long-acting contraceptives such as depot medroxyprogesterone acetate or progesterone implants during the first postpartum year have been used with limited success. Girls who continue regular use are less likely to experience a repeat birth; however, the rate at which these girls stop using the long-acting contraceptives is fairly high. Even though most adolescent girls report their repeat pregnancy was unplanned, research into their ambivalence about contraception, and inconsistent use of contraception, is needed to explain these inconsistencies (Thurman et al. 2007).

Prevention of rapid repeat pregnancies among at risk adolescents will depend on early identification and treatment of the girl's mental health issues and traumatic experiences. This makes screening and assessment for symptomology of a mental health disorder and trauma essential. Protocol is needed to quickly identify and treat pregnant adolescents who present with unexplained injury, traumatic experiences, suicidal ideation and suicidal attempts, and symptoms related to a mental disorder. Such intervention and treatment will improve the outcome of the adolescent mother and her child. It will also help reduce the number of rapid repeat adolescent pregnancies.

The Mental Health of Children of Adolescent Mothers

This section covers the research on mental health problems experienced by children of adolescent mothers. The primary focus will be on the child's risk of developing a mental health problem during his or her lifetime simply because the child was born to an adolescent mother. There is a large and credible body of knowledge that supports the notion that children of adolescent mothers are more at risk of behavioral problems and mental health disorders during their lifetime than children born to women 19 years old and older.

We know that parents influence the behavior and emotional well-being of their children in many ways. Primarily through dyadic contact, parents shape the development of their child by teaching, coaching, trying to manage their child's environment, particularly their child's social environment. We also know that failure in any one of the areas that are essential for normal growth and development can result in adverse outcomes for the child (Dodge 1990). Consequently for many, the explanation is fairly simple; children develop pathology as a result of failures in parenting. Even though in political circles, failed parenting is often a popular scapegoat, there is substantial empirical research and logic behind a model of child development that includes factors and other major domains to explain a child's deviant behavior. Genetic predisposition, environment, socialization, and the interactional effects of all of these inherent factors have long been understood as influencing the personality development and mental health of each child (Rutter and Quinton 1984).

In the case of the children of adolescent mothers, especially very young adolescent mothers, all else being equal, the children are still more often identified as antisocial (Jenkins et al. 2006; Levine et al. 2001; Wakschlag et al. 2000) and these children are more likely to experience depression in their lifetime (Hofferth 1987; Moore et al. 1997). Subsequent adjustment disorders have also been found to last into adulthood (Brooks-Gunn and Furstenberg 1986; Furstenberg et al. 1987a, b).

The factors that are associated with this risk can be organized into internal and external determinates. Internal influences, such as genetic makeup and a predisposition for developing a mental health problem, affect child behavior and development. External influences that are associated with behavioral and mental health problems are largely the product of a deprived environment; yet, an environment that can be modified if the will exists. Unfortunately, it takes substantial social capital; the commitment of considerable social and mental health services to insure a reasonably positive outcome for all at risk children being damaged by inadequate care and support.

What we do know is that, children of adolescent mothers are more often low-birth-weight deliveries and often premature. Sadly, they are also at more risk of dying in the perinatal period (i.e., five months before and one month after birth) (Elfenbein and Felice 2003; Klein 2005). Beers and Hollo (2009) go as far as declaring that 'All children born to adolescent mothers including the healthy term infants are at risk for future developmental and behavioral problems even when controlling for other background characteristics' (p. 217). Without little to indicate otherwise, physical and mental maturity of the mother are crucial to the child's future. In the area of academics, these children do not fare as well academically as children with adult mothers. In one study, the children of adolescent mothers as a group scored lower on a kindergarten readiness scale that measured cognitive and social skills. Interestingly, the children of mothers who were 17 years old or younger at their child's birth scored lower on kindergarten readiness than children of mothers who were 18 and 19 years old at the time of the child's birth. Factors associated with a higher level of maternal education and better living conditions for the child explained much of the difference (Luster et al. 2000).

In addition to having more academic problems and school adjustment problems, these children are more likely to experience developmental delay (Terry-Humen et al. 2005). Behaviorally, these children are at greater risk

for substance experimentation and use, and of becoming sexually active at a young age (Klein 2005; Pogarsky et al. 2006). These behavioral outcomes of children with adolescent mothers are similar to outcomes of children who experience less sensitive and responsive parenting. Sadly, because of a lack of maturity, depression, and other mental health issues, this is a parenting style that is often observed among struggling adolescent mothers.

Depression by far has been shown to be the most common mental health problem among pregnant adolescent and adult mothers. Because of the consequences of depression, the high prevalence of adverse child outcomes and the high burden associated with disability and poor infant development, the treatment of perinatal depression is considered a public health priority (Rahman et al. 2008). In studies, conducted in the United States and other countries, over 60 % of pregnant women were reported to have experienced clinical depression for some period during their pregnancies (Pawlby et al. 2009). Accordingly, research on the extent of depression among pregnant women (at least since the 1990s) has focused on the differential effect of the mother's depression on her child's development. Some of the crucial events and factors associated with a mother's depression that are more likely to affect the mental health of her child have been identified, that is the time during the prenatal and postpartum period when the depression occurred, the severity of a depressive episode, and the chronic nature of the mother's depression (Abbott et al. 2004; Halligan et al. 2007). Intergenerational transmission of depression and the child's inherit tendency toward depression must also be included among those major forces involved in determining a child's outcome (Hammen and Brennan 2003).

Rate of Major Depression During Pregnancy

Over the years, studies from different countries (e.g., Australia, China, Honduras, India, Japan, Malaysia, United States, and United Kingdom) suggest that approximately 20 % of mothers can be expected to experience a major depression. Wulsin et al. (2010) reported that the rate of major depression among rural mothers was approximately 18 %, but they found 56 % of mothers in rural Honduras had experienced mild depression. Given the growing literature on maternal depression in different countries from around the world, it is likely that maternal depression is a substantial problem that has negative consequences on the health of both mother and child.

In a longitudinal study from the United Kingdom conducted to learn more about the incident and effect of depression experienced during pregnancy, Pawlby et al. (2009) recruited and followed 127 pregnant women throughout their pregnancy and conducted follow-up interviews with them over the next 16 years. The women were chosen from two communities that were demographically known to have a high level of socioeconomic deprivation. These communities were selected, because in communities where residents struggle with socioeconomic deprivation, it has been observed by numerous researchers that the residents also struggle with higher rates of depression (Ostler et al. 2001).

First, it is informative to look at the characteristics and influences where no differences existed between mothers who experience depression and mothers who did not. Not surprisingly, there were no significant differences between the mothers identified as depressed during pregnancy and mothers not identified as depressed on such demographics as maternal age, marital status during the pregnancy, social class, level of education, and ethnicity or gender of the child. While much of this homogeneity among group characteristics can be attributed to the small convenient sample used in this study, the lack of difference on these characteristics also speaks to the genetic nature of depression.

What they did find was that among these women, 65 %, or 3 in every 5 women reported at least one episode of depression during their pregnancy and the 16 year timeframe that followed the delivery. Moreover, the researchers

found that the highest number of depressive episodes for these mothers occurred during their pregnancies. Of this group of mothers who experienced depression during pregnancy, 90 % reported at least one additional depressive episode during the 16-year follow-up. This is important information for practitioners in the field of mental health and service providers.

Another significant indicator of depression during the pregnancy or during the 16-year follow-up was a reported visit to a general medical practitioner because of a mental health problem. Among this group of mothers who reported being depressed during the 16-year long study, over 50 % had visited a general practitioner complaining of a mental health problem before becoming pregnant. In sum, based on this and similar studies, 90 % of women who present as depressed during their pregnancy are likely to experience another depressive episode before their child reaches the age of 16.

What is abundantly clear, from the research since the 1990s, is that a large and significant group of women, adolescent girls, and preteen girls experience depression that reaches clinical significance at some point during their pregnancy. It is also realistic to expect that these pregnant women and girls who become depressed will be offered treatment for their depression as part of their prenatal care. Identification and treatment for depression during pregnancy or during the postnatal period is feasible given the expected contact mothers have with health care professionals during the prenatal and postnatal timeframe. Support and treatment of the mother's depression can make all the difference in the world to the child and the mother.

Rate of Diagnosed Depression among Children of Depressed Mothers

Research over the years has left little doubt about there being an intergenerational predisposition for depression. This is not to say that people cannot be depressed if there is not depression in their family; nor is it saying that a person will be depressed if depression does run in their family. Clinicians working in the mental health field see this type of depression as intergenerational. When working with a depressed patient, it is not uncommon to interface with a depressed father, mother, sibling, or child.

Kraepelin (1921) was the first to write about children raised by depressed parents and to declare that the children of depressed parents were at risk of developing depression or other pathology during their lifetime. Rutter (1966) was the first to observe the intergenerational transmission of depression, which has been confirmed in a number of subsequent studies. Schizophrenia had been recognized as having a genetic link since the 1970s (Garmezy 1974a, b). The genetic link and predisposition for depression was well established by the 1990s (Rutter and Quinton 1984; Trad 1986).

The estimates for the strength of this genetic predisposition vary, but based on the accumulative evidence, it is reasonable to assume that the children of depressed parents are 2–3 times more likely to be diagnosed with a maladaptive or depressive disorder in their lifetime than children who were not exposed to parental depression (Beardslee et al. 1983; Weissman et al. 2006).

Infants of depressed mothers have been shown to be fussier, score lower on mental and motor development, and develop less secure attachments to their mother than infants of non-depressed mothers (Hipwell et al. 2000). Toddlers of depressed mothers tend to react more negatively to stress and are slower in the development of self-regulation behaviors. School-age children from this group have more school problems, particularly behavioral problems, are less socially competent and have a negative or poorer concept of self, than children whose mothers were not depressed (Field et al. 2005; Cummings and Davies 1994; Gotlib and Goodman 1999; Gotlib and Lee 1996; Riley et al. 2009).

Going back as far as the 1980s, children of depressed mothers have been identified as being at risk for developing a depressive disorder (Boyd and Weisman 1981), aggressive behavior (Weisman et al. 1984), anxiety (Weisman et al.

1984), somatic symptoms (Whiffen and Gotlib 1989), attention deficit disorder (Weissman et al. 1984), insecure attachments (Hipwell et al. 2000), and emotional dysregulation (Field et al. 1985). To modulate the consequences for these children early detection, treatment, and psychosocial support are essential.

In their longitudinal study, Pawlby and her associates also tested for differences between children of the depressed mothers and children of the non-depressed mothers that they were studying. Children exposed to maternal depression during pregnancy or in the 16 years that followed the pregnancy were significantly more likely to be diagnosed with a depressive disorder at the age of 16. In this UK sample of children, 20 % or 1 in 5 of these children were diagnosed with a depressive disorder (dysthymia or some other depressive disorders) when they were psychiatrically evaluated at the age of 16. The diagnosis of depression was based on the DSM-IV criteria that the depression had been significant for at least three months preceding the diagnosis. Given the stringent nature of the definition of depression, this criterion excludes any experiences or problems these children may have had with depression before being diagnosed at age 16. The researchers diagnosed 127 children who were the offspring of the mothers in the study sample. In this group, 18 (14.2 %) of the children were diagnosed with a depressive disorder. Of these 18 depressed offspring, over three times as many girls (14) as boys (4) were diagnosed with a depressive disorder when evaluated at age 16. This difference in the incident of depression by gender is not out of line with estimates, for the most part, because boys are most often diagnosed with a conduct disorder rather than depression. Clinically, agitated depression would be a more accurate diagnosis for many boys who are acting out their fears and frustrations associated with their experience with depression. The strength of intergenerational depression was present, in that all of the children diagnosed with a depressive disorder had been born to mothers who were themselves diagnosed with a depressive disorder. Finally, as a way of emphasizing the serious nature of the depression faced by these children, 6 of the 18 adolescents diagnosed as depressed had also planned to commit suicide or had made a suicide attempt.

Maternal Depression and Infant Risk for Illness and Impaired Developing

Most of the initial research on the rate of depression among pregnant women and the effect on their offspring were conducted in the United States. Since the 1980s, however, similar investigations into the rate of depression and the effect of maternal depression on her child has been replicated and expanded by researchers in other countries both developed and in developing countries, especially in countries where depression and other psychiatric disorders are seen as treatable and the wherewithal is available to treat them (Swami et al. 2010).

One research finding that cuts across all studies and countries and is not a surprise is that providing adequate infant care and attention is an extremely demanding task for any mother. Caring for an infant is even more stressful and demanding than caring for a toddler or young child. If the mother is in poor physical or mental health, this poor health will impact in an adverse way the child’s health, nutrition, and emotional well-being. As discussed previously, the association between poor mental health and the mother’s reduced capacity to care for her child is well established for mothers and children living in developed and industrialized countries.

Not as well studied is the incidence of mental illness among mothers in developing countries. What research is available has empirically linked poverty in poor and developing countries with a high prevalence of mental illness (Lund et al. 2010). In rural Pakistan, for instance, one study found among that 25 % of men and 66 % of women reported depression and anxiety reached clinical significant (Mumford et al. 1997). This is comparable to findings from a study from Japan. Ishikawa et al. (2011) reported that 32.0 % of the Japanese women they studied experienced clinically significant depression during pregnancy. In

fact, 21.6 % of the women were found to have experienced serious depression at least one day during the five-day period following delivery. In another study, children from a Brazilian slum whose mothers presented with poor mental health were found to be malnourished significantly more often than others who were not struggling with mental health issues (De Miranda et al. 1996). By the mid-1990s, research was also showing higher rates of HIV/AIDS among mothers with mental health disorders in developing countries (Patel and Kleinman 2003).

It seems reasonable to assume that being a mother of an infant under the best of circumstances can still be stressful at times. Added to the stress of being a new mother is the stress of being a parenting adolescent with few psychosocial and economic resources. Another important stressor can be a lack of available child care services. Another important stressor can be a lack of available child care services. Under these circumstances, it would not be a surprise to find that their children were given less than optimal maternal care. This is a serious problem, but for infants in many developing countries, the mother's care is the difference between living and dying. As Rahman et al. (2002) pointed out, in some developing countries, the level of maternal care is more important than it is in developed and industrialized countries. In developing countries, he observed, the environment is often harsh, there is overcrowding, inadequate sanitation, and food insecurity. In these situations, maternal care is often the difference between infants who survive and infants who perish.

The perinatal period is likely to be the time when infants in developing countries are likely to be at the greatest risk. Of course, the perinatal period is a time when infants need the most care in both developed and developing countries. Consequently, we would expect and the research seems to support a conclusion that infants of mothers, particularly adolescent mothers, who are in poor mental health in developing countries with limited resources to support the perinatal period, would have infants with higher rates of physical illnesses, stunted growth, and infant mortality.

Adolescent girls and adult women with a mental health disorder are as likely to bear children as females without a mental health disorder in the general population. Nonetheless, the burden of carrying a child to term and providing adequate care for the infant during the perinatal period, as the research confirms, is particularly more difficult for mothers with a mental health disorder, especially when the mother is also an adolescent. The mental health disorder and the mother's youth, however, while creating a situation where the mother and child will need supplemental services and support, is not as predictive of an adverse outcome as the failure or inability of the mother child dyad to obtain the necessary services and supports Meintjes et al. (2010).

Numerous reasons may exist for supporting or not supporting adolescent mothers with a mental health problem who are carrying or parenting a child. From a mental health perspective, however, there is abundant evidence that adult and adolescent mothers with mental disorders can and do provide a nurturing environment for their child(ren). Given appropriate rehabilitation assistance and interventions that address parenting as a rehabilitation goal have been successfully used for years. Assisting mothers to modify their environments and social context has improved parenting. Finally, helping adolescent and first-time mothers develop knowledge of child development and individual parenting skills has been shown to be effective in both developed and in developing countries (Rahman et al. 2008).

Discussion

As is apparent from this review, risk factors that affect the physical and emotional development of adolescent mothers and their children are widely reported in research studies. Although the endogenous and physiological risk factors related to mental health problems are fairly clear; for the most part adverse outcomes observed among pregnant adolescents are related to the degree to which resources are available to and utilized by young mothers. This includes circumstances where the adolescent may not be able to take full

advantage of available sexual and reproductive services due to her age or judgmental provider; or, because of a mental health disorder, she may be struggling with at the time.

Researchers have produced an overabundance of studies showing that obvious risk factors in terms of the baby's development are correlated with the mother's age. The influence of age is based on the effect of age on adolescent maturity. The mother's level of maturity is important in terms of the effect of the mother's maturity on her child's psychological development. The conclusion is that the older the adolescent, when she gives birth, the better her child's cognitive and psychosocial development. What we also know is that when resources are available to meet the mother and child's needs, outcomes are not significantly different for children of younger and older adolescent mothers.

The positive side of the findings from these studies is that material differences are creating situations and circumstances that can be modified and changed to reduce the risk to adolescent mothers and their children are exposed to. This is especially true for adolescent girls who have mental health issues that are activated or complicated by pregnancy.

Poverty is the most widespread of the harmful environment for pregnant adolescents. It even exists in the many developed countries where there is a thriving middle and upper class. Human beings have basic needs that must be provided if a child is going to develop normally. Anything less must be defined as poverty. When adolescent girls grow up in poverty, in a community with little or no social capital, the girl's socioeconomic status puts her at increased risk of developing mental health problems and of experiencing an adolescent pregnancy (Geronimus 2004).

Based on the research that has accumulated from around the world, since the 1970s, it is clear that untreated maternal mental illness results in an unacceptable global burden. A cost so great at the individual level that this global burden demands the provision of mental health care as an integrated part of prenatal and postnatal care for both adult and adolescent mothers and their children.

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Pregnancy, Marriage, and Fatherhood in Adolescents: A Critical Review of the Literature

Jorge Lyra and Benedito Medrado

Keywords
Adolescent fathers · Adolescent morbidity and mortality · Cultural construction · Mother-to-child transmission of HIV · Unmarried adolescent fathers · Risk behavior · Precocious pregnancy · Politics of pregnancy · Sexually transmitted diseases

Introduction

Adolescent fatherhood is an issue that is poorly understood and insufficiently covered in the professional literature. Even more problematic, there are few intervention programs in the field of sexual and reproductive health to address their needs and concerns. Starting in the 1980s, however, there has been a growing interest in adolescent fathers by researchers, specialists, activists, government workers in the area of reproductive and human rights (especially those of children and adolescents), and international bodies such as the World Health Organization. In this chapter, the authors will provide an overview of adolescent demographics in both developed and developing countries regarding pregnancy, marriage, and the role of adolescent fathers; this is a demographic group that is often overlooked in the literature as most research targets the plight of pregnant adolescent girls.

Adolescents: A Global Picture

Demographic studies show that young people now make up a significant proportion of the world's population (Salgado and Cheetham 2003). Although the definition of age range for children and adolescents may vary, the UN collects global statistics using the following definitions: children, 0–18; adolescents, 10–19; youth, 15–24; young people, 10–24; dependent young, 0–15. Nearly half of all the people in the world are under 25. The world today has the largest ever generation of young people between 15 and 24 and this age group is rapidly expanding in many countries. The vast majority of these young people, however, some 890 million, live in developing countries. Most adolescents (aged 10–19) come from developing countries and more than half are both out of school and out of work. Some 715 million adolescents live in Asia, 184 million live in Africa, 105 million live in Latin America and

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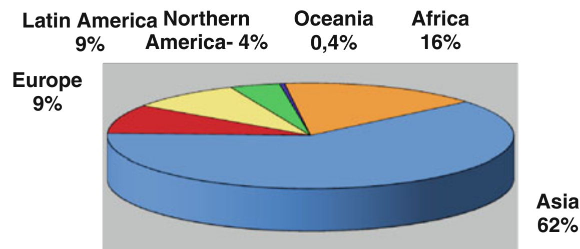

Fig. 1 Adolescents (aged 10–19) by area, 2000 (in millions). *Source* Salgado and Cheetham (2003)

the Caribbean, 98 million reside in Europe, 43 million reside in North America, and 4 million are found in Oceania, as Fig. 1 shows.

The proportion of young people (aged between 10 and 19 years) in relation to the overall world population stood at 21 % in 1980, 19 % in 1995 and 17 % in 2010 (McCauley and Salter 1995; World Bank 2011). In 1980, the lowest percentages were found in Europe, North America, and Oceania; the highest were found in Asia, Latin America and the Caribbean, and Africa. By 1995, East Asia had become one of the regions with the lowest percentage of young people, while the figure for the world, as a whole remained almost the same. However, comparison of the percentage of growth between 1980 and 1995 with that projected for 1995–2010 reveals a worldwide tendency toward a slowing down of the growth of the population as a whole; especially in the 10–19 age groups (Table 1).

It should be pointed out that the socioeconomic situation of these young people is quite complex. For example, 57 million young men and 96 million young women living in developing countries cannot read or write and only 76 % of girls, compared to 96 % of boys, receive some level of primary schooling. Over 70 million young people are unemployed and looking for work. The International Labor Organization (ILO) estimates that unemployment rates among young workers almost everywhere are at least twice as high as the adult average.

Only 17 % of sexually active young people use contraceptives and about 14 million women between the ages of 15 and 19 give birth each year. In the least developed countries, 1 in 6 births is to a young woman aged 15–19. Worldwide, 10 teenage girls undergo an unsafe abortion every minute. The risk of dying from complications related to pregnancy or childbirth is 25 times higher for girls under 15, and twice as high for 15–19 year-olds, compared to women in their mid-20s. Adolescent mothers will have more children than women who start childbearing later. Raising the mother's age at first birth from 18 to 23 could reduce population momentum by over 40 %. At least 1 in 10 abortions worldwide occurs among women aged 15–19. More than 4.4 million adolescent women undergo abortions every year, 40 % of which are performed under unsafe conditions.

So far as HIV/AIDS and other sexually transmitted diseases are concerned, it has been shown that every minute, five people under 25 are infected with HIV. The highest rate of new cases of HIV transmission occurs among young people aged 15–24. During 1998, more than 8,500 children and young people became infected with HIV each day—six every minute. Women and girls are most vulnerable to infection. Every year, one in 20 adolescents contracts an STD. Some 23 million adolescent girls are believed to be infected with Chlamydia, which is often without symptoms, and can leave women infertile. The highest rates of gonorrhea are among women aged 15–19 and men aged 20–24. In addition to risky sexual behavior, more than 100,000 young people commit suicide each year.

So far as marriage between adolescents is concerned, in some countries it has been shown that half of all girls under the age of 18 are married; this is often in response to poverty or fear of out-of-wedlock pregnancy. The

Table 1 Young adults in the world population—estimated populations for 1980 and 1995 and projected populations for 2010. All ages and ages 10–19, world and regions

Region	Population (in millions)									% Increase			
	1980			1995			2010			1980–1995		1995–2010	
	All ages	Ages 10–19	10–19 as % of all	All ages	Ages 10–19	10–19 as % of all	All ages	Ages 10–19	10–19 as % of all	All ages	Ages 10–19	AAll ages	Ages 10–19
Sub-Saharan Africa	384	87	23	596	136	23	896	211	24	5	56	0	55
Northern Africa[1]	110	25	23	161	37	23	215	44	20	6	48	4	19
East Asia	1,179	271	23	1,424	228	16	1,605	234	15	1	16	3	3
South-Central Asia	990	222	22	1,381	294	21	1,817	365	20	9	32	2	24
Southeastern Asia	360	84	23	484	104	21	607	116	19	4	24	2	12
Western Asia	113	26	23	168	35	21	234	48	21	9	35	9	37
Europe	693	109	16	727	100	14	729	83	11	5	8	*	17
North America	252	44	17	293	40	14	332	46	14	6	9	13	15
Latin America and Caribbean	358	83	23	482	101	21	604	111	18	5	22	5	10
Oceania	23	4	17	29	5	17	35	5	14	2	25	1	*
World	4,444	950	21	5,716	1,073	19	7,032	1,253	18	9	13	3	17

*Less than 1/2 %. *Source* Medium variant from United Nations. The sex and age distribution of the world populations 1994 (488). http://www.jhuccp.org/pr/j41edsum.stm (McCauley and Salter 1995)

[1] Including Western Sahara

Table 2 Median age at first marriage (among women ages 20–24 and 45–49 when surveyed) and legal age for marriage for men and women

Region, country, and year of survey	Median age at first marriage		Minimum legal age of marriage	
	20–24	45–49	Women	Men
Africa, Sub-Saharan				
Cameroon 1991	17.3	16.0[d]	21	21
Ghana 1993	19.0	19.0	Varies	Varies
Kenya 1993	19.5[a]	18.1	18	18
Madagascar 1992	19.5	17.1	18	18
Namibia 1992	24.9[b]	23.3[d]	NA	NA
Nigeria 1990	17.8	17.3	Varies	Varies
Rwanda 1992	20.9[a]	18.7	21	21
Senegal 1992–1993	18.3	15.8[e]	16	20
Sudan 1989-1990	20.5[a]	16.3[d]	NA	NA
Zambia 1992	18.6	16.6	21	21
Asia and Pacific				
Bangladesh 1993–1994	15.3	13.6	18	20
India 1992–1993	17.4	15.5[e]	18[c]	21
Indonesia 1991	19.8	16.9	16	19
Pakistan 1990–1991	18.9[a]	18.8	16	21
Philippines 1993	21.8[a]	21.1	18	20
Latin America and Caribbean				
Bolivia 1993–1994	20.6[a]	21.2	14	16
Brazil 1991	20.6[a]	20.2	21	21
Colombia 1990	21.5[a]	20.0	18	18
Domincan Republic 1991	19.8[a]	17.7	18	18
Nicaragua 1992–1993	18.6	18.2	18	18
Paraguay 1990	20.8[a]	21.0	12	14
Peru 1991–1992	21.8[a]	20.7	18	18
Near East and North Africa				
Egypt 1992	19.9[a]	18.3	16	18
Jordan 1990	21.2[a]	18.9	18	18
Morocco 1992	22.3[a]	17.6[f]	[g]	21
Turkey 1993	20.0[a]	18.3	15	17
Yemen 1991-1992	18.1	15.7	16	18

[a] Median is for women ages 25–29; median for 20–24 was not calculated since less than 50 % had married
[b] Median is for women ages 30–34 because median for younger groups was not calculated since less than 50 % had married
[c] The minimum age for women is reported to have been raised to 18 years
[d] In these countries, the measure excludes single (never-married) women
[e] Women ages 40–49
[f] Women ages 40–44
[g] Parental consent required for all ages
NA = Not available
Sources Demographic and Health Surveys except India: International Institute for the Population Science 1995 (583) and Nicaragua: Stupp et al. (1993) (466); minimum legal age at marriage from United Nations 1989, 1991 (490, 491) and Alan Guttmacher Institute 1995 (18)
Note In survey reports, “marriage” is defined to include consensual unions—couples living together—as well as formally recognized unions, either civil or religious

percentage of girls aged 15–19 who are already married include 74 % in the Democratic Republic of Congo; 70 % in Niger; 54 % in Afghanistan, and 51 % in Bangladesh (Salgado and Cheetham 2003).

The Table 2 shows data collected on the median age at first marriage among women aged 20–24 and 45–49 when surveyed, in sub-Saharan Africa, Asia and the Pacific, Latin America and the Caribbean, the Middle East and North Africa. This Table 2 also shows the legal age for marriage for men and women. It should be noted that the legal age for women varies between 12 (Paraguay) and 21 (Cameroon, Zambia, Rwanda, and Brazil), while the legal age for men is generally older, varying between 14 (Paraguay) and 21 (Pakistan, India, Cameroon, Zambia, Rwanda, Brazil, and Morocco). The age at first marriage, however, does not necessarily follow such conventions. The youngest ages reported varied from 13.6 (in Bangladesh) to 21.8 (in Peru).

The high-profile attention that these data have received in recent years has been accompanied by discourse and practices founded on the notion that marriage, pregnancy, and fatherhood in adolescence is somehow untimely, that it is *precocious* and *premature* and, as such, undesirable.

Adolescent Fatherhood Research and Programming

In order to understand the complexity of the issue of pregnancy and fatherhood among adolescents, it is necessary to comprehend the multiple meanings of adolescence that guide research and current programming. A basic assumption that is not questioned in the vast majority of the literature is the belief that adolescence is a vulnerable age.

Is Adolescence a Vulnerable Age?

Discussions about adolescent sexuality produce a variety of contradictory reactions. Adolescence at the same time fascinates and scares, amuses, and worries most of us. It is cause for admiration and envy, but also jealousy and fear. It seduces and captivates, but is also seen as aggression. Adolescence is at the same time synonymous with confusion, life, threat, energy, haphazard discovery, happiness, a sense of adventure, freedom, romance, problems, and solutions.

Publications (scientific or not), Internet sites, and television programs that address the issue of adolescence or claim to be aimed at an adolescent audience, tend to expose a variety of different facets of this stage of life. In general, however, they directly associate it with ideas of crisis, disorder, and irresponsibility. In short, they see adolescents as a problem for society.

The concept of being at risk is strongly linked to this litany of associations respected by phrases such as "at risk or highly at risk of getting pregnant," at risk from HIV infection, vulnerable to illicit drug use, at risk of falling into "bad company," and at risk of being a victim of violent crime. Risk and vulnerability seem to define and circumscribe this *chaotic* time of life (Medrado and Lyra 1999).

Scientific studies in the West have conformed to the image of adolescence as an "age of risk" (seeing risk as a constitutive part of being an adolescent) or an "age at risk" (exposed to risks because of various organic, psychological, psychosocial factors that supposedly characterize adolescence and lead to greater vulnerability) and this seems to be especially closely linked to the classical epidemiological definition of risk as the probability of occurrence of an undesirable, morbid or fatal event. It is also influenced by the development of increasingly accurate techniques for calculating risk that seek, by way of various scale models, to measure behavior, perceptions, and risk-taking (Arnett 1992; Fagot et al. 1998; Ojeda and Krauskopf 1995; Yunes and Rajs 1994; Gullome and Moore 2000).

Studies cover various issues. Research on "risk behavior," for example studies both forms of behavior considered "risky" *per se* such as alcohol consumption, smoking and illicit drugs, dangerous driving, and unprotected sex, but the term also deals with the negative consequences of these forms of behavior (accidents, mortalities related to drug abuse, unwanted pregnancy, and

sexually transmitted diseases, including AIDS). More recently, the question of violence and the use of aggressive behavior to resolve conflicts (covering both acts of self-aggression, including attempted suicide, and aggression directed at others, physical violence and homicide) have come to be highlighted in such studies (Tursz 1997; Wiselfisz 2000). As Oliveira (2001), points out, an obviously "sanitary" approach to adolescence and adolescents can be seen in such studies. While, the adolescent is generally described as naturally adventurous, immature, and as one whose sense of invulnerability puts his or her physical well-being constantly at risk.

Additionally, some authors have come to reflect on exposure to risk using the notion of *resilience,* given the fact that not all people react to adversity in the same way. As defined by Rutter (1993), *resilience* can be seen as the capacity to recover and sustain acceptable behavior after suffering harm. This point of view has given rise to research that seeks to identify the needs and the mechanisms capable of diminishing emerging problems, including as a priority the reinforcement of exogenous and endogenous defenses in the face of exposure to trauma and stress in children and adolescents (Serrano 1995).

Psychological Studies on Adolescent and Risk

This association between adolescence and risk can also be found in psychological studies. In research carried out by the Center for Research in Social Psychology and Health, coordinated by Mary Jane Spink, the aim was to understand the role psychology plays in constructing "the social language of risk," focusing on the linguistic repertoires to be found in discourse in this area. The main source of information was the indexed literature found in *Psychological Literature* (PsycLit), the database of the American Psychological Association (APA), which contains publications in psychology and related fields from more than 50 countries and has been published regularly since 1887 (Oliveira 2001).

On the whole, the results suggest that the concept of risk has become an issue of considerable importance in psychology. In particular in the case of publications that contain the word "risk" in the title, there has been a startling rise in frequency from the 1950s onwards, this being an excellent indicator of the high profile that the concept of risk has assumed in the field.

A representative sample of these publications that contain risk in the title was analyzed. The authors were particularly interested in indexed references in the fields of *psychological and physical disorders* and *developmental psychology*. Both categories contained a high number of references to adolescence and adolescents.

Texts classified in the *psychological and physical disorders* category which emphasizes the "risk factors" approach to psychological, physical, and social disorganization focus on adolescence as a disturbing time of life. The references included an article by Tursz (1997) that discusses the methodological problems associated with the research design and analytical epidemiological procedures used in studies of risk, morbidity, and mortality at this period in human development. This study is described in more detail below.

Research on risk in the *developmental psychology* category focused on themes such as juvenile delinquency, alcohol use, and pregnancy in female adolescents who drop out of school. Hagan's 1991 article, entitled *Destiny and drift: subcultural preferences, status attainment, and the risks and rewards of youth*, for example, uses risk in the common sense everyday sense of the word and focuses his discussion on the concept of *drift*—in the sense of drifting away from the family and from school—and its relation with the subculture of delinquency and parties. Taking *transition* as the main feature of adolescence, risk in this work is the determinate of the possibility (or not) of the adolescent attaining the *status* of an adult (Montemayor, 1986).

Colder and Chassin (1997), on the other hand, in their article, *Affectivity and impulsivity: temperament risks for adolescent alcohol involvement,* examine various dimensions of

temperament (impulsivity, and negative and positive affectivity) that are considered risk factors for alcohol use among adolescents.

Manlove (1998), focusing on the issue of pregnancy in adolescence, has tried to develop a predictive model for pregnancy in young females of school-going age by incorporating as explicatory factors, the family environment, race and performance at school, and using data from a longitudinal nationwide study.

Taken as a whole it is possible to perceive in these texts a clear division of risk by gender and even a distinction between subage groups of adolescence. Gullome and Moore (2000), for example, in their research on the relation between personality (seen as a whole rather than as a collection of characteristics or traits) and *adolescent risk-taking*, conclude that younger adolescents (aged 11–14) and girls are better able to assess the degree of risk of a given situation and generally take less risks than older adolescents (aged 15–18); thereby corroborating, according to the authors, the findings of earlier research.

Sexuality and reproduction, with the exception of so-called precocious pregnancy, the major risk factors are in general attributed to the adolescent or young person of the male sex, described as naturally violent, aggressive, promiscuous, irresponsible, adventure-seeking, and impulsive (Ojeda and Krauskopf 1995; Yunes and Rajs 1994). The tendency, however, to view adolescence as an "age of risk" or an "age at risk" is generalized and taken as being characteristic of this so-called stage of human development described as essentially dangerous, irrespective of the lived-experience and social conditions within which the adolescent is growing up.

The arguments of those who define adolescence as a time of life when the sensation of invulnerability leads to greater exposure to risk are, first and foremost, numerical ones. Statistically speaking, adolescents, according to authors such as Arnett (1992), register high scores in all the categories of risk-taking behavior. Researchers, however, do not always agree even about the numbers.

An interesting article published in the *Journal of Adolescent Health*, by Tursz (1997), as cited above, reports recent epidemiological data (from the 1990s) on juvenile morbidity and mortality and high-risk behavior from various countries and identifies some methodological problems both with the collection of data and the interpretation of epidemiological research on the adolescent population. Although Tursz does not propose to undertake a comprehensive review, she gives a number of relevant examples that help to explain the complex (and at times equivocal) association between adolescence and risk. Her question is extremely simple: What is really specific to adolescence? Is risk really a fundamental characteristic of adolescence?

Tursz (1997) questions, for example, the fact that, in general, research tends to take adult behavior as a yardstick or measure of what constitutes low, medium, and high levels of risk. Yet, Tursz points out, that most research does not provide the same wealth of detailed information for other age groups, thereby making it impossible to make comparisons and may lead to biased interpretations.

Tursz also asks why in sports, for example, experiences that involve risk are considered "gratifying" and morally enriching, as is the case with the whole industry of radical sports and adventure activities. Sport, she reminds us, is one of the few kinds of aggressive violence that people are allowed to express in Western society. It is, at root, a question of the values that underlie the definition of what is considered "risky" and what is not.

In short, Tursz points out three major problems with the research on adolescent risk behavior. First, there are serious methodological problems with the collection of data that may affect the reliability of the results. Secondly, there are not enough data available to justify the affirmation that high-risk behavior is specific to adolescence. Finally, she postulates that the statistical approach may lead to analyses that are too superficial or too rigid to identify the complex causes behind the statistical differences related to race, gender, geographical location, or place of origin. This occurs because high-risk behavior originates in a multiplicity of psychological, social, and cultural factors that influence

not only what is seen to be "in fact" a risk, but also the meanings that are attributed to risk.

Transitionally as a Characteristic of Adolescence

Much of the research on adolescences can be described as attempts to produce a precise (natural and objective) definition of what adolescence is. Making a sharp break with this approach, Levi and Schmitt (1996) propose a dynamic definition of adolescence, which highlights the fluid and imprecise character of adolescence. Their definition emphasizes that adolescence is a transitory phase between infantile dependence and the autonomy of adult life.

This transitionally has a fleeting nature loaded with feelings of "promise and threat, potential and fragility…which in all societies, receives careful attention full of expectations" (Levi and Schmitt 1996, p. 8). These authors quite clearly state that this "time of life" is *reflexively* "defined by in definition:"

This "time of life" cannot be defined clearly using demographic quantification, nor by legal style definitions, and, for this reason, it seems to us quite useless to try to identify and establish, as others have, very clear limits (Levi and Schmitt 1996, p. 8).

The idea of transition to adult life, however, is loaded with ambivalent feelings of "hope" and "distrust," leading to protective impulses and taking chances. This is perhaps the central characteristic of the transition to maturity: ambivalence and uncertainty.

It should also be pointed out that, of the categories that are used as the basis for classifying and governing populations (i.e., such as sex and race/ethnicity), age has one special feature: it is transitory from the point of view of the individual. In other words, people do not *belong* to any one age group. On the contrary, as Levi and Schmitt argue, they *pass through* age groups.

Unlike social classes (that individuals experience difficulty in leaving, although in some cases they do succeed in realizing their hopes of social mobility), and unlike sexual difference (that is unequivocal, fixed once and for all), to belong to a given age group—and especially youth—represents a temporary condition for each individual (Levi and Schmitt 1996, p. 8).

This notion of *transitionally,* from the government point of view, according to Levi and Schmitt (1996), may generate societies that are "hotter" or "colder." In "colder," more structurally static societies, certain legal and symbolic processes tend to be based on and emphasize features that represent continuity and the reproduction of predefined places, roles, and attributes at each stage in development. They are guided, therefore, by governmental strategies based on control, prevention, and discipline. On the other hand, a "hotter" society recognizes the value of transition and change, being tolerant toward the inevitably ambiguous and critical character of transition from one age to another. Such a society is thus concerned mainly with the transmission of rules and knowledge from one generation to the next.

What Happens When Adolescents Do "Adult Things"?

What happens when an adolescent decides to get married and have children? According to Levi and Schmitt, they would be breaking with the supposedly natural "cycle of life" according to which it is expected that pregnancy and motherhood or fatherhood are experiences restricted exclusively to adult life. So, in general, married adolescents or adolescent parents are treated in the literature and in intervention schemes primarily as adolescents. The fact that the adolescent is married or a parent is treated as a secondary characteristic. By adopting this point of view, the most common tendency is invariably to focus exclusively on the problems and to attribute all the difficulties faced by the newlyweds and/or adolescent mothers and fathers to the simple fact that they are adolescents. Thus, the provision of services are problem oriented and are not focused on the needs of adolescent parents and their children.

Sposito (1997) in an article providing an overview of contemporary trends in the study of

youth, from the perspective of the Sociology of Education, brings to bear an interesting discussion of the transformation of the perception of adolescence and youth as a linear process. Although youth and adolescence refer, in principle, to distinct phenomena in the human and social sciences literature, there is often confusion as to the use of the terms. Whereas sociologists usually employ the term *youth*, psychologists prefer the term *adolescence* to refer to the transitional stage between childhood and adult life.

Inspired by the work of Chamboredon (1985), Sposito (1997) rescues the concept of decrystallization to analyze the discrepancy, or lack of synchrony, characteristic of the transition from real youth, and from the heteronomy of childhood to the autonomy of adult life. The concept of decrystallization is understood to refer to the process, which, together with latency is thought to be indicative of the transitory nature of contemporary youth.

Chamboredon (1985) cites as examples of these processes, in first place "performing adult sexual activities while still in puberty, dissociated from their reproductive and family functions," (or not, we should add!). In second place she cites the "undertaking of professional training offered by the education system without immediate entry into the job market…"

This first aspect decrystallization can be seen in Brazilian and Latin American research that shows a pattern of sexual activity in both male and female adolescents. Mundigo (1995) relates, for example, the extent to which premarital sexual experience among adolescents is common in Latin America. The percentage of young people between the ages of 15 and 19 of both sexes who claimed to be sexually experienced was 42 % in Costa Rica, 44 % in Mexico City, 73 % in Rio de Janeiro, Salvador and São Paulo, and 78 % in Jamaica. In all these places, the mean age for the first sexual relationship was around 15 years for males and 17 for females. The most common form of initiation for the male adolescent, in many societies, is still provided by sex workers. However, researchers and those who work in this area are noting that changes are taking place in the sexual behavior of adolescent boys so far as the choice of the partner with whom they first have sexual relations is concerned.

One of the tangible consequences of this type of behavior, as observed above, is the possibility of becoming pregnant and the adolescents becoming parents. However, parents' expectations of their adolescent children (especially middle-class parents) are focused on school, and later on, a good job, and starting a family and having children is seen as a more long-term goal. To put it another way, middle-class parents, along with social institutions, generally seem to have incorporated the model of adolescence as a transition to adulthood (at least for males) with the following stages: finish school, find a good place in the job market, get married (to someone of the same social class), set up a home and, finally, have children.

In the case of the less privileged sectors of society, Sarti (1994) provides important information on the place parents attribute to children in families and raises a number of questions concerning what it means for parents when their adolescent children gets pregnant and become parents themselves. In cases of separation or the death of one of the parents, in other words, in the absence of a male or female role model, others may be chosen to occupy this role, for example, the elder brother or sister. The position of children is determined by the roles attributed to men and women in the family.

When a son or daughter is forced to play the role of head of the household, and at the same time has to divide his or herself between being responsible for the family and dealing with a pregnancy, it is worthwhile to examine the way the family acts as a network of support.

> Having children, like getting married, implies responsibility… When they have a child men and women come of legal age and must be responsible for themselves, which ideally implies removing themselves from their parents' family and setting up their own new family unit. Having a child can, therefore, become a way of achieving this separation (Sarti 1994: 47–50).

According to the same author,

> A woman's authority is tied to her value as a mother, in a world which sees a woman as a

> woman, and ensures that she is recognized as such… A man exercises his authority by acquiring material resources, respect and protection for his family, as breadwinner and intermediary with the outside world… (Sarti 1994: 47–48).

So, in our societies we live with models of transition from adolescence and youth to adult life that are not always equal; for the middle strata of society, the model is supposed to follow a more rigid sequence; for the lower strata, the passage to adult responsibility may be brought about by vicissitudes imposed on the family or by cultural factors. We should also bear in mind the meanings and diverse possibilities that the experience of school has for different social classes.

As numerous studies have shown, the duration of youth has been prolonged, mainly, because of staying longer in school, at least in developed and developing countries (Chamboredon 1985). The experience of attending school is not the same for children and adolescents of different social strata. In spite of the value attributed to education as a strategy for social ascension, the barriers children from low-income strata come up against within the school system are more difficult to overcome than those faced by children from the middle classes. Expulsion from school is linked, in a complex fashion, with the desire to work on the part of children and adolescents from low-income homes. School, in this case, does not prolong the transition period of adolescence, but runs parallel to a relative autonomy stemming from precocious entry (in comparison with middle-class standards) into the job market.

At this point, it is worthwhile to make a distinction between the two sexes. While autonomy for the young male stems principally from his entry into the work market, in the case of the young female, it can come from two different directions: working outside the home (economic independence) or starting a family, by marrying and having children. Thus, some studies, especially those on low-income classes, have pointed out that adolescent girls do not always get pregnant due to lack of care, irresponsibility or chance, but also, because they want to be a mother and see this as a way of becoming independent. *Wanted* pregnancies among adolescent girls do, therefore, exist (Paula 1992, 1999).

It is worthwhile discussing pregnancy in adolescence, albeit briefly, at this point, as a far greater wealth of information on and discussion of this subject is available than is the case with pregnancy for this age group. Despite the paucity of information we have on their adult or adolescent partners, these pregnant adolescents may be the adolescent fathers' main partners, and it is the former who make it possible, in most cases, to have access to the latter. It is also on this subject that most questioning of "catastrophic" discourse and repressive policy has arisen in recent years.

Pregnancy in Adolescence

Rosenheim and Testa (1992) re-examined the preconceptions implicit in conventional approaches to prevention of pregnancy in adolescence and re-assessed the extent to which a rise in the problem of motherhood/fatherhood requires that the issue be addressed.

Fatherhood and motherhood in adolescence in the 1970s, according to Rosenheim and Testa (1992), were, and still are, seen as a public health problem. The prognosis at that time was that rates would decline because of sex education for adolescents and access to contraception and abortion. However, although the birth rate in the United States is now lower than in the 1950s, there has been no significant reduction in pregnancy in adolescence since the 1970s. Between 1986 and 1989, the rate for the adolescent population actually rose 15 % (National Center for Health Statistics 1991; Testa 1992: 1). This increase has worried experts in the field, who are now carrying out studies and proposing different kinds of intervention in accordance with the significance they attribute to it.

Elster (1986) points out that the experience of pregnancy and fatherhood in adolescence may affect the fathers differently from the way it

affects older fathers, as the situation is perceived as a premature transfer of roles. Adolescent couples are, generally, engaged in relatively unstable relationships and social forces opposing their relationship affect their level of commitment. Some authors think that this leads to the perpetuation of poverty and ignorance, the figures for pregnancy being higher among young people who are illiterate or have minimal schooling, whose chances of escaping from the cycle of misery are virtually nil (Madeira and Wong 1988). Concern over the perpetuation of the poverty cycle has guided a large number of the studies on the subject, as well as public policy aimed at this segment of the population.

Some authors, however, have adopted a different position (Macintyre and Cunningham-Burley 1993; Pearce 1993; Reis 1993) criticizing, as we do in this text on pregnancy and fatherhood, the specialist discourse on pregnancy in adolescence. Alberto Reis (1993), in his doctoral thesis, analyzed articles in the area of health indexed by the *index medicus* (which lists international periodicals in the field of health) on the subject of the pregnant adolescent between 1930 and 1989. This study made it possible to show how medical discourse has changed over this sixty-year period. These changes, the author argues, reflect phases or dominant tendencies that have the following characteristics:

> In the 1930s and 1940s the subject was closely associated with bio-naturalism,…and the notion of risk. In the 1950s, in the United States, pregnancy and adolescence came to be treated together using collective and preventive, obstetric and pediatric methods. Between the 1950s and the 1960s…the pregnant adolescent came to be seen as a wider problem. In the 1970s, the first proposals were drawn up using a community-based approach. In the 1980s, this was translated into directing public health strategies towards the most vulnerable groups in society, [with] a new aim of preventing pregnancy, in spite of the fact that the adolescent might want it… (Reis 1993: 148–150).

In his criticism of the public health discourse on pregnancy in adolescence, this author sees the need to question the negative and moralistic way the subject is viewed, based on the criterion of age and seeing pregnancy as a problem.

Two other studies recently published in *The Politics of Pregnancy: Adolescent Sexuality and Public Policy* (Lawson and Rhode 1993) also question the meanings attributed to motherhood in adolescence by specialists in the United Kingdom (Macintyre and Cunningham-Burley 1993) and the United States (Pearce 1993). Macyntire and Cunningham-Burley point to two recurring problems in the literature on pregnancy in adolescence. The first is that the authors tend to start out with the preconception that pregnancy in adolescence is a problem. Secondly, their arguments lump together analytically and empirically distinct aspects of pregnancy in adolescence, such as chronological age, marital status and whether the pregnancy was planned and/or wanted or not. Generally speaking, it is presupposed that the pregnant adolescent is single and the pregnancy was unplanned.

For example, much has been written about the rise in the rates of pregnancy in adolescence. However, at least in the United Kingdom, Macintyre and Cunningham-Burley (1993) did not find significant differences between the numbers of births attributed to the 15–19 age groups, in comparison with the rest of the population. According to these authors, what have in fact gone up, for this age group, are the rate of births out of wedlock (from 45 % in 1971 to 66 % in 1986) and the rate of abortions (from 26 % in 1975 to 33 % in 1985).

Studies tend to view all the difficulties faced by adolescents as being inherent to pregnancy or adolescence, and this ends up guiding their argument. Rarely are authors concerned to define clearly which problems exactly are directly related to pregnancy in adolescence. This is a problem, according to these authors, since, though there are problems, these can be minimized if an adequate network of support is available (Taucher, 1991).

In the same way, Pearce (1993) is fairly vehement in her criticism of the US social mobilization campaign's use of the slogan "children

having children" in view of its impact on public policy. For this author, in US history and at many stages in the history of the world it has been normal for adolescent women to marry and have children. "To define adolescents who get pregnant as children thus reflects a cultural construction of the end of childhood that is substantially later than the real transition" (Pearce 1993: 47).

The ambiguity of the phrase "children having children" has consequences for intervention, as Pearce points out (1993: 47). Pregnancy in an adolescent or child is a consequence of two related but distinct forms of behavior: having sexual relations and not using effective methods of contraception. When the pregnant adolescent is regarded as a child, sexuality will be repressed (by moralistic, alarmist discourse and an emphasis on this in sex education), as the full right to sexuality is reserved exclusively for adult men and women. An article by Patrícia Decia, *1927 Law is revived to curb teen pregnancy*, published in the *Folha de S. Paulo* newspaper 28/07/96, nicely illustrates this controversy. This article reports that a public prosecutor in the city of Emmet Idaho in the United States charged six "teens" with fornication.

> The purpose of the prosecutor, however, did not have much to do with morality. He aimed to eradicate, or at least, reduce the number of pregnant adolescents in the State, especially those that seek financial assistance from the government to have their babies. About a million U.S. teens get pregnant each year. The cost of feeding these families has reached $25 billion (…)

If the emphasis is placed on "responsible sex," however, the adolescent will be treated as an adult, at least so far as sexuality is concerned, thereby paving the way for public policy compatible with accepting that adolescent boys and girls are also sexually active.

As we have seen, pregnancy in adolescence has been seen as a problem for less than 60 years. As an object of study and intervention, it has been scrutinized, pathologized, categorized, and subjected to attempts to prevent it in a repressive, or as in recent years, more understanding manner. Adolescence and womanhood and motherhood are not mutually exclusive. Adolescent fatherhood, on the other hand, has been cloaked in silence and its timid voice is only now beginning to be heard.

Conscious of this ambiguity, we should be careful not to turn adolescents into adults, but to bear in mind that they are young people in a phase of transition who share some aspects of adult life, such as sexuality. Seeing this as a process of decrystallization in the transition from the heteronomy of childhood to the autonomy of adult life (Sposito 1997), in association with the ethical position advocated by Reis (1993)—of respecting adolescents—leads to a fairly sensitive style of intervention that attempts both to shy away from repression and negation and, at the same time, not treat adolescents as fully fledged adults, offering them the support they need at this time of life, in the form of educational, and not just work, opportunities, special health services, and so forth.

Searching for Information

The first stage in producing this paper on fatherhood and pregnancy and marriage in adolescents was to visit the PAPAI Institute's Documentation and Information Center, which houses a relatively large collection of texts, images, and videos on issues relating to gender, sexuality, and reproduction. Subsequently, we entered into dialogue with key informants—academic researchers and/or professionals who work in NGOs—with a view to gathering their opinions, suggestions, and references. These contacts allowed us both to locate reference material, published or not, and moreover to identify the main controversies, impasses and dilemmas in the field. All the texts recommended were read in their entirety and are cited in the introduction, and the argument and analysis throughout the paper.

A Systematic Survey

In a more systematic fashion, we contracted a professional librarian to help draw up our search strategies, with a view to locating published

scientific or technical texts on marriage, pregnancy, and fatherhood among adolescents, based on the following predefined criteria:

(1) Texts published (English and non-English literature—Portuguese, Spanish, and French in various database);
(2) Texts published 1985–1995 (Lyra 1997); 1990–2002 (Lyra and Medrado 2004); 2000–2009 (Medrado et al. 2011).
(3) Studies covering adolescents and young people aged 10–24;
(4) Studies on fatherhood or that have focused on married and pregnancy female adolescents, but also report on the implications for and actions of the male partners.

Database Given the scope of this study, we chose to confine ourselves to seven large-scale database:

MEDLINE/PubMed—MEDLARS Online. International literature

LILACS—Literatura Latino-Americana e do Caribe em Ciências da Saúde (Latin American and Caribbean Health Sciences Literature)

WHOLIS—WHO Library Information System

PAHO—Pan-American Health Organization Head Office Library Catalogue

ERIC—Educational Resources Information Center

PsycInfo—Source for Psychological Abstracts by American Psychological Association

Web of Science

Bank of theses and dissertations for the Coordination of Improvement of Higher Education Personnel (CAPES)

SciELO—Scientific Electronic Library Online

This survey consisted, on the one hand, of a search using descriptive phrases (or indexed keywords—fatherhood; pregnancy; marriage and adolescents) in Health Sciences, but searches were also carried out using isolated words, used as standards by search engines and database, with distinct adaptations for searches and results.

This systematic analysis, along with the dialogue with specialists and the literature available at our Documentation Center, has provided us with an broad overview of the issue of pregnancy, marriage, and fatherhood in young people and has led us to conclude that married or mother/father life and the acts of conceiving and raising children are human experiences culturally attributed to adults, especially women, with little attention being paid to young men and young fathers. Fatherhood, when the subject is broached, is seen from the woman's point of view, thereby reinforcing the idea that women alone are responsible for pregnancy. Men are almost never asked about the part they play in reproduction, their wishes, and responsibilities.

This lack of interest or social engagement does not in itself justify its relevance for society or as a source of concern. Research, reflection, and intervention across the world show what is obvious to some, but a novelty for others. The importance of men being involved in reproductive life, and the desire on the part of some men to participate in it suggests that better knowledge of male practices and representations could help to improve the outcome of programs in the areas of children's health, prevention of sexually transmitted diseases, and family planning (Mundigo 1995). A better understand of fatherhood could also help alleviate the suffering of men who feel a desire to get involved in a world that society tends to reserve for women (Kaufman 1995).

To make up for shortcomings in this area, the main aim of some sexual and reproductive health policies have been to "increase the level of responsibility of men in all areas relating to raising a family and human reproduction," as the International Conference on Population and Development in Cairo/Egypt (ICPD 1994) put it: As a result, growing interest has been shown in recent years in "men" and "masculinity" in studies and interventions that are said to deal with sexual and reproductive health. It is worthwhile explaining how this area of work is understood.

As the International Conference on Population and Development, 1994, action plan Chapter VII states, sexual and reproductive rights are understood to be individual human rights with a gender relations perspective; "…reproductive health is a state of total physical, mental and

social well-being in all aspects of the reproductive system, its functions and processes… [it] also covers sexual health, whose objective is to enhance life and personal relations."

Reproductive rights include some human rights already recognized by national law, in documents on international human rights and other relevant United Nations consensus documents. "Special attention should be paid to promoting relations of mutual respect between the genders, and particularly, meeting the needs of adolescents in terms of education and services that enable them to deal with their sexuality in a positive and responsible manner" (ICPD 1994: 17).

Despite such efforts, as Mundigo (1995) observes, this is not as simple an undertaking as it seems, since, in order to ensure greater participation on the part of men, various cultural, ideological, institutional, and personal barriers need to be overcome by both men and women. However, there are some signs that intensive, specific interventions involving male and female adolescents may help them assume the responsibilities of parenthood.

More importantly, it should be mentioned that the lack of interest in the issue constitutes a public health problem, in so far as there is evidence that action to provide support for adolescent fathers can have a positive impact on the life of these young people and their children and creates opportunities for broader reflection on responsibility in sexual and reproductive life and childcare. This is an interactive process: The difficulties adolescents have been found to have assuming adult responsibilities are, sometimes, reinforced or even generated by social institutions that make it difficult or impossible for adolescent fathers to take on the responsibilities expected or wished of them by their children and partners. For this reason, discussion of this issue and the proposal of alternative ways of understanding and dealing with it are of great scientific interest and social importance.

Analyzing articles on pregnancy in adolescence written in the 1970s, Robinson and Barret (1982) found five main problems that stand in the way of acquiring knowledge in this area:

- Studies of parenthood (fatherhood and motherhood) in adolescence tend not to include fathers in the sample. When adolescent fathers are included in other study samples certain inferences are made (for example regarding single fathers);
- Information on fathers is obtained in an indirect manner, through the mothers;
- The results are too imprecise for any analysis of psychological and cultural change; and
- Samples that are not representative are commonly used.

Eleven years later, another study, this one carried out by Adams et al. (1993), came to similar conclusions, without merely replicating the earlier study. These authors concluded that it is difficult to obtain data on young fathers, because studies focus on the role of the mother, surveys do not ask what men think about reproduction or fertility, and the information available is generally restricted to those who actually live with their children. It is unlikely that an absent father will admit that he has a child that he does not assume responsibility for. Studies tend to include in their samples only young fathers who are already past adolescence and men who are already participating in young fathers programs. Consequently, not many young fathers' voices are heard.

According to Adams et al. (1993), the exact number of male adolescents who get female adolescents pregnant is difficult to measure, as many mothers refuse to identify the fathers of their children, and the age of the father has not been included in statistical studies carried out in the United States. Nevertheless, according to these authors, some studies in the United States. show that the male partners of pregnant girls tend to be 2 or 3 years older than the mother of their child (McCoy and Tyler 1985; Westney et al. 1986; Robinson 1987).

Cartwright (1994) provides a fairly in-depth descriptive study of adolescent fathers in the United Kingdom. Cartwright observed that more young men than young women describe themselves as sexually active, and that young men tend to have more sexual partners. Even so, fewer men under the age of 20 were identified as

fathers. For example, in 1991 of the 52,386 live births to women under 20 years of age, only 12,959 (25 %) named men under 20 as the father. If we add to this the number of young women who would not name the father, the total would still only add up to 28,208 (less than 50 %) live births for adolescent fathers.

There are a number of hypotheses that might explain these results:

1. the survey of live births and rate of fertility do not collect data on fathers;
2. female adolescents have more than one partner and, when they become pregnant, name the oldest partner as the father;
3. pregnancies with adolescent males may show a higher tendency to end in abortion;
4. young men may be less fertile than young women;
5. young men may use more effective methods of contraception when their partners are adolescents.

Chambers concludes that surveys typically used to gather demographic data of adolescent sexual activity and its consequences need to be redesigned to obtain more accurate results.

As is known, the specific issue of young people needs to be more visible and should be better recognized by society to make it possible to develop public policies specifically designed for this segment of the population and effectively incorporated into overall policy planning. The attempt to develop a precise sociodemographic profile of young people is, therefore, far from being purely of theoretical or academic interest.

The changes in values and customs occurring in contemporary society, which are reflected in and by the dynamic of family relations, have given rise to a restructuring of rules for behavior and opened up the possibility of initiating sexual relations earlier, principally for girls, and have broadened the reproductive options available at this time of life. Studies of reproductive behavior among adolescents have considered marriage, pregnancy, and fatherhood and motherhood within the broad social context of the prolongation of the transition of adolescence to independence in adult life in postindustrial society (Rosenheim and Testa 1992).

Social Images, Stereotypes, and Adolescent Fathers

Social images are shot through with stereotypes of adolescents in general, and particularly of adolescent fathers. These stereotypes repeatedly obscure the way the adolescent father is perceived. Various studies and social intervention programs have shown that such stereotypes should not be applied in a generalized fashion to all adolescents. Studies of pregnancy in adolescence point out that some adolescent fathers are involved in the experience, both physically and psychologically, having loving relationships with both mother and child. The deficiencies of a backward education system and economy produce severe difficulties for adolescents, frequently causing them great anxiety in the face of the responsibility of providing for the material needs of their families.

Some recent US studies that are more sensitive to social and psychological factors, and are guided by more accurate indicators, suggest that not all adolescent fathers are reckless and that not every experience of fatherhood is negative for adolescents.

Apart from this, these studies seek to understand a little more about the statement that the act of fathering a child is an irresponsible one in an adolescent. Adams et al. (1993), in a study for the Child Defense Foundation (Washington, D.C.), analyze the decline in rates of pregnancy among adolescents who get their partners pregnant. The study questions the recurring stereotyping of adolescent fathers who do not get married as irresponsible, indifferent toward their partners, and lacking interest in their children. The authors argue that the situation of these men is much more complex than this stereotype suggests, although it is impossible to generalize for all young people. They suggest the need to investigate this complexity and the pressures put on adolescent fathers.

For these authors, fathers try to support their child and its mother. Such assistance, however, is highly informal, as the adolescent fathers are generally more economically vulnerable, have difficulty finding a job, and have little formal education. So they make other family arrangements, as they cannot themselves support the family that was brought about by the pregnancy. According to Adams et al. (1993), the first sign of a feeling of responsibility would be recognizing they are father to the child (both legally and informally/voluntarily). In cases where they recognize themselves as the father of their own free will, the adolescent tries to accompany the rearing of the child and makes an effort to support the mother. This takes the form of contact with the mother and the child involving feeding and caring for the child, including financial and emotional support. The father thereby establishes a loving relationship with the child, and in some cases with the mother as well. In other words, there is a need to break the stereotype of the adolescent father and thereby see what can be done in the way of intervention or affirmative action.

Methodologically speaking, research that makes a direct association between fatherhood (or motherhood) in adolescence and a negative impact on the children fails to observe that such children are usually the firstborn and that experiences with firstborn children tend to be more problematic.

If methodological care is taken and the impact of stereotypes on the researchers is controlled, the results of US research show that adolescents are not always worse fathers than adults. For example, Heath and McKenry (1993) carried out a study of family life, highlighting aspects relating to the instability of intimate relations, to evaluate two main elements: conjugal satisfaction (well-being in pregnancy) and parental satisfaction (interest in family activities), based on data from a national survey. A comparison of the responses of men who fathered their first child during adolescence ($n = 227$) with those of men who first fathered a child at an age older than 20 ($n = 1{,}032$) was done—all men interviewed were between the ages of 18 and 40 at the time of the interview. The analysis of the data carried out by these authors suggests that men who become fathers in adolescence experienced levels of marital satisfaction and instability in relationships similar to those of older men. However, men who became fathers in adolescence reported a greater increase in parental satisfaction in the course of their relationship than men who became fathers after 20 years of age. The importance of networks of support—by way of strengthening those already in existence in the community or by creating new ones—has been emphasized in reports of the impact on adolescents of services intended for them.

One important structural component of this network of support that has been stressed in various studies is the family of the adolescent (Burton and Stack 1993; Cervera 1991; Dellmann-Jenkins et al. 1993). Based on the premise that families have their own agendas, their own interpretations of cultural norms and their own histories, a number of factors stand out that need to be taken into account when dealing with these families: the temporal and interdependent dimension of the transition of roles, the creation and transmission of intergenerational norms, and the dynamics of negotiation, exchange, and conflict surrounding the way they construct their life trajectories (Burton and Stack 1993).

Adolescent Father Friendly Programming

Another important component of this network of support is programming that is designed to include the adolescent father. The Department of Pediatrics at the University of Utah Medical Center (United States) includes work with adolescent fathers, relying on the permission and help of mothers in identifying them. Information on the pregnancy is collected in an interview with the adolescent couple. The objective is to involve the father in all aspects of care for the child and caring for himself. Training is also available for clinic staff with a view to changing preconceptions, transmitted verbally and nonverbally, regarding

the participation of young men, and ensuring that young men feel welcome at such clinics. Action is also taken to provide careers advice, work opportunities, and accommodation for the fathers. This kind of intervention shows that adolescent fathers end up getting more involved in the pregnancy of their partners and, subsequently in childcare, these programs succeed in minimizing the structural difficulties, such as financial problems, social isolation, and other difficulties faced by adolescents (Roye and Balk 1996).

This US experience is a very rich one, as it points to the complexity and the interrelatedness of channels opened up by an intervention project to include the adolescent father. This would not require a new program. By taking advantage of the already established social fact that support for the pregnant female adolescent is already institutionalized, it is more like adding a component to existing programs for pregnant adolescents. There is an investment in the training of the staff that provides services for pregnant adolescents, and the scope of the services is broadened. Nevertheless, given the assumption that fatherhood has a positive impact on the mother and the child, programming that included adolescent fathers would reduce the health burden.

Moreover, programming designed to include adolescent fathers changes the analytical focus of interest. Such a shift in perspective would also mean that the support given to fatherhood in adolescence does not respond exclusively to the father's needs, but also to the small child's (Fagan and Lee 2011). One approach including fathers is laws that give rights of service to the child. For example in Brazil, a place in a preschool crèche, which has been the right of every working parent, is now legally the right of every child in Brazil. This change of focus amounted to a political victory. In a similar way, children have a right to have their father involved in their life as much as is feasible.

Another interesting scheme providing incentive for adolescent fathers to get involved in childcare is the *Teenage Pregnancy and Parenting Project* (*TAPP*), introduced in San Francisco, California (United States). In this program, the fathers have access to all the services available to the mothers, including guidance, health care, an educational program, and lessons in childcare. In particular, fathers who still have not lived with the mothers and their babies have greater involvement in prenatal activities when using this service. The involvement of adolescent fathers in this program has been shown to increase the weight of the babies at birth compared to babies born to adolescent mothers where the father was not involved.

In Brazil, in 1997, the PAPAI Institute (which means DAD in English) founded in the northeast part of the country was the first Brazilian Adolescent Fathers' Support Program. The main aim of the program was carving out a social space for the adolescent father, both in terms of public policy and in studies on sexual and reproductive health in society at large.

Nowadays, in hospitals and public health centers in Recife, the PAPAI Institute is holding weekly meetings with young fathers and/or partners of pregnant adolescents who are attending prenatal classes or at childcare facilities for recent mothers. These meetings take the form of workshops and using a "waiting room" system, focus on issues relating to pregnancy, childbirth, childcare, and paternal responsibilities.

Apart from this, in an effort to promote the widespread participation of men in childcare, PAPAI uses art education. An example of this is the 3.5-m-high PAPAI mascot, which is brought out for public events, especially at carnival time. The mascot represents a young man carrying his child in a baby bag, thereby symbolizing the association of the male image with childcare, an area culturally restricted to the female.

These experiments give us a glimpse of the positive impact on adolescent fathers, their partners and children that is brought about when networks of support are created or strengthened. They also show the need to develop multiple strategies, mobilizing not only the father, but also the mother, the family and specialists by way of various programs and interventions.

Nevertheless, analysis of some research on sexuality in adolescence shows that the approach tends to focus on the girl's health issues, pregnancy in adolescence having been seen primarily from the point of view of the mother and child,

leaving the father out of the picture. One relevant exception to this rule was the research on sexual and reproductive health recently carried out by the Sociedade Civil Bem Estar Familiar no Brasil (BEMFAM 1992, 1997), where information was collected on adolescents and young people of both sexes.

Ethical Values

Investigation of this issue and intervention in the area of pregnancy and fatherhood in adolescence entails discussing deep-rooted prejudices, stereotypes, and reflection on the possibility of adopting a different set of values. We shall therefore mention those values that have guided work in this area internationally, and which so far as we know, may guide research and action proposals for this segment of the population that is coming out from under the burden of repression by supporting the adolescent in his or her passage toward autonomy.

Equal opportunity between men and women in all areas, including in family and community life is a goal of many. People, who are in favor of equal opportunity between the sexes, have admitted that not only productive work activities should be shared between men and women, but also responsibilities regarding reproduction, children, and housekeeping. (European Commission Childcare Network 1990; ICDP 1994).

Programming that adopts this perspective should, thus, consider questioning the double standard in existence in society whereby the initiation of sexual activities is encouraged in boys while restrictions are put on girls (Parker 1991). Discussion of new standards of behavior is bringing men into the public health sphere and stressing the importance of their involvement in family planning. Given the reality that among other things, males live continually with the possibility of getting the female they have sexual relationships with pregnant (because male's fertility is constant and not periodic like that of women) including males as an essential player in family planning would reduce unintended pregnancy (ICDP 1994).

Concepts that include fathers (including adolescent fathers) became more visible at the IV International Conference about Population and Development, in 1994 in Cairo, and the IV World Conference about women, in 1995 in Beijing. At these two forums, guidelines were laid out for ensuring greater male participation in promoting sexual and reproductive rights. The recommendations of the Cairo Conference (ICPD 1994) are:

> Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of unwanted and high risk pregnancies; shared control of and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children (ICPD 1994, Sect. 4.27).

It is from this perspective that Mundigo (1995) states that one of the major problems presently confronting reproductive rights policies is the need for increased knowledge of, and access to and use of contraception in adolescence. In other words, there is a need to discover ways of encouraging a review of the concepts of masculinity during adolescence—principally in so far as they affect sexual behavior.

Respect for younger generations. This issue has two facets. On the one hand, it refers to respect for adolescents who become fathers (or get married), helping them become independent and empowering them. *Empowerment* is understood as a process that strengthens and builds the capacity of specific social groups (Parker et al. 1996). On the other hand, it means respecting children by admitting that their lives can be healthier and that they are more likely to develop their full potential when both mother and father are involved in their care. This does not imply, necessarily, that the nuclear family is the only way of ensuring the presence and

involvement of both mother and father in childcare. Accepting that a plurality of ways of organizing the family exists may result in better care for the small child.

Adolescent pregnancy is not always unwanted. When we speak of unwanted pregnancy, we are emphasizing a general tendency in the literature on adolescent pregnancy that takes this adjective to be the rule for all adolescents. We looked up the definition of the Portuguese word "indesejada" but could not find it. Instead we found the word: "Indesejàvel/Undesirable," defined as "not desirable, that is not to be desired;…" (Ferreira 1998). Pregnancy, fatherhood, or rather *parenthood*, may bring substantial emotional benefits for some adolescent mothers and fathers. *Parenthood* refers to the position of two social actors of both sexes in the process of constituting a parental tie, and no longer presumes a priori that this tie is the result of sexual intercourse between the two (Combes and Devreux 1991). Although, generally speaking, researchers and clinics tend to view pregnancy in adolescence negatively, some adolescent couples have shown a good performance at school, in family life, and in childcare (Elster 1986). Pregnancy in adolescence has almost always been viewed a priori as a social problem, characterized by a generally alarmist discourse, associated with negative aspects that may occur for the adolescent and her baby (dropping out of school, difficulty getting a job, low birth weight of baby, etc.) and with pejorative adjectives such as *unplanned, unwanted, precocious, and premature* (Cerveny 1996; Melo 1996).

This criticism of the prejudice against pregnancy, motherhood, and fatherhood in adolescence does not mean that we accept that becoming a mother or father in adolescence is always the best option for all involved or for any adolescent. What we are trying to highlight is the fact that, it is becoming increasingly necessary to discuss and question who gains from the repressive and exclusionary approach to the reproductive life of adolescents and what is the impact (Reis 1993).

A less coercive approach would make it possible, in our view, to design programs that better suit the needs of adolescents, without preconceiving fatherhood and motherhood at this stage of life as something purely negative that are caused, inevitably, by irresponsible behavior on the part of the young people.

In general terms, as Rosemberg (1999) suggests, the issue of sexuality and reproduction among adolescents does not elicit a neutral stance on the part of the specialist. For example, health studies have tended to view the pregnant adolescent or adolescent mother differently from country to country and from one historical epoch to another. The way adolescent pregnancy is currently viewed is a relatively recent social construct based exclusively on the female adolescent experience. As such, the transition into adulthood is not based on as precise physical and social indicators as it is for male adolescents whose transition is marked by entry into the job market or military service.

In contemporary society, one of the tendencies when discussing the issue of procreation in adolescence is the assumption that childbirth inevitably leads to negative consequences for the mother and child. Only rarely are fathers mentioned. Pregnancy is considered to be undesirable, precocious, and the cause of dropping out of school, unemployment, family/conjugal instability, mortality, and morbidity of the child and the female adolescent, and perpetuation of the poverty cycle. Hence, the need to curb pregnancy in adolescence is only logical conclusion. This can be brought about either by way of information/training in the area of reproductive rights, or by improving education.

Another tendency we identified is the search for the causes of the "pathology" of pregnancy/motherhood in adolescence in broader social phenomena (including its pathologization in society), which would explain what the other school of thought considers to be an impact on the condition of being an adolescent itself. From this point of view, even though there is no ready-made theory, it is suggested that a complex dynamics of relations of class, gender, and generation (and possibly race and ethnicity as well) are in play alongside individual characteristics. According to this view, it would be desirable to admit from the outset that pregnancy

in adolescence (as determined by age group) is not always unwanted, as it may form part of the individual's life plan. The end result of such an approach would be to put forward policies for protecting adolescents who get pregnant and become mothers and fathers, to prevent the undesirable impact of the "pathologization" of pregnancy, motherhood, and fatherhood in adolescence.

A Critical Reading of Protagonist as a Strategy for Managing Adolescence

In a recent study, Medrado et al. (2011) analyzed an historical series of UNICEF publications and identified three contemporary strategies for managing life based on the individual's place in the life cycle: (1) care based on protection of the *developing individual,* who, by his or her very nature "needs help," (2) respect for citizens' rights, according to which the needs of the individual become a right and a duty of the state, (3) encouraging the participation of the individual in implementing and managing strategies for solving the problems that affect his or her own development.

Medrado noted that as the target-public broadens (from child to "developing individual") and as the notion of rights is incorporated into the description of strategies, UNICEF progressively guides its strategies in the direction of *participatory* management, in which the individual him or herself takes out a commitment to and has responsibility for transforming and overcoming the difficulties that stand in the way of "full development."

Generally speaking, these management strategies found in UNICEF documents suggest a tendency to change the paradigm for management of life on the basis of age, moving from a model based on norms and authority to a local, contextualized approach, guided by the responsibility, in the first place, of communities and families, and, secondly, of the individual person, for solving social problems, by encouraging "self-management." However, one may well ask oneself, "What practical and ethical implications does this paradigm shift represent?"

From the point of view of social and educational intervention, this reorientation has been well received by some activists and young people involved in health and education programs. As Madeira and Rodrigues (1999) point out:

> In response to the importance that the question of youth has assumed, there have been a growing number of projects and programs aimed at young people coming from social work institutions and human service agencies. Generally speaking, although they are still in the minority, they have shown themselves to be open to "youth protagonism," suggesting that this is effectively a more appropriate space for participation in experimenting with new ways of thinking and innovative social action (p. 54).

Thus, under the aegis of the concept of youth protagonism, programs and projects have been developed that aim to bring about a more effective presence of young people not only in the implementation of projects, but moreover in the planning of activities and participation in the development of social and educational strategies.

There are, however, an ever growing number of social intervention projects that use the "label" *participation* to define their action plans, but which in practice do not develop this concept, resulting in products where the *participation* of young people is restricted to public events or the implementation of techniques and resources previously determined by the adult project coordinators.

Other experiments, with greater commitment to social transformation, have sought to introduce genuinely *participatory* management into work with young people and these have encountered various difficulties. One such issue is the dilemma of the educator, who frequently comes to disregard the pedagogical function of an activity in which both teacher and learner exercise complementary and reciprocal functions. If the desire of the young person is imperative in an education for health project, what is the place and the role of the educator supposed to be? In what sense do we want *participation*?

History has shown that authoritarian models of education based on the figure of the adult and a unilateral attitude to the production of knowledge is inefficient from the point of view of human development. Apart from this, management based solely on the calculation and prevention of risks has given rise to public administration strategies for adolescents that are not particularly democratic and these are still present in our "postmodern" world.

Thus, today, we have a mass media that extols and exploits the "values of youth" (creativity, adventure, beauty, and freedom) and a number of educational initiatives that give pride of place to adventure. On the other hand, we also find adverse reactions that suggest an exaggerated degree of concern, based on fear, distrust, control, and repressive prevention. However, is making young people entirely responsible for their actions and the course of their development a strategy that necessarily leads to "freedom" and "equity?"

From an ethical point of view, we should be attentive to the fact that encouragement of greater participation on the part of young people, as part of a progressive, self-management approach, may be anchored in new forms of public administration. These do not necessarily involve control in the disciplinary sense—based on explicit pacts and fixed rules—but a form of regulation based on an invisible, but perhaps, for this reason more effective self-governing strategies (Ayres 2001).

This chapter is an effort to make the critical point that understanding unmarried adolescent fathers is a complex issue and one needs to avoid simplistic assumptions about so-called absent unmarried adolescent fathers. Another challenge when calling attention to married or unmarried young fathers is the lingering question about their roles as fathers. In recent years, there has been significant research in the child development and public health field about whether fathers matter (mostly in Western Europe, North America, and the Caribbean), a question that extends to adolescent fathers or fathers/partners of adolescent mothers. Taken as a whole, the emerging consensus in the fields of child development and health is that men's participation as fathers, as co-parents, and as partners with women in domestic chores and childcare and childrearing does matter. Depending on the quality of the father's presence, child development can be enhanced. Father presence is generally also positive for household income. When fathers participate in household chores, in general, women benefit. And finally, positive engagement as caregivers and fathers is generally good for men themselves.

Final Considerations

With this brief overview, we offer the following recommendations for research, program development, and policy when considering the roles of young fathers:

Rather than a stand-alone area within the area of adolescent mothers and married adolescent women, we recommend that issues of young married men and adolescent fathers be incorporated within all aspects of research, program development, and policy regarding married adolescents and adolescent parents.

- We suggest that existing documents and UN pronouncements on the importance of engaging men and boys in the promotion of gender equality be taken into account when making recommendations on the issue of married adolescents.
- These include previous documents by UNAIDS on men and AIDS; the Cairo Program of Action; WHO documents on adolescent boys; and the recommendations from the Commission on the Status of Women, made at their expert meeting on the role of men and boys in achieving gender equality (Brasilia 2003).

Research Recommendations

- Listen to the needs of the partners of adolescent mothers and married adolescent women and seek to understand the cultural context of gender and manhood as related to the demand

for young brides and the pressure that may exist for men to marry young women.

- Conduct additional research on the sexual initiation of young men and the preference for "virgins" or sexually inexperienced girls/young women.
- Carry out research on the social norms related to gender and manhood that encourage and reinforce age differences between partners.
- Conduct research with "positive deviants" (aka positive outliers or voices of resistance)—men who do not support early marriage. Such research is extremely useful for designing interventions and campaigns by identifying "cracks" in existing social norms. Indeed, a more complete picture will be obtained by looking at attitudes across the continuum of how young men act in their relationships with their partners and their children.
- Carry out research on younger adolescent boys to understand the early socialization patterns that promote early marriage.
- Support research on family formation, pressures to work, migration patterns, and sexual behavior among young married men and young fathers who migrate for work.
- Include additional questions both for and on men and male partners within existing research instruments (e.g., Demographic and Health Surveys), particularly questions more appropriate to understanding the realities of young men, and obtain information from them directly rather than indirectly.

Program Recommendations

- Carry out campaigns targeting social norms and take advantage of positive outliers that already question early marriage and the age difference between married partners. These campaigns could be associated with existing campaigns targeting men, such as the White Ribbon Campaign (the campaign of men working to end violence against women), and could include men who serve as role models for young men and demonstrate positive aspects of manhood.
- Provide training for service providers in the health and education sectors on the aforementioned issues, including offering skills in how to engage young people in discussions about these issues.
- Implement workplace-based approaches in the formal and informal sector, as well as via the military (i.e., places where large numbers of men can easily be reached).
- Engage young fathers and young husbands/partners in activities conducive to maternal health. A number of programs in India and sub-Saharan Africa are beginning to engage men (many of them younger) in maternal health programs, some with positive evaluated outcomes. These program examples could be considered as models for expansion. Some of these programs also involve men in the prevention of mother-to-child transmission of HIV.
- Engage young fathers and young husbands/partners in sexual and reproductive health programs. Many programs in sub-Saharan Africa and Asia have taken this approach, with generally positive results. In Zimbabwe, for example, a joint project of the Centre for Population Studies at the University of Zimbabwe and the Horizons Program engaged couples via antenatal clinics to promote maternal and child health and reduce mother-to-child transmission of HIV. Whether and to what degree these programs serve married adolescents and what special attention this population needs are areas for intervention research.
- Work with young men to help them consider their potential future roles as fathers or as caregivers in general. The majority of the world's adult men will at some point in their lives be fathers, although this is a role for which men often are unprepared. A few programs that work with young men are doing this. In Trinidad and Tobago, the nongovernmental organization (NGO) SERVOL program requires that all participants in its vocational training—

both young men and women—spend some time in the day care centers caring for young children. For young men, SERVOL staff report that this is often their first experience in caring for young children or providing caregiving of any kind. In Brazil and Mexico, a coalition of four NGOs (Promundo, Papai, Salud y Genero, and Ecos) have developed a field-tested curriculum with group educational activities for young men designed to promote changes in attitudes related to gender, including a set of activities on fatherhood and caregiving. As mentioned above, this series of manuals—entitled Program H—also includes an impact evaluation study to measure quantitatively changes in attitudes and behaviors on the part of young men, including attitudes related to fatherhood.

- Support young men who already are fathers by providing information, counseling, and training on the fatherhood role. Instituto Papai in Brazil is one of the handfuls of NGOs in sub-Saharan Africa, Latin America, and the Caribbean carrying out these kinds of activities.
- Enhance vocational training/employment creation to take into account the issue of early marriage and early parenthood. This may include the need to consider special programs for young people in areas with high rates of migration for work.
- Reflect carefully on when to work with couples together, and when to work with men and women separately.

Policy and Advocacy Recommendations

- Carry out awareness-raising workshops/events for senior policymakers. Include the issue of early marriage within existing HIV/AIDS policy.
- Prepare briefing documents for policymakers that present existing and evaluated models for engaging young men, including interventions that have been shown to lead to attitude and behavior change among men. In short, this would entail demonstrating to policy makers that it is possible and desirable to change some aspects of traditional male roles.
- Influence existing HIV/AIDS funding, particularly in sub-Saharan Africa, making changing norms about masculinity part of national AIDS campaigns.
- Carry out efforts to show that engaging men is part of promoting gender equality and that funding such efforts does not detract from funding for efforts to enhance the status of women.

Finally, a major aspect of existing gender inequity is the great disparity between fathers and mothers regarding roles and responsibilities related to childrearing. Data suggest that, worldwide, fathers contribute far less time to the direct care of children than do mothers, although there is tremendous variation across countries and among men. Studies from diverse settings find that fathers contribute about one-third to one-fourth of the time that mothers do to direct childcare. However, even if they are not as involved in caring for children, fathers make decisions about the use of household income for children's well-being, education, and health care, in addition to contributing income. Engaging fathers—and young men who will likely be fathers in the future—has the potential to set the stage for greater gender equality over the life course.

In this chapter, we argue that there is an emotional and material benefit to including adolescent male partners and adolescent fathers in services provided to adolescent girls who are sexually active, pregnant, or parenting. We also point out how critical working assumptions are in the design and provision of health services. For example, when the assumption is that adolescent sexual behavior is inappropriate or "bad," there is no compelling or logical reason to reward adolescent fathers for inappropriate sexual behavior by including them in pre- or postnatal care. Conversely, when services are based on the assumption that adolescents and their children have a right to services appropriate to their need, adolescent fathers will be provided the support they need to be able to play a positive and responsible role in their partner relationships and in the lives of their children.

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Adolescent Pregnancy: A Feminist Issue

Catriona Macleod

Keywords

Constructive nature of discourse • Empowerment in care • Evidence-based policy • Feminism • Foucauldian feminist • Non-discriminatory health services • Poststructuralist postcolonial feminism • Reproductive health justice • Sexual and reproductive rights • Unwanted pregnancies

Introduction

Pregnancy and mothering are enduring and central concerns of feminism across a range of contexts. DiQuinzo (1999) sums this up in stating that "mothering is both an important site at which the central concepts of feminist theory are elaborated and a site at which these concepts are challenged and reworked" (p. xi). Stephens (2004) argues, "reproduction and mothering are central to theories of patriarchy and women's unequal position in Western society…Childbirth can paradoxically be seen as both a cause of women's subordinate position in society and a means of empowerment" (p. 41).

Yet, despite the pivotal nature of pregnancy and mothering in feminist literature, there has been surprisingly little direct engagement by feminists in the area of 'adolescent pregnancy.' The engagement that there has been is a whisper in relation to the plethora of public health, medical and psychological writings on 'adolescent pregnancy.'

The feminists who have engaged with 'adolescent pregnancy' have, from their initial engagement and to varying degrees, tried to undermine easy readings of 'adolescent pregnancy' as a social problem and to link micro- and macro-level gender relations to occurrence of, and responses to, 'adolescent pregnancy.' Thus, for example, in the 1980s, Chilman (1985) asserted that "sexism particularly afflicts programs and policies for these young people (unmarried teenage parents) as well as the behaviors that lead up to their becoming unmarried parents" (p. 225); in the 1990s, Pillow (1997), using a combination of feminist and postmodern theory, argued that "teen research and policy interventions can be understood as entrenched in the dilemmas of modernism, resulting often in normative assumptions that reflect our paradoxical attitudes and practices concerning female sexuality" (p. 147). More recently, Wilson and Huntington (2005) have indicated that the focus on 'adolescent

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pregnancy' at a time when rates of fertility among young women are decreasing in 'Western' societies is 'underpinned by changing social and political imperatives regarding the role of women in these countries' (p. 59).

In this chapter, I argue that both the relative lack of engagement of feminists in 'adolescent pregnancy' and the manner in which some have engaged with the issues surrounding early reproduction must be seen as strengths. Those feminists who write about sexuality and reproduction in general, without engaging directly with 'adolescent pregnancy,' are, in effect, refusing to acknowledge 'adolescent pregnancy' as a separate reality from the reproductive lives of women who find themselves in similar socioeconomic, cultural, and racialized circumstances. Given the research that points in the direction of age, per se, not being the key factor in negative health and social outcomes relating to pregnancy (Macleod 2011), this approach highlights the sexual and reproductive struggles and successes of women of all ages living in similar social conditions. This has significant strengths as will be argued later in this chapter.

Nevertheless, 'adolescent pregnancy' has become a real phenomenon in the sense of being a socially constructed reality that is taken up in social policy, educational reforms, sexuality education initiatives, health and welfare interventions, and public concern. All of these will have real effects in young women's and men's lives. In this respect, it is vitally important for feminists to engage in debates around 'adolescent pregnancy.'

In light of this, the question that this chapter addresses is how feminism(s) should respond to research, practice, and policy regarding 'adolescent pregnancy.' Clearly, such a response depends on the type of feminism being considered, on the context within which the conversation is occurring, and the particular local cultural and social circumstances within which the topic is being considered. In this chapter, I utilize a poststructural, postcolonial feminist framework that draws on Foucault, Derrida, and Mohanty and that has underpinned much of my work in the area of 'adolescent pregnancy' to argue for a twin approach to 'adolescent pregnancy.'

In the first instance of this twin approach, feminists should be vigilant about the power relations that the very notion of 'adolescent pregnancy,' and the associated research and interventions, allow. This involves, as argued below, an analytics of the gendered power relations that cohere around young women and reproduction and a refusal of abstractions that pre-define the pregnant teenager. In the second instance, feminists should advocate for pre-, ante-, and postnatal care and interventions that are attuned to gendered dynamics and that are aimed at empowering young women. This should be achieved by attuning statements and interventions to local specifics while at the same time identifying and acting upon transversal relations of commonality through a reproductive justice approach. Each of these feminist takes on 'adolescent pregnancy' is discussed below together with examples of work that have taken the particular tack under discussion. These examples are meant to be illustrative rather than exhaustive in terms of the feminist literature on 'adolescent pregnancy.'

First Instance of the Twin Approach: Unmasking Power Relations

In the following, I suggest that the first instance of a twin feminist approach to 'adolescent pregnancy' entails, on the one hand, an analytics of gender power relations associated with the technologies of representation and the technologies of intervention with regard to 'adolescent pregnancy' and, on the other hand, a refusal of abstractions concerning the pregnant or mothering teenager. These two methods are, of course, intertwined, with each, in some ways, presupposing the other (analyzing power relations puts abstractions of the object of surveillance into question while refusing abstractions of the pregnant teenager speaks to power relations). The overlap of insights from the examples provided in each section illustrates this intertwining.

An Analytics of Gendered Power Relations Around Adolescent Pregnancy

The signifiers 'adolescent pregnancy,' 'teenage pregnancy,' or 'teen motherhood' have become so common and are in such frequent usage both in the popular media and in formal documents (e.g., World Health Organisation 2004) that it is hard to imagine that the terms have in fact a very recent history, appearing for the first time in the USA, for example, in the late 1960s/early 1970s (Vinovskis 1988, 1992). Using a Foucauldian framework, Arney and Bergen (1984) analyze this emergence, indicating how the morally loaded concepts of 'unwed mother' and 'illegitimate child' dissolved into a single new scientifically neutralized concept of 'teenage pregnancy.' This shift 'began to break down the barriers of exclusion and, for the first time, pregnant adolescents became publicly visible' (Arney and Bergen 1984, p. 13). They caution, however, against seeing this as heralding a better understanding of early reproduction or more humane treatment of young women. Although pregnant teenagers ceased, on one level at least, to be moral problems, they now became technical problems requiring endless scrutiny and measurement, and an in-depth knowledge of their structure. This shift in power meant that women who became pregnant in their teenage years were no longer disciplined by moral exclusion, but rather by scientific inclusion.

This work points to a productive avenue of engagement for feminists using Foucauldian analytics of power. Arney and Bergen's (1984) analysis of the shift from moral exclusion to scientific inclusion of the pregnant teenager opens space for the elucidation of the knowledge/power nexus surrounding 'adolescent pregnancy.' Within a Foucauldian (Foucault 1977, 1978) analytics of the power/knowledge nexus, knowledge is not either 'objective' or 'subjective,' 'true' or 'false.' Instead, it is linked to power, with certain forms of knowledge, such as scientific 'facts' concerning the consequences of 'adolescent pregnancy,' gaining precedence over others, such as teenagers' 'gossip.'

Two forms of expertise, each of which have significant bearing on young women's lives, have been analyzed by feminists: (1) The researcher and his/her practices of knowledge production, or what Miller and Rose (1993) call the technologies of representation; and (2) the psychomedical service provider and his/her practices of health and welfare production, or what Miller and Rose call the technologies of intervention. Much of this work has been conducted using discourse analysis, as Foucault emphasized that discourse links knowledge and power, and as such, power is not merely repressive, but actually productive of knowledge and subjectivity. Discourse, defined by Parker (1990) as 'a system of statements, which constructs an object' (p. 191), has a dual character in that it is the mode through which the world of 'reality' emerges, but at the same time it restricts what can be known, said, or experienced at any sociohistorical moment.

The productive or constructive nature of discourse is an important aspect of the work of feminists in relation to the discourses surrounding 'adolescent pregnancy.' Thus, for example, a Foucauldian feminist would not ask 'What is the true nature of the pregnant teenager?' but rather, 'How have scientific and professional discourses constructed or positioned her as a subject?'

Wilson and Huntington (2005) take this up in their analysis of research literature emanating from the USA, UK, and New Zealand. They argue that normative perceptions of motherhood have shifted over the past few decades to position teenage mothers as stigmatized and marginalized. Young women who have children are vilified not because of poor outcomes but because they do not conform to a life trajectory that dovetails with governmental objectives of economic growth through higher education and increased female workforce participation. They conclude, 'Evidence-based policy development has masked the ideological basis of much policy in this area and highlights the importance of critical evaluation of the discourses surrounding teenage motherhood' (p. 59).

In Macleod (2002), I take a similar tack, indicating, in my analysis of South African scientific literature, that dominant discourses concerning

proper economic activity are entrenched through the appeal to 'national' security, societal stability, and the welfare of the country. Predictions of the probable disastrous economic consequences of early reproduction engender a knowledge concerning the immature, ignorant, psychologically unstable, or socially deviant nature of reproductive teenagers. At the same time, regulatory practices to stem the tide of early reproduction, or at least to contain its effects, are legitimated. The oft-cited solution to vexing twin problems of 'adolescent pregnancy' and poverty is more or better education. Through this means, it is proposed that the teenager may mimic the rational economic man, despite the fact that unacknowledged gendered incongruencies disallow such a simple proposal. The rational economic man is masculinized, while poverty and domestic or maternal duties are feminized. Therefore, the economic woman is never equivalent to the rational economic man as, to enter his world, she either has to forego childbearing or perform the dual roles of economic woman and mother (neither of which are required of the rational economic man).

Breheny and Stephens (2007a), in their examination of scientific literature on 'adolescent' mothering, argue that much of this research has constructed early motherhood as problematic for the mothers, their children and the state. They indicate that there are alternative approaches that propose new ways to view adolescent mothers. These are, however, not necessarily empowering. For example, the literature that focuses on what Breheny and Stephens (2007a) call 'Factors related to success' locates the intra-individual factors that predict success or failure. These factors are divorced from their cultural, social, and structural context, with the accompanying assumption that these factors may be subjected to improvement in isolated individuals. Responsibility for success thus lies within the ambit of individual effort.

Turning to the technologies of intervention, Breheny and Stephens (2007b) show how health professionals in New Zealand draw on 'Developmental' and 'Motherhood' discourses to position adolescent mothers as problematic. In the former discourse, young mothers are seen as 'adolescents' who are naive, distracted, and self-centered. In the latter, certain behaviors are attributed to 'good' mothers. The simultaneous deployment of these discourses allow for young mothers to be positioned as unable to mother properly as the characteristics of an 'adolescent' cannot be reconciled with the attributes of a 'good' mother.

In my own work (Macleod 2006a), I utilize Foucault's theorizing on 'security' to explore the deployment of the management of risk as a governmental technique in everyday interactions between health service providers and teenagers in South Africa. I examine how this management of risk reproduces racialized, class, and gender boundaries. Risk is conceptualized here as not merely a technique of statistical probability and prediction, but also as a way in which we govern and are governed.

The examples presented above indicate how some feminists are starting to analyze power relations cohering around the technologies of representation and of interventions surrounding 'adolescent pregnancy.' The power relations implicit in these technologies are not uniform or stable and will vary historically and across circumstances. What is important about these kinds of analyses, however, is the activity of unpicking taken-for-granted assumptions and drawing out the gender, class, and raced relations that underpin many scientific statements and professional interventions with regard to pregnant and parenting teenagers. This kind of analysis implies a questioning of common depictions of the pregnant teenager and a refusal of abstractions that position pregnant and parenting teenagers in particular ways through particular discursive practices. It is to this that I now turn in the next section.

Refusing Abstractions that Pre-define Pregnant Teenagers

Broadly speaking, the usual types of questions asked by social science researchers in the field of early reproduction are: What causes 'adolescent

pregnancy'? What are the consequences of early motherhood? What are the consequences when a teenager has a termination of pregnancy? Are young women able to make decisions on their own when it comes to a termination of pregnancy? What are the best interventions to prevent pregnancy? What are the best interventions to ameliorate the consequences of early reproduction or termination of pregnancy?

In the attempts to answer the above-mentioned questions, there are various points of tension in the literature, which is by no means a seamless body of knowledge. For example, criticisms concerning methodology and approach abound. Much of the literature, however, confirms the standard assumption that 'adolescent pregnancy' is an individual calamity and a social problem. Within this body of the literature, the consequences of 'adolescent pregnancy' are listed as the disruption of schooling, the perpetuation of a cycle of disadvantage or poor socioeconomic circumstances, poor mothering practices, and poor child outcomes, health risks associated with early pregnancy, welfare dependency and contribution to unacceptable demographic patterns. A more recent concern is the association of HIV and 'adolescent pregnancy.' The consequences of a termination of pregnancy are listed as increased obstetric risk and psychological fall-out. Factors leading to early pregnancy are postulated as being reproductive ignorance, risky behavior patterns, early menarche, psychological problems, cognitive deficiencies, dysfunctional family patterns, and poor socioeconomic status.

Thus, the dominant depiction in the literature of the pregnant or mothering teenager is as a person who is: ignorant of basic sexual and reproductive knowledge; prone to risky behavior; psychologically or cognitively deficient; from a poorly functioning familial background; undereducated; an inadequate mother; responsible for perpetuating poverty and welfare dependency; at risk for health complications and HIV.

The standard research questions listed above as well as the (contested) answers to them focus attention on the individual teenager—examining her individual emotional, cognitive, and social characteristics to explain why she gets pregnant, why she mothers in a certain way, how she makes a decision about her pregnancy, how she responds to abortion, and how best to help her. In this process, power is 'masked,' as pointed out by Foucault (1977), by the modern discourse that locates responsibility for action and intention within the individual. It is this masking, according to Foucault, that makes modern power tolerable. It is exercised 'through its invisibility; at the same time, it imposes on those whom it subjects a principle of compulsory visibility' (Foucault 1977, p. 187).

Feminists have, for a long time, refused abstractions of women that pre-define them in particular ways. In doing this, they expose the workings of power that imposes visibility of a certain nature on women. In extending this to 'adolescent pregnancy,' i.e., in refusing the kind of abstraction of the pregnant or mothering teenager referred to above, there are two paths open to feminists. The first is to refute the picture painted by questioning the conclusions that allow for such a depiction. The second is to demonstrate how, in isolating the pregnant teenager as an object of surveillance, we are invoking underlying assumptions concerning the nature of adolescence, adolescent (hetero) sexuality, family formation and function, and motherhood.

The first of these tactics has been taken up by what have been termed 'revisionist' writers. Some of these writers (e.g., McDermott and Graham 2005; Oz et al. 1992) are concerned about the manner in which the weaknesses and failings of teenage mothers are focused on rather than their emotional and cognitive strengths. Others (e.g., Geronimus 1991, 2004; Preston-Whyte and Zondi 1991, 1992) view 'adolescent pregnancy' as an 'alternative life course' which is functional for certain adolescents in a variety of ways, e.g., young mothers tend have a better access to the familial caretaking nexus than older women, and people living in poverty have a foreshortened healthy life expectancy, which means that early childbearing is functional in the sense of providing longer healthy parenting

time. They postulate that early childbearing represents a rational and conscious choice for disadvantaged teen-aged women for whom there is little advantage in delaying pregnancy. The revisionists counter the negatively appraised 'causes,' arguing that early childbearing makes sense in situations of poverty, as under these conditions teenage mothers enjoy comparative advantages vis-à-vis older mothers.

Various writers (e.g., Cunnington 2001; Geronimus 2003; Levine et al. 2007) have questioned the methodological soundness of research that allows for the depiction of pregnant or parenting teenagers as experiencing negative consequences as a result of the pregnancy. The 'adolescent' adjective of 'adolescent pregnancy' foregrounds age as the most important aspect of a young woman's identity in relation to pregnancy. Age becomes the key variable utilized in research, in isolation from other social variables, including socioeconomic status, partner relationships, family structure, living conditions, health conditions, and employment opportunities.

When the factors highlighted above are taken into consideration, the effect of early reproduction, in and of itself, is far less catastrophic than commonly assumed. Geronimus (2003), in summarizing the conclusions of well-designed comparative studies on educational or economic outcomes, states that these outcomes are 'slightly negative, negligible, or positive' (p. 881). In the words of Cunnington (2001), who conducted a systematic review of the literature on the health consequences of teenage pregnancy, 'Critical appraisal suggested that increased risks of these [negative health outcomes were predominantly caused by the social, economic, and behavioral factors that predispose some young women to pregnancy' (p. 36). In terms of child outcomes, Levine et al. (2007) indicate:

> It is equally plausible … that timing of parenting itself does not cause children's poor outcomes. Instead, background factors such as poverty that select women into early childbearing may also select their children into experiencing negative outcomes. Thus, correlations between early parenting and children's poor outcomes may be noncausal (p. 106).

It is these kinds of conclusions that provides some credence to feminists who refuse to see 'adolescent pregnancy' as a separate sexual and reproductive issue, but focus rather on women, young or older, who face pregnancy and mothering within particular classed and raced environments.

The second strategy referred to above is to deconstruct the notion of the 'pregnant adolescent.' This work draws off Derridian 'deconstruction.' Derrida (1976, 1978) critiques 'Western metaphysics' which has always been structured in terms of dichotomies or polarities (e.g., truth versus error; man versus woman). He invokes what he calls 'undecidables' to disrupt these binary oppositions. Undecidables slip across both sides of an opposition but do not properly fit either. They undermine the very premise of the binarism (such as the zombie which is neither alive nor dead, neither living nor non-living). Paying attention to the absent trace also disrupts binary oppositions. The first term within the oppositions created by Western metaphysics is given priority, creating a sense of being as presence, unity, identity, and immediacy, with the second term always subordinated to it, the absent trace. Derridian deconstruction shows how the present and absent terms define, and interpenetrate each other, and how the present is always already inhabited by the absent and hence is mediated and derivative.

This second strategy (deconstruction of the signifier 'pregnant adolescent') is a tack that much of my work has taken. Thus, for example, in Macleod (2003a, 2011), I analyze how the dominant construction of adolescence as a transitional stage: (1) acts as an attempt to decide the undecidables (viz. the adolescent who is neither child nor adult, but simultaneously both)—an attempt which collapses in the face of 'teenage pregnancy'; (2) relies on the ideal (masculinized, white, heterosexual, middle-class) adult as the end point of development; and (3) is saturated with colonialist assumptions concerning human development. In Macleod (2003b), I argue the 'unwed' signifier insidiously interpenetrates the term 'adolescent pregnancy,' allowing the scientific censure of non-marital adolescent

reproduction without the invocation of moralization. Marriage is the authority that decides the undecidable pregnant teenager, allowing her to join the ranks of adult reproductive subjects. In Macleod (2001), I contend that the literature on 'adolescent pregnancy' is inhabited by the absent trace of the 'invention of "good" mothering,' with the taken-for-granted assumptions concerning mothering (e.g., mothering as an essentialized dyad; motherhood as a pathway to feminized adulthood; fathering as the absent trace) being implicated in the regulation of mothering through the positioning of the teenage mother as the pathologized other, the splitting of the public from the private, domestic space of mothering, and the legitimation of the professionalization of mothering.

To conclude, feminists should problematize standard explanations of 'adolescent pregnancy' through the interweaving tactics of, firstly, analyzing gender power relations with regard to the technologies of representation and the technologies of interventions surrounding young pregnant and parenting women, and, secondly, a refusal of abstractions that pre-define the pregnant and parenting young women. Readers may intimate from the above, however, that I am simply arguing for a feminism of critique. Indeed, much of my own work could be classed as critique from a distance, with little active involvement in the messy business of care or interventions. In what follows, I turn to the second of the twin feminist approach I suggest should be part of the feminist arsenal with regard to 'adolescent pregnancy,' this being advocating for pre-, ante-, and postnatal care and interventions that are attuned to gendered dynamics and that are aimed at empowering young women. This second instance, I argue, is not in opposition to the first, but rather an extension, where the insights gleaned in the first are integrated into practices that have a feminist agenda in relation to pregnant and parenting young women.

The Second Instance of the Twin Approach: Gender Dynamics and Empowerment in Care and Interventions

Together with a critique of the technologies of intervention, feminists need to advocate for care and interventions that speak to and overcome gender dynamics that are oppressive to young women (and men) and that empower women in exercising their sexual and reproductive rights, including the right to accessing appropriate sexual and reproductive health information, the right to decide on the timing of first sex, the right to safe and uncoerced sex, the right to control fertility, the right to have pregnancies that are well timed in terms of their life trajectory, and the right to care during pregnancy, at parturition, and after giving birth.

Within poststructuralist postcolonial feminism, this advocacy needs to speak to the plural and complexly constructed social identities of young women and men in various 'cultural' and social milieus. Thus, care and intervention would need to be attuned to the 'cultural' and group specificity. This is discussed below.

Some feminists have expressed concern, however, that the movement away from viewing women as a single oppressed class across space and time has resulted in the total displacement of the category women and therefore the impossibility of feminist political action (see Mouffe's 1995 discussion of this). As I have argued elsewhere (Macleod 2006b), this difficulty is overcome by identifying, as Mohanty (1999) does, transversal relations of commonality. These chains of equivalence highlight contextual differences alongside gendered commonalities that take root in a range of spaces. Thus, as discussed below, attuning statements and actions to local specifics must to paired with the identification of transversal relations of commonality.

Attuning Statements and Interventions to Local Specifics

In terms of 'adolescent pregnancy' attuning statements and actions to local specifics means understanding the unique conditions under which pregnancy among young women occur. For example, in India, despite the ban on marriage before 18 years of age for women and 21 for men, early marriage continues to be a feature for many young women, with just less than half being married by the age of 18. For many of the 16 % of 15–19-year-old young women who have experienced pregnancy or motherhood, this occurs within the context of marriage (Nath and Garg 2008). In South Africa, on the other hand, the percentage of women never married in the 15–19 age category is 96 %. Age at first marriage is relatively high, with the median age being 27 years old (Department of Health [South Africa] 2007). Thus, teen-aged pregnancy and mothering tends to take place outside of marriage (Makiwane and Udjo 2006).

The implication of these kinds of differences in local specifics with regard to 'adolescent pregnancy' is that the liberatory or empowering status of actions or interventions is not determined through theoretical or political pronouncement. Rather, these determinations are a matter of social and historical inquiry in which the gendered, political, cultural, socioeconomic, geographical, health, welfare, and educational context and history are considered.

For example, in the context of India with high rates of early marriage, the input from the United Nations Population Fund (UNPFA) and Population Council (2009) is pertinent:

> Several factors conspire to increase childbearing among young brides. The bride's young age, often combined with the older age of her partner, intensifies power differentials in the relationship. Her young age is indicative of a relatively low level of education. Her lack of knowledge and skills may make her more reliant on high numbers of children for security within the marriage as well as long-term social security. It may further exaggerate the power imbalance between spouses and, thus, undermine the bride's ability to negotiate for sexual relations in which she is protected from STIs and HIV. These gender norms may prevent her from using contraception and other means to achieve her desired timing and spacing of children (p. 40).

Interventions that are empowering of young women need to take these kinds of gender relations into account and to adapt to the particular cultural circumstances surrounding them. For example, Santhya and Jejeebhoy (2003) argue that programs need to find ways to enhance married young women's autonomy within their marital homes, to encourage education, to enhance their life and negotiating skills, and to help generate livelihood opportunities. Interventions should, they indicate, target not only young women but also family decision makers, such as husbands and mothers-in-laws.

This may be contrasted with South Africa. Qualitative data suggest that marriage is delayed until education has been completed and/or some form of income secured. Where pregnancy occurs before marriage, it is less likely to result in marriage than previously (Kaufman et al. 2000). However, survey data suggest that early pregnancy often occurs within the context of highly inequitable gender relations. Pregnant young women experience significantly more violence in their relationship and are more likely to have been forced to have sex for the first time than their never pregnant counterparts (Jewkes et al. 2001). Dunkle et al. (2007) found that 97 % of women who reported first intercourse before 13 years of age, and 26.7 % of those reporting at the ages of 13 and 14 years also reported non-consent to coitus. Interventions that are empowering of young women will thus focus on gender relations outside the marital alliance. For example, Varga (2003) argues that sexual and reproductive programs could be strengthened by 'addressing the criteria adolescents use for selecting potential partners and by paying attention to gender-specific sociobehavioral norms that influence their ability to control sexual decision-making and negotiation' (p. 169).

Contrasting these two countries' trends with regard to 'adolescent pregnancy' is informative in terms of feminist politics. These examples illustrate how global feminism can never be a

matter of unity around common concerns, but rather becomes a matter of alliance around shared interests. Interventions in India may, for example, focus on empowering young women within the marital relationship and undermining taken-for-granted assumptions of the role of the wife, while interventions in South Africa may focus on empowering young women in relation to understanding their sexual rights and undermining taken-for-granted assumptions of male sexual drive and women's bodies as commodities. Even within these countries, interventions would need to be fashioned to fit the specific circumstances of the particular group of young people under consideration, as disparities in social and life circumstances abound within as well as across countries.

Despite these different foci for the interventions suggested above, the commonality in terms of gender power relations underlying the occurrence of unwanted pregnancies among young women is clear. This leads to the following section in which I discuss the need for feminists to identify and act upon transversal relations of commonality.

Identifying and Acting Upon Transversal Relations of Commonality: A Reproductive Health Justice Approach

The necessary complement of the cultural, social, and historical specific approach discussed in the previous section is a pursuit of transversal relations of commonality. This means identifying issues that, no matter the location of women, have central and enduring meaning in terms of their sexual and reproductive lives. In locating the transversal relations of commonality with respect to 'adolescent pregnancy,' I propose that feminists adopt a reproductive justice approach.

A reproductive justice approach highlights the contextual nature of women's lives and the overarching socioeconomic inequalities, racism, and sexism that shape women's lives, but also identifies, within this, the commonality of conditions that are necessary for comprehensive reproductive and sexual freedom (Fried 2006). As indicated by West (2009):

> Reproductive justice requires a state that provides a network of support for the processes of reproduction: protection against rape and access to affordable and effective birth control, healthcare, including but not limited to abortion services, prenatal care, support in childbirth and postpartum, support for breastfeeding mothers, early childcare for infants and toddlers, income support for parents who stay home to care for young babies, and high quality public education for school age children (p. 1425).

In such an approach, the lens shifts from the individual teenager and her failings, to the systemic requirements that need to be in place to ensure sexual and reproductive freedom.

In working on these transversal relations of commonality, feminist action becomes, as stated above, a matter of alliances which recognizes differences within commonality and establishes multiple points of resistance and action to ensure reproductive justice that is attuned to the myriad relations of inequality and domination that occur in women's reproductive lives. In terms of 'adolescent pregnancy,' there are a complex array of points of practice, intervention, and resistance. In the following, I concentrate on just three fundamental aspects in terms of reproductive justice: (1) the prevention of unwanted pregnancies, (2) the imperative of promoting access to non-discriminatory and legal termination of pregnancy services; and (3) the provision of non-discriminatory health and education services that address the inequities young women may face.

The Prevention on Unwanted Pregnancies

The prevention of unwanted pregnancies among young women requires, in the first and most minimal instance, access to, and knowledge of, contraception. The role of publicly funded contraceptive services is clear here; for example, the Guttmacher Institute estimates that approximately 1.3 million unintended pregnancies are

prevented annually in the USA through federally funded contraceptive services (Cohen 2006).

However, while necessary, the provision these kinds of services are insufficient. Unwanted pregnancies occur for a range of complex sociological and personal reasons, with gendered relations being key to many, particularly for young women. For example, in South Africa, Jewkes and Abrahams (2002) report in a paper on the epidemiology of rape and sexual coercion 'Forced sexual initiation is reported by almost a third of adolescent girls. In addition coerced consensual sex is a common problem in schools, workplaces and amongst peers' (p. 1231). Similar levels of sexual coercion have been found in other developing countries in sub-Saharan Africa countries (Moore et al. 2007) and in India (Jaya and Hindin 2007). In the USA, just less than one in five of the teen-aged women surveyed in the National Youth Risk Behavior Survey reported being physically hurt by a date in the previous year. In the UK, one in three of 13–17-year-old women experienced sexual intimate partner violence (Barter et al. 2009). While the specific dynamics of these kinds of encounters will be culturally mediated and thus different across settings, the accumulation of data points to coercive and violent sexual encounters as a key commonality in young women's sexual and reproductive lives.

Research has shown the link between these patterns and unwanted pregnancy. In the USA, young women hurt by a date are vulnerable to contracting sexually transmitted diseases and becoming pregnant (Silverman et al. 2004), with similar patterns being found in South Africa, as reported above.

Thus, in terms of reproductive justice, feminists need to not only advocate for accessible and appropriate contraceptive services, but also for the acknowledgment, within these services, of sexual encounters as sites of inequitable gender relations. In the words of Wood and Jewkes (1997),

> All too frequently, health promotion interventions fail to acknowledge sexual encounters as sites in which unequal power relations between women and men are expressed. It is these power relations, which determine women's ability—or inability—to protect themselves against sexually transmitted disease, pregnancy and unwelcome sexual acts (Wood and Jewkes 1997, p. 41).

The acknowledgment of heterosexual sexual encounters as potentially coercive or violent should also be an essential feature of dialogues that occur under the rubric of sexuality education. That this is seldom the case is borne out by the analysis of sexuality programs in developed and developing countries conducted by Rogow and Haberland (2005). Where gender is featured, it is usually dealt with in a superficial manner, concentrating quite obviously on male behavior.

Promoting Access to Non-discriminatory and Legal Termination of Pregnancy Services

Advocating for accessible and affordable contraceptive services and undermining the unequal gendered power relations that lead to coercive and violent sex are important feminist primary prevention measures in the sexual and reproductive health of young women. At the same time, the provision of accessible and affordable termination of pregnancy services where unwanted pregnancy does occur is one of the cornerstones of feminist activism.

If termination of pregnancy is taken as an indicator of the unwantedness of a pregnancy, then it is clear that young women frequently find themselves in the situation of carrying a severely problematic pregnancy. In the USA, 17 % of legal abortions are performed for teenagers (Guttmacher Institute 2008). In South Africa, 12 % of women presenting for legal termination of pregnancy are minors (Department of Health [South Africa] 2006). In England and Wales, the rates of legal termination of pregnancy for young women aged 15–19 years were 24 per 1,000 women in 2006 (Department of Health [United Kingdom] 2007).

One of the chief elements of feminist activism with respect to abortion is advocating for the legalization of termination of pregnancy on request, as restrictive legislation is highly

associated with the incidence of unsafe abortion, which can have severe physical and psychological consequences (World Health Organisation 2007). It is estimated that in 2003 about 20 million unsafe abortions took place, and 98 % of which were performed in developing countries. Of these, 14 % were performed on women under the age of 20. Although data are unreliable, it is assumed that 'adolescent' women's risk of morbidity and mortality from unsafe abortion is higher as they may be biologically more vulnerable and have fewer resources to access less risky procedures (World Health Organisation 2007).

With increasing recognition of women's rights and the effects of unsafe abortion, there has been a global trend toward liberalizing abortion laws. Boland and Katzive (2008) found that 16 countries either increased or expanded the grounds on which abortions may be legally performed between 1998 and 2006. Others adopted changes that affected access to the procedure. Despite this, however, restrictions have increased in the Americas and in East and Central Europe. In addition, the legalization of abortion does not automatically mean access:

> Even where it is legally permitted, safe abortion may not easily be accessible; there may be additional requirements regarding consent and counseling, and countries often impose a limit on the period in which abortion may be performed. In addition, the attitudes of medical staff may be discouraging, and abortion services may be insufficient to meet the demand, unevenly distributed or of poor quality. Finally, women may be unaware of the availability of abortion services or their right to access them within the legal framework (WHO 2007, p. 2).

This implies that in addition to advocacy for the liberalization of abortion laws, feminists need to concentrate on factors that increase access such as the number and distribution of facilities, the attitudes of staff, and women's (in particular young women's) knowledge of their rights and where to access services.

But once again, these efforts may, in and of themselves, be insufficient. Abortion is not simply a health decision but is located within cultural and personal narratives concerning fetal personhood, the role and responsibility of women, the value of children, the morality of abortion, the constitution of a family, and the consequences of abortion. Overt and subtle cultural narratives may act as significant barriers to women accessing termination of pregnancy under safe and legal conditions. For example, in South Africa colleagues and I (Macleod et al. 2011) found that the newly legalized abortion on request was constructed in rural areas of the Transkei as being destructive of cultural values and traditions, in particular gendered and intergenerational relations. Legal abortion was equated with colonialist interventions and seen as something that should be opposed in the preservation of culture. These constructions enabled everyday interactions to induce shame and negative experiences of abortion.

One of the major recent cultural narratives of abortion, particularly in developed countries, is that of post-abortion stress (PAS), which is seen as similar to post-traumatic stress disorder (Speckhard and Rue 1992). Despite evidence that contradicts the inevitability of psychological consequences following safe abortion (Major et al. 2008), the notion of PAS has taken root in much anti-abortion activism. While previously anti-abortion activism centered on the rights of the fetus (which inevitably led to an impasse in terms of the rights of the pregnant woman), the notion of PAS constructs not only the fetus as the victim but also the woman (Hopkins et al. 1996). Women who live in contexts in which the idea of PAS has taken root will inevitably have to deal with personal questions regarding how she will cope psychologically if considering a termination of pregnancy. Rubin and Russo (2004) argue that talk of PAS makes abortion a more threatening, stressful and stigmatized event than it would otherwise have been. They believe that therapists need to work with clients who have undergone an abortion to reappraise some of the anti-abortion rhetoric that suggests psychological fall-out and feelings of guilt.

Interventions that improve the chances of young pregnant or parenting women being able to access adequate health care, education, employment, and child care, and that make

motherhood a feasible option at any point in a woman's life course, would assist in reducing the possibilities of women experiencing unwanted pregnancies, and thus opting for a termination of pregnancy. In the following, I deal specifically with the provision of non-discriminatory health services and education.

Provision of Non-discriminatory Health Services

International research on health service provider practices in relation to the sexual and reproductive health of teenagers paints a less than rosy picture. The South African Demographic and Health Survey of 2003 (Department of Health [South Africa] 2007) shows that compared to pregnant women 20–34 years old, pregnant women under the age of 20 are less likely to receive care at all and are less likely to be informed of the signs of pregnancy complications, to have their weight, height, and blood pressure measured, to have urine and blood samples taken, and to receive iron supplements. The World Health Organisation (2007) reports that providers in places such as Nepal, Ghana, and Senegal were found to be hostile to young pregnant women seeking health care; they were reluctant to interact with the young women and to discuss issues relating to sexuality with them. Similar patterns have been found in research in Kenya and Zambia (Warenius et al. 2006), and New Zealand (Breheny and Stephens 2007b). The latter authors conclude: "If health professionals talk about the behavior of young mothers in ways that are essentially negative, then those women may well avoid situations in which they are viewed as deficient. … If young women are distrustful of health professionals, then they may be less likely to follow professional advice or even seek such advice" (Breheny and Stephens 2007b, p. 123).

Health service providers operate, of course, within local discursive and social contexts and within the structural constraints of the public health system. Thus, for example, Kim and Motsei (2002) emphasize in relation gender-based violence that primary health care nurses 'are women and men first—and as such, experience the same cultural values, and indeed, similar or higher levels of violence, as the clients they are expected to counsel and treat' (p. 1243). Indeed, in relation to 'adolescent pregnancy,' health service providers will be operating within the broader discursive context in which representations of pregnant teenagers draw on and reproduce discourses concerning the nature of adolescence, good mothering, sexuality and morality, family formation, race, gender, and correct economic activity. Health service practices, the actions carried out upon the lives and conduct of teenagers and their families by those vested with the authority to do so, are intricately connected to the truths generated about 'teenage pregnancy' in a range of social spaces including academic texts, media messages, and popular literature. In the words of Holland (2010), 'signifiers, such as being young and/or single, can come to negatively and predominantly shape a young mother's experience of the maternal healthcare system' (non-paginated).

One of the responses to these kinds of patterns within sexual and reproductive health services has been the institution of 'adolescent friendly' services. The World Health Organisation (2002) advocates this approach and has produced a document that is,

> …intended for policy makers and progamme managers in both developed and developing countries, as well as decision makers in international organizations supporting public health initiatives in developing countries. It makes a compelling case for concerted action to improve the quality – and especially the friendliness – of health services to adolescents. Drawing upon case studies from around the world, it reiterates that this can be – and has been done – by non governmental organisations and government bodies working with limited financial resources.

Although the emphasis is on health in general, sexual and reproductive health features as a key component of the proposed 'adolescent friendly' services. Adolescent friendly service initiatives have been set up in a number of countries.

Tylee et al. (2007), in their review of the effect of these initiatives on the health of youth,

indicate that the evaluations conducted have not allowed for definitive statements about the effectiveness of such initiatives. However, they indicate 'enough is known to recommend that a priority for the future is to ensure that each country, state, and locality has a policy and support to encourage provision of innovative and well assessed youth-friendly services' (p. 1565).

While these kinds of initiatives can be seen as positive, vigilance concerning the dominant discourses and power relations that are played out in this kind of health service provision is required. For example, Ecuador's National Plan for Adolescent Pregnancy Prevention focuses on the implementation of 'adolescent friendly services' through the already existing public health facilities. Despite this, policy makers' and service providers' talk about adolescent pregnancies is deeply embedded in gender norms, as indicated by Goicolea et al. (2010):

> Adolescence was constructed as an underdeveloped stage, sexuality as negative and dangerous for girls, and adolescent pregnancies as a problem that should be dealt with mainly by health professionals. Those repertoires also idealized motherhood, stigmatized abortion, oriented services towards married women, and idealized marriage and the traditional nuclear family, despite the acknowledgment of the high levels of violence within such institutions (p. 13).

The provision of non-discriminatory health services implies not simply applying technical measures, but also inspecting, at a range of levels, the kinds of discourses deployed by those invested with authority to speak about, and implement, these services.

Provision of Non-discriminatory Education Services

Turning to education, one of the frequently cited concerns with regard to early reproduction is the possibility of school dropout. With this in mind, many schooling programs have been instituted to retain pregnant and parenting teenagers in school. For example, in the USA by the late 1970s, most school districts had developed policies to keep students in regular classes, with pregnancy and parenting programs being adopted by many (Luker 1997). Evaluations of these kinds of programs are mixed. Sadler et al. (2007) argue that the parent support program and school-based child care setting they evaluated offered 'promising opportunities to help young mothers with parenting, avoid rapid subsequent pregnancies, and stay engaged with school, while their children are cared for in a close and safe environment' (p. 121). Baytop (2006), on the other hand, in her meta-analysis of programs for pregnant or parenting unwed African-American teenagers aimed at improving maternal life course outcomes (e.g., subsequent fertility, increased education, employment, reduction in public assistance) suggests that these programs had minimal impact on increasing rates of educational attainment among these young mothers.

While feminists should champion programs that potentially increase young women's options in terms of education, it is equally important that young women are sufficiently supported so that they can choose to not return to school or work but rather to concentrate on child care. Austerberry and Wiggins (2007) report on the Sure Start Plus program, a pilot project aimed at supporting pregnant and parenting young women as part of the UK government's inclusion initiative. They note that the government targets for return rates to school are at odds with the expressed interests of the young women who wanted to have the same choices as older mothers in terms of work/life balance. The authors conclude,

> [Government] policies toward motherhood and employment are inconsistent: they promote flexibility for middle-class mothers living in households with one or more members in regular employment while being prescriptive towards unwaged mothers, who are dependent on state benefits (p. 12).

In addition, how these programs are set up and administered requires attention. Despite the overt intention of increasing educational attainment, programs may re-exclude teenagers by segregating them in alternative settings or by failing to provide them with sufficient support (such as on-site child care) in regular school

settings (Kelly 2000). Kelly (2003) discusses the teenage parent program (TAPP) in Canada, indicating that the program emerged in response to the exclusion of teen mothers (first formally and then informally) from mainstream schooling. She views TAPP as a 'relatively successful embodiment of previous discursive and material struggles to give pregnant and mothering young women access to public space and consideration' (p. 128). Run by women who identified themselves as feminists, the program countered the dominant discourse of the good citizen who conforms to conventional schooling aims, is independent of government assistance, and seeks help from experts, as well as the assumptions underlying the dominant definitions of good mothers and workers. In setting forth these ideas for discussion and debate, TAPP empowered young mothers by expanding the discursive space.

Finally, feminists need to locate their arguments concerning schooling for young pregnant or mothering women within the context of schooling as a gendered and class-based endeavor. For example, a survey conducted among rural youth in South Africa found that 13 % of 16-year-old females had left school, but only 5 % of the sample that had left school was pregnant (Hargreaves et al. 2008). Some of the major reasons for leaving school before the end of Grade 12 cited in a South African study of poor, rural schools include poverty, and a lack of motivation to complete school owing to foreshortened economic possibilities (Mokgalabone 1999). Young pregnant and mothering women's engagement with schooling will be tempered by the general schooling environment, which, in many circumstances of poverty, fails not only these young women but young women in general.

Conclusions

Geronimus (2003) asks the question: 'In the light of actual scientific evidence (to the contrary), why does the conventional wisdom on the consequences of teen childbearing continue to be at once overstated and never in doubt?' (p. 884). This question speaks to the fact that young women who conceive are not only pregnant, but also have a range of other characteristics. They occupy a certain socioeconomic level, with the accompanying living conditions, health care possibilities, quality of schooling, and employment opportunities. They live in particular family structures and have particular partner relationships. Foregrounding age as the key variable or characteristic has been seen by researchers such as Geronimus (2003) as problematic, as research that compares the consequences of reproduction or a termination of pregnancy among younger women with the consequences for older women of *similar socioeconomic and other social circumstances* shows that there is, for the most part, negligible difference between the two (Geronimus 2003).

With this in mind, the refusal of some feminists to treat 'adolescent pregnancy' as a separate phenomenon has some appeal. In Macleod (2011), I have argued for a concentration on unwanted pregnancies because, in defining unwanted pregnancies as the key issue, we undo the imaginary wall between younger and older women, thus opening up the space for understanding how women in similar social circumstances face similar dilemmas, difficulties, barriers, and possibilities around reproduction.

This having been said, feminists also need to acknowledge that 'adolescent pregnancy' as a signifier has cultural and social capital. As such, the social construction of 'adolescent pregnancy' as a real phenomenon with social and personal consequences has material effects in young women's lives. They are subject to endless scientific scrutiny, regulated through health and educational interventions, and discursively positioned as, at best, naïve and, at worst, personally deviant and deficient.

Geronimus (2003) answers the question she poses (cited above) by arguing that the narrative of 'adolescent pregnancy' as necessarily deleterious 'helps maintain the core values, competencies, and privileges of the dominant group' (p. 884). 'Adolescent pregnancy,' she argues, is used as a political tool to entrench ideas about race, responsibility, sexuality, and 'family

values.' With this in mind, it is contingent upon feminists to engage with 'adolescent pregnancy' in order to expose the power relations implicit in the technologies of representation and the technologies of intervention that cohere around the pregnant and parenting teenager. In this, feminists need to refuse abstractions of the pregnant or mothering teenager that predefine her in specific ways. Instead of concentrating on the individual deficiencies (or otherwise) of these young women, feminists need to advocate for interventions that empower young women in their sexual and reproductive lives. This advocacy must be attuned to the local specificities of young women's and men's lives while at the same time highlighting the transversal relations of commonality around reproductive justice. In particular, the prevention of unwanted pregnancy, the accessibility of termination of pregnancy, and the provision of non-discriminatory health and education services need to be advocated for, with the complex gender relations that feed into these processes being paid careful attention.

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Teenage Pregnancy as a Social Problem: A Comparison of Sweden and the United States

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Keywords
Adolescent pregnancy epidemic · Abortion · Claimsmaking · Cultural construction · High risk · Pregnancies · Mass media · Pregnancy rate · Families policy · Sex education · Socially constructed problem · Social control of sexuality · Teenage sexuality

Introduction

Teenage pregnancy has been treated as an urgent social problem in the United States since the 1970s. Scholars, politicians, interest groups, and media actors have all contributed to a seemingly ceaseless debate about what can and should be done about teenage pregnancy. Fueling the debate is the persistent high pregnancy rate among teenagers in the United States in comparison with their peers in other developed nations. In sharp contrast, teenage pregnancy in Sweden is not a recognizable problem in its own right. No one studies *only* teenage pregnancy, and no one in the public debate focuses exclusively on teenage pregnancy. In combination with a very low teenage pregnancy rate, it is as if the problem does not exist. And yet, even if teenage pregnancy itself is not a distinct problem in Sweden, more comprehensive activities involving teenagers and sexuality are certainly subject to concern and debate. Therefore, it would be a mistake to conclude that the different statuses of teenage pregnancy as a social problem in the United States and Sweden are all about objective magnitude.

A number of observers of teenage pregnancy in the United States have concluded that it is a socially constructed problem in the sense that claims about it are exaggerated and/or misguided and that the problem is fundamentally misrepresented in the public debate (Luker 1996; Vinovskis 1988). Indeed, teenage pregnancy in the United States displays most of the spectacular features that typically accompany the problems selected for social constructionist analyses (crisis language, front-page stories, extensive debate, and high public visibility). In contrast, none of these features characterize the Swedish case. Comparing the two therefore provides an opportunity to examine aspects of social problem construction that are not readily available in analyses of a single case (Bensen and Saguy 2005; Bogard 2001; Linders 1998). Following a constructionist approach, but seeking to extend its explanatory reach, we argue

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that the differences between Sweden and the United States are not best explained by differences in the condition itself (different teen pregnancy rates) but rather by the historical trajectory of claimsmaking surrounding teenage pregnancy and constructing it as a particular kind of social condition with more or less problematic features. The comparison of teenage pregnancy in Sweden and the United States as different kinds of problems also points to a few limitations with analytical approaches developed on the basis of spectacular social problems. In short, the focus on the spectacular features of social problems has encouraged analysts to conflate problem status with the highly visible claimsmaking activities that characterize these types of problems (Best and Horiuchi 1985; Fritz and Altheide 1987; Gentry 1988).

This analytical strategy has two largely unintended consequences for our understanding of how social problems are constructed, both of which are revealed in the comparison with nonspectacular problems; first, it gives analytic priority to the *emergent* phase of social problems, and second, it serves to exaggerate the *novel* elements of problem constructions. As the analysis in this paper shows the far less visible and far more routinized claimsmaking activities surrounding the teenage pregnancy issue in Sweden have been more intent on *maintaining* the problem than constructing it anew. Thus, the absence of widely publicized claimsmaking activities indicates not the absence of a socially constructed social problem, but instead a different kind of problem (Ball and Lilly 1984; Miller 1993), this one sustained by a set of routine claims designed to maintain the issue as a particular kind of problem with an established and institutionalized set of interventions. The comparison between Sweden and the United States provides an opportunity to examine how the same issue—teenage pregnancy—has generated two different claimsmaking processes, one immersed in spectacular claims (United States) and one immersed in administrative routines (Sweden).

In both nations, activities associated with teenage sexuality were in various ways monitored and controlled long before the notion of teenage pregnancy took hold in the 1970s. The arrangements whereby teenage sexuality were monitored and controlled can be expressed as more or less institutionalized claims that maintain the problem and its solutions over time. As such, claims of this kind are not only critical elements in the persistence of social problems, but also hold the key to the transformation of social problems. From this perspective, then, the different problem paths of teenage pregnancy in Sweden and the United States can, in part at least, be explained by different patterns of institutional involvements in the issue/problem. Such involvements are obviously linked to larger institutional practices and arrangements, signaling different welfare state arrangements in Sweden and the United States. For the purposes at hand, however, the key observation is that the arrangements that reinforced the "old" teenage pregnancy problem in both nations were sustained longer in the United States than in Sweden, but then collapsed almost instantaneously, leaving large institutional and interpretive voids to be filled. In contrast, the Swedish problem was transformed over a longer period of time and was subjected to frequent negotiations and adjustments, and thus was better able to withstand and absorb the flood of counterclaims that emerged in both nations in the 1970s.

Teenage Pregnancy as a Social Problem

In what follows, we briefly summarize the histories of teenage pregnancy as a social problem in Sweden and the United States. Our aim is not to recast what is generally known about the two cases, or to resolve evidentiary disputes, but instead to use the comparison to throw new light on the different understandings of teenage pregnancy as a social problem in Sweden and the United States (Furstenberg 1998). The comparison of Sweden and the United States is a suitable example for several different reasons; first, it involves one case that displays most elements of a spectacular social problem (United States) and one that displays virtually no spectacular features

(Sweden); second, the United States displays a claimsmaking field marked by conflict and disagreements whereas claimsmakers in Sweden are far less likely to engage in factual contests; and third, as a social problem, teenage pregnancy in both Sweden and the United States has attracted a wide range of claimsmakers, albeit differently distributed across the two cases. Taking advantage of the fairly substantial secondary literature around teenage pregnancy, and some illustrative examples from primary sources, we focus the analysis on the 1970s and 1980s. For the United States, this period captures the rise and proliferation of teenage pregnancy as a new social problem, whereas for Sweden it points to institutional processes that served to deflect the construction of a new social problem along the lines of the American case.

Prior to this time, teenage pregnancy was not a recognizable problem in its own right in either the United States or Sweden; this was so, in large part, because the very notion of "teenager" as a meaningful social category was not readily available until well into the twentieth century (Arney and Bergen 1984; Davis 1989; Harari and Vinovskis 1993; Hine 1999; Lesko 2001; McLeod 2003; Weatherley 1987). This does not mean, however, that previous generations had *no* concerns about pregnant teenagers. In both nations, such teenagers were problematic primarily and especially if they were unmarried, thus making illegitimacy the main problem under which concerns about pregnant teens was discussed, categorized, and addressed (Gordon 1994; Persson 1972). In this sense, the issue had long historical roots and remedies were in place in both nations. In other words, in so far as pregnant teenagers constituted a public problem in need of a solution, it was sustained in both nations through an existing legal and normative framework and an organizational apparatus aimed at containing and monitoring the social behavior purportedly comprising the problem.

The remedies in place were not identical in the two nations, however, which were to have consequences for the emergence of the "new" teenage pregnancy problem in the 1970s. In short, and anticipating the discussion below, the solutions to the problem of pregnant teenagers in the United States essentially collapsed during the early 1970s when the combined pressures of the women's liberation movement and the sexual revolution brought about new sexual practices and attitudes (Cherry et al. 2001). For teenagers especially, these changes meant better access to contraceptives and abortion and also abolition of various discriminatory practices involving pregnant teenagers (e.g., school expulsion for pregnancy, ineligibility for various benefits and rewards). In Sweden, in contrast, the old punitive "illegitimacy" remedies had already been reformed and modified to such an extent that the new challenges brought by the 1970s could be accommodated without much public outcry and without much opportunity for claimsmakers to single out teenage pregnancy as a unique, novel, and urgent problem to address.

Teenage Pregnancy in the United States

The emergence in the mid-1970s of teenage pregnancy as a social problem in the United States, as several studies have documented, looks very much like an instance of a new spectacular social problem, accompanied as it was by a flurry of crisis claims with high public visibility (e.g., Luker 1996; Selman 2003; Vinovskis 1988; Wong 1997). Public claimsmakers typically referred to the newly discovered problem as an "epidemic," following the lead of the Alan Guttmacher Institute, which in 1976 published a pamphlet entitled *11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States*. Over the next few years, the crisis claims were repeated over and over again in the popular press, in academic journals, and in government documents (Luker 1996). Teenage pregnancy, as the U.S. Department of Health, Education (1977), and Welfare announced, had become "everybody's problem". To support the conclusion that teenage pregnancy had reached epidemic proportions, claimsmakers introduced a plethora of statistical data. These data typically

included estimates of both the magnitude of the problem, or "basic facts" as the Guttmacher report called them, and the social consequences of teenage pregnancy for the mother, the child, and society at large.

The mounting concern about teenage pregnancy as an urgent problem in need of a solution was almost immediately met with criticism, thus pointing to the competitive field of claimsmakers seeking ownership of the problem (Gusfield 1981). In the popular as well as scientific press, a growing number of commentators pointed out that the problem with teenage pregnancy was overstated and/or misrepresented. It was not true, critics argued that teenage pregnancy had reached epidemic proportions; in fact, the teenage birth rate was declining after a peek in the 1950s (Thompson 1995; Putnam-Scholes 1983; Vinovskis 1988). Moreover, while few observers took issue with the fact that the rate of *unmarried* teen births had increased, there was a fair amount of disagreement about what this fact meant for how the problem of teenage pregnancy was to be perceived—some used it to criticize the notion of an epidemic (Scharf 1979), others used it to key in on the auxiliary problems statistically associated with unmarried teen mothers (Suri 1994; Vinovskis 1988), and yet others used teenage pregnancy as an indication of the loosening of traditional mores concerning family, gender, and sexuality.

Although there was significant dispute over what made teenage pregnancy problematic, the overwhelming number of claimsmakers during these decades agreed that it *was* a problem; that is, in the United States, there was little debate about *whether* teenage pregnancy was a problem, but lots of debate about what kind of problem it was (e.g., Lawson 1993; Warren 1992). Even those who lamented the use of crisis language seldom concluded that the problem was illusionary, only that it was misconstrued in various ways (e.g., Bader 1988; King and Fullard 1982; Pearce 1993).

From an analytical perspective, then, the teenage pregnancy debate in the United States through the 1980s cannot simply be reduced to a battle over claims versus facts, but instead signals an underlying disagreement over what kinds of facts are relevant, and ultimately, what kind of problem teenage pregnancy really is (Furstenberg 1998; Macintyre and Cunningham-Burley 1993). Here, the dimensions of disagreement were plentiful and wide. One major dimension refers to *whose* problem it was and ranges from everybody's to the pregnant teenagers themselves. Claimsmakers intent upon presenting the problem as "everybody's" (U.S. DHEW 1977), typically described it in as dramatic terms as possible, while those framing their concerns around the teenagers themselves typically rejected the epidemic claims, and instead emphasized elements of individual hardship (e.g., Green and Poteteiger 1978; Putnam-Scholes 1983). Another dimension, this one multilayered refers to the *whys* of the problem, and here suggestions ranged from cultural degeneration to structural obstacles, from lax morals to rational responses to difficult circumstances, and from too much *sex* education to too little sex *education* (Irvine 2002; Kantner 1983; Scharf 1979; Shornack 1987; Stafford 1987; Suri 1994). Other dimensions of disagreement were more *content* oriented, and, accordingly, pulled the center of the problem in somewhat different directions, including illegitimacy, sexuality, abortion, gender, youth risk, poverty, welfare, and race/ethnicity (e.g., Murcott 1980; Pearce 1993; Weatherley 1987). A final dimension refers to the kinds of *remedies* claimsmakers proposed, ranging from abstinence to expanded contraceptive services, from increased access to abortion to prohibition of abortion, from expanded to contracted health and welfare services, and from increased family involvement to increased school involvement (e.g., Furstenberg 1991; Marsiglio 1985; Maynard 1995, 1997; Waters et al. 1997; Warren 1992). Given these multiple disagreements over who, why, what, and what to do, it is not surprising that *evaluations* of various remedial programs, the number of which confirms the entrenched problem status of teenage pregnancy as a problem, were as divergent as the initial problem definitions (e.g., Gilchrist and Schinke 1983; Hoffereth 1991; Plotnick 1993).

Teenage Pregnancy in Sweden

In sharp contrast to the United States, teenage pregnancy in Sweden during the 1970s and 1980s was not a spectacular or highly visible problem, which is reflected in the negligent number of studies, reports, and commentaries devoted exclusively to the subject. To say that teenage pregnancy was not a front-page problem in Sweden, however, is not to suggest that it was not a problem *at all*. Thus, while few of the spectacular features that characterized the American problem were present in Sweden, there was still a fair amount of claimsmaking addressing the putative condition; statistics were carefully monitored and refined, numerous public agencies, at both state and local levels, were charged with issues related to teen sexuality, especially the school system, which occupied a prominent position in the preventive effort, and many youth and women's organizations were actively involved in helping, teaching, and disseminating information about sexuality, contraceptives, and intimacy issues. It is in this sense that teenage pregnancy was not a highly visible emergent problem in Sweden but instead a problem maintained by a set of stable institutional arrangements and practices. Thus, one reason why there were no statistical contests in Sweden is linked to the interconnected institutional setting wherein claims about teenage pregnancy were produced and disseminated. Most claimsmakers accepted that the concerted effort to reduce the number of unwanted pregnancies, begun in earnest in conjunction with the liberalization of the abortion law in 1974, was particularly successful among teenagers. And indeed, undisputed "basic facts" revealed that the teenage pregnancy and birth rates steadily declined since the mid-1970s, as did the teenage abortion rate (Socialstyrelsen 2000).

With this background, it should come as no surprise that disagreements over the who, why, what, and what to do aspects of the problem were much less pronounced in Sweden than in the United States. While it would be a mistake to conclude that there were no disagreements at all among Swedish claimsmakers, it is nevertheless clear that the question of *whose* problem teenage pregnancy is was for the most part settled: The problem was primarily the teenage girl's and secondarily her child's. This observation is not meant to suggest that the potential social consequences of teenage pregnancy and childbearing were less appreciated in Sweden than in the United States. Rather, the point is simply that teenage pregnancy in Sweden was never understood as a social crisis. A subcategory of unwanted childbearing generally, childrearing at a young age was, according to most claimsmakers, more likely to bring financial and other hardship. This was a concern of old standing in Sweden (Hatje 1974; Liljeström 1974) that over time had generated a multifaceted policy package aimed at erasing as far as possible the consequences for children of different economic and marital statuses among parents (Carlson 1990; Kälvemark 1980). Although no one went so far as to argue that the economic circumstances of childrearing had in fact been equalized, it was generally agreed that the inequalities were much less pronounced and less devastating than they would have been without this concerted policy effort. Hence, teenage parenting in Sweden was not quite as intimately linked to poverty in the public debate as it was in the United States and, accordingly, did not trigger the same kinds of concerns.

Swedish discussions about the *whys* of teenage pregnancy, similarly, amounted to variations around a generally agreed-upon theme: basically, the distinction between good and bad sexuality. This distinction had produced (and continues to produce) a massive effort to educate young people in healthy sexuality, to train them to behave responsibly in sexual interactions, and to steer them away from unhealthy influences, or, at the very least, to provide them with the knowledge necessary to reject those influences. In this environment, the stubborn persistence, monitored by statistics, of practices such as teen abortions, unsafe sex, rape and sexual abuse, pornography consumption, and various forms of sexual harassment served as constant reminders of work left undone (Folkhälsoinstitutet 2000).

Thus, social and political demands were—and still are—formulated almost entirely around improving and expanding existing programs and services that targeted youths, including sex education in schools, contraceptive programs, state subsidies for birth control pills, and various abortion prevention programs (SoU09 1999/2000; SoU10 1998/99; SoU12 1997/98).

In contrast to the United States, Swedish claimsmaking activities, in terms of both *content* and *remedies*, came to coalesce around an approach that acknowledged and took for granted teenage sexual activity, while at the same time, placing a strong emphasis on the distinction between "good" and "bad" expressions of that sexuality (Linders 2001), where "good" refers to maturity and conditions of equality, and "bad" all forms of coercive, unsafe, and irresponsible sexual behavior. Thus, the Swedish understanding of teenage sexuality, in short, amounts to an effort to coax teenagers toward good (loving, caring, safe, and preferably stable) and away from bad (hasty, thoughtless, temporary, and unsafe) sexual behavior, including ending up with an unwanted pregnancy (Linders 2001).

Policy measures along these lines have long had wide social and political backing in Sweden, as is indicated by the wide political spectrum from which political demands has originated. What this means is that virtually no one in the Swedish debate suggests that the Swedish approach to youth sexuality should revert back to an earlier and more restrictive position. Teenage sexuality, along with adult sexuality outside of marriage, has lost its taint of immorality and has become accepted as a fact of life. Thus, the very fact that teenagers *do* expose themselves to the risk of pregnancy—by having sex—is not in itself viewed as an indicator of the problem or of the in/effectiveness of various programs designed to alleviate the problem (Linders 2001).

Explaining the Difference

Following a constructionist approach, but seeking to extend its explanatory reach (Best 2003; Bogard 2003), we argue that the differences outlined above between Sweden and the United States are not best explained by differences in the condition itself (i.e., different teen pregnancy rates) but rather by the historical trajectory of claimsmaking surrounding and constructing teenage pregnancy as a problematic social condition. In both nations, activities associated with teenage sexuality were in various ways monitored and controlled long before the notion of teenage pregnancy took hold in the 1970s. The arrangements whereby teenage sexuality were routinely monitored and controlled can be expressed as more or less institutionalized claims that sustain the problem and its solutions over time. As such, claims of this kind are not only critical elements in the maintenance of social problems, but also hold the key to the transformation of social problems. From this perspective, then, the different problem paths of teenage pregnancy in Sweden and the United States can, in part at least, be explained by different patterns of institutional involvements in the issue/problem (Ungar 1998). Such involvements are obviously linked to larger institutional practices and arrangements, signaling different welfare state arrangements in Sweden and the United States (Esping-Andersen 1990; Olsson 1990; Orloff 2002).

Teenage Pregnancy as an Institutionalized Problem

Since the late nineteenth century, in both Sweden and in the United States, teenage sexuality, including pregnancy and birth, has been subjected to interventionist claims; these claims were originally aimed at controlling and managing a range of social behaviors considered problematic, including extramarital sexual activity, prostitution, promiscuity, and other forms of behavior deemed inappropriate. Formal remedies in both nations included criminal categories, age of consent, confinement and maternal homes, school and work regulations, juvenile reform centers, and restrictions on the availability of abortion, contraceptives, and sexual materials and information. More informal but no less

effective were claims organized around shame, embarrassment, and moral disapproval. In neither nation were these types of solutions designed to eliminate the problem; rather, the remedies were primarily aimed at maintaining the moral boundary between acceptable and unacceptable forms of young women's behavior. As long as the boundary remained intact, moral transgressions could be accommodated and contained. In both nations, the claims upholding this moral boundary came under intense attack in the 1960s, thus setting the stage for the emergence of the "new" problem of teenage pregnancy.

While sharing this general history of claims around teenagers, sexuality, and pregnancy, as well as the flurry of subsequent counterclaims, there are still some significant differences between the two nations (Cherry et al. 2001; Jones et al. 1986). Most importantly, the two nations differ with regard to the historical paths of these claims and solutions. Specifically, while the traditional claims surrounding and constructing deviant sexual behaviors had undergone a slow but steady transformation in Sweden for a few decades prior to the 1960s, the institutionalized remedies in the United States were remarkably resistant to change until the challenges of the 1960s, which led to the subsequent collapse of the traditional approach to teenage sexuality and unmarried pregnancy. This collapse, which paved the way for the emergence of the "new" problem of teenage pregnancy in the United States, was precipitated by rapid changes in several different areas, including birth control and abortion, sex education, and public assistance to needy mothers. While none of these changes in themselves were organized directly around teenagers, they nevertheless had a profound impact on the process by which "teenage pregnancy" was identified as an urgent problem in need of a solution. Because of the much more gradual transformation of claims in these areas in Sweden, and the greater reach of official claims, the institutional structure could better withstand and/or absorb the onslaught of counterclaims, and thus preempted the emergence of a "new" social problem.

The Institutional Environment of Birth Control and Abortion. In both Sweden and in the United State, the introduction of the pill and the IUD in the 1960s, and the decriminalization of abortion in the 1970s, seemed to confirm the arrival of a "sexual revolution," and in both nations, these new methods for avoiding the reproductive consequences of sexual intercourse brought public concerns about the consequences for the young (Garrow 1994; Linnér 1967). In Sweden, however, these concerns found no politically effective following. The official ban on the dissemination of contraceptives and birth control information was lifted already in 1938, while it was not until 1965 that the United States Supreme Court, in Griswold v. Connecticut, ruled that banning contraceptives infringed on married couples' right to privacy. Similarly, while both Sweden (1974) and the United States (1973) decriminalized abortion at around the same time, Sweden had begun reforming its abortion law some 40 years earlier. Thus, the significance of the earlier institutionalization of counterclaims in Sweden lies not only in the practical implications of those claims but also in the transformation, however modest, of the linkage between problem definitions and remedies. The early involvement of the Swedish state in population control (which was the immediate "social problem" the laws concerning birth control and abortion were designed to remedy) served as a bridge to more modern state intervention in the area of teenage pregnancy. Thus, the question of whether the state should be involved in the citizens' sexual and reproductive lives has long since disappeared from the Swedish debate. This development can be contrasted with the United States. In 1958, President Eisenhower's response to a commission that recommended increased official attention to issues of birth control: "I cannot imagine anything more emphatically a subject that is not a proper political activity or function or

responsibility [of the federal government].… This is not our business" (quoted in Nathanson 1991: 40).

Sex Education. In both Sweden and the United States, sex education is linked to the issue of teenage pregnancy, but from an institutional perspective, the link is differently articulated. Sex education for children and youths was introduced in Sweden in the 1940s, and was made a compulsory part of the school curriculum in 1955. At that time, the sex education curriculum was limited, and still rooted in the traditional claims package. Nevertheless, the early institutionalization of sex education for the young eased the transition to the more comprehensive programs that were introduced a few decades later. As a result, sex education, generally speaking, is a noncontroversial issue in Sweden. Consequently, sex education is not implicated in the teenage pregnancy problem the same way as it is in the United States—that is, what is at issue is not whether teenagers should be given comprehensive sex education, including information about birth control, but rather how to make that education more effective. In contrast, sex education entered American public schools much later, and remains controversial to this day. For example, President Richard Nixon announced in 1972 that he would not support the distribution of birth control services and information to teenagers (Nathanson 1991). As late as 1975, several states still prohibited sex education and only a handful mandated some form of sex education (Alan Guttmacher Institute 1976). Estimates of how many students are actually exposed to sex education vary, of course, but even generous estimates suggest that somewhere between 20 and 30 % of high school students receive no sex education at all from their schools (Luker 1996; Bennett 1988). Moreover, the content of sex education classes vary considerably, ranging from comprehensive sex education, including birth control, to abstinence only education. While there is variation among schools and teachers in Sweden as well, the nationalized school curriculum leaves much less discretion to individual schools and districts, and thus fewer opportunities for local oppositional claimsmaking campaigns to intervene in the curriculum than in the United States.

Public Assistance to Needy Mothers. In both Sweden and the United States, the state takes some responsibility for the support of poor women and their children, thus providing institutional linkages between the teenage pregnancy problem and the social welfare system. In general, however, the interpretive foundation of that linkage is more complex and more subject to conflict in the United States than in Sweden (Furstenberg 2007; Harris 1997; Maynard 1995). The claim that teenage pregnancy, especially among young black women, is positively related to the distribution of welfare benefits was widely disseminated in the 1960s (at a time when white teenage pregnancy remained "invisible," and the war on poverty had expanded the welfare rolls, particularly to black women), and has lingered in the debate ever since, despite vigorous attempts at dispelling myths and exaggerations about the young, unmarried, black welfare mother (e.g., Collins 1991; Kaplan 1997; Luker 1996; Nathanson 1991; Williams 1991). And yet, the emergence of the "new" teenage pregnancy problem in the 1970s was in large part an accomplishment of claims suggesting that all "eleven million" teenagers were "at risk," and not just those who were poor and/or of minority background (Hulbert 1984). In sharp contrast, the claim that the welfare system is implicated in the problem of teenage pregnancy has virtually no adherents in Sweden. Teenagers who have children do receive public assistance, but many claimsmakers agree that the way government-provided maternity benefits are structured (as a percentage of income), if anything, serves to delay childbearing. Moreover, while public assistance to needy mothers has a fairly long history in both Sweden and the United States, the implementation of Aid to Dependent Children (ADC) in the United States never quite resolved the dilemma of unmarried mothers (Luker 1996; Gordon 1994). The Swedish approach, as an aspect of the social democratic state building project, was soon translated into a concerted, rational effort to remove some of the economic distinctions between married and

unmarried motherhood, despite the fact that the marital union remained the moral ideal well into the twentieth century (Hirdman 1989; Kälvemark 1980).

Conclusion

In this paper, we have sketched a comparative constructionist analysis of "teenage pregnancy" as a social problem in Sweden and the United States. Teenage pregnancy in the United States displays most of the spectacular features that typically accompany the problems selected for social constructionist analysis (crisis language, front-page stories, and high public visibility) whereas teenage pregnancy in Sweden displays few if any of these features. Comparing the two therefore provides an opportunity to examine aspects of social problem construction that are not readily available in analyses of a single social problem. More specifically, we have identified two interrelated limitations with the focus on spectacular social problems, the first linked to the conflation of highly visible claimsmaking with problem construction, and the second to the contested relationship between claims and facts.

First, while several scholars have pointed to the limitations of relying on publicly visible claimsmaking for our determination of what constitutes social problems (e.g., Collins 1989), our concern here has to do with the privileging of some social problem aspects (emergent phase, contested definitions) over others (maintenance phase, consensus definitions) that follows from such a reliance. The different claimsmaking patterns (content, venues, and claimsmakers) revealed in the comparison between the United States and Sweden point to the different status of teenage pregnancy as a social problem in the two nations. The much more varied and contested problem definitions in the United States have generated precisely the kind of data that constructionists typically use to demonstrate the "constructedness" of social problems, whereas the issue in Sweden has generated very little of these kinds of data; that is, teenage pregnancy in Sweden has not been subjected to much social conflict, does not generate front-page news (or much news at all), and is not an issue that has galvanized conflicts among various interest groups. As we have demonstrated, this does not mean that teenage pregnancy is not a socially constructed problem in Sweden. What it does mean, however, is that teenage pregnancy in Sweden is maintained as a social problem through different kinds of claimsmaking activities—institutional rather than public—than those that characterize the problem in the United States.

Thus, despite the fact that teenage pregnancy in Sweden lacks spectacular features, and despite the fact that the number of teenage pregnancies does not serve as claimsmaking fuel in Sweden, it is still appropriate to approach the issue as a social problem. This is so not because of its factual features but because it is surrounded and maintained by an official claimsmaking apparatus, designed to monitor, manage, and control the social behaviors captured by teenage pregnancy. Moreover, although a host of popular claims about the teenage pregnancy problem in the United States are no doubt suitable for debunking, that approach essentially turns a blind eye to the quite extensive social scientific literature designed to dispel the myths about popular and misconstrued conceptions of teenage pregnancy. While much of this literature is aimed at "rescuing" the teenage mother from the various real-life hardships associated with single parenthood, such as poverty and educational handicaps, it has, at the same time, contributed to the contested claimsmaking field that constructs the problem and generates the facts that sustain it.

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Adolescent Pregnancy Among Lesbian, Gay, and Bisexual Teens

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Keywords

Both-sex attractions · Coerced sex · Contraception · Dating violence · Heterosexual camouflage · LGB · Physical abuse · Sexual orientation · Sexual behaviors

Introduction

When most people think of adolescent pregnancy, they assume it is an issue exclusively for heterosexual youth. After all, pregnancy during the teen years usually requires penile–vaginal intercourse; there are no known countries where clinicians will provide artificial insemination to adolescents wishing to become pregnant, as adult lesbian women may do. After thinking about it, people might also consider bisexual adolescents to be at risk for teen pregnancy, because they could have opposite-sex partners, but gay and lesbian teens?

A growing body of evidence suggests that not only do some lesbian, gay, and bisexual (LGB)[1] adolescents adolescents become pregnant or get someone pregnant, they are actually at *higher* risk for pregnancy involvement than their heterosexual peers. This chapter will review the global evidence of this higher risk for teen pregnancy, explore possible reasons for this risk among sexual minority young people, and whether this also translates to higher rates of teen parenthood among LGB teens. At the same time, the chapter will suggest some reasons that this has been a relatively hidden issue in adolescent reproductive health, what research is still needed, and what it means for teen pregnancy prevention efforts.

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[1] The term LGB is used, rather than LGBTQ, because there are no population-based studies about pregnancy among transgender or questioning adolescents, the reported studies include only lesbian, gay and bisexual students. Where studies include a wider range of sexual minority youth, we have used the acronym LGBTQ.

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What is the Evidence for Higher Rates of Teen Pregnancy Among Sexual Minority Adolescents?

The first population-based evidence for higher rates of teen pregnancy involvement among sexual minority youth comes from the Midwestern United States in 1986, when a Minnesota statewide adolescent health survey of students in high school included a question about sexual orientation, attraction, and identity. An analysis of teen pregnancy by sexual orientation among girls in the survey found that girls who identified as lesbian or bisexual were twice as likely to report having been pregnant than girls who identified as exclusively heterosexual (Saewyc et al. 1999). Subsequent school-based surveys of youth throughout the 1990s in the USA and Canada found similar results, for both girls and boys. For example, the Seattle Youth Risk Behavior Survey (YRBS) of 1995 and 1999, the Massachusetts and Vermont YRBS of 1997, the British Columbia Adolescent Health Surveys of western Canada in 1992 and 1998, and the Minnesota Student Surveys from those same years, all found that LGB adolescents in school were two to four times more likely to be involved in teen pregnancy than heterosexual students (Reis and Saewyc 1999). Even while rates of teen pregnancy and births declined in the general population during that decade, in Seattle, Minnesota, and British Columbia, pregnancy rates among LGB adolescents increased between the earlier and later years of that decade (Saewyc et al. 2004b). The trends for British Columbia reversed in the early part of the next decade, although lesbian and bisexual girls were still more than twice as likely as heterosexual girls their same age to have been pregnant once or more, and gay and bisexual boys were nearly four times as likely as heterosexual boys to have caused a pregnancy (Saewyc et al. 2008b).

Only one large-scale US survey that included sexual orientation measures did not find this relationship. The National American Indian Adolescent Health Survey of 1991, conducted among reservation-based schools throughout the USA, found relatively higher rates of teen pregnancy involvement compared to other ethnic groups in the USA, with nearly 1 in 4 American Indian girls and more than 1 in 10 American Indian boys having been involved in pregnancy. However, LGB native youth were no more likely than heterosexual native youth to have been pregnant or caused a pregnancy (Saewyc et al. 1998).

As more school-based surveys in the USA, Canada, New Zealand, and elsewhere began to include measures of sexual orientation in their questionnaires after 2000, the opportunity to document this phenomenon increased. This did not always occur, however, even when researchers focused on comparing sexual health issues among LGB youth to heterosexual adolescents. The serious risk for HIV/AIDS and other sexually transmitted infections (STIs) among gay and bisexual young men seems to have focused research on sexual health primarily on risky sexual behaviors related to STIs, rather than on the other potential outcome of unprotected sexual behaviors, pregnancy (Gangamma et al. 2008). This was the case for recent analyses of the 6 metropolitan and 7 state-level YRBS that included a measure of sexual orientation between 2001 and 2009, which reported various sexual risk behaviors, but not pregnancy (Kann et al. 2011). In the Massachusetts YRBS from 1995 to 2001, pregnancy was analyzed only among girls, not boys (Goodenow et al. 2008).

Despite missed analyses of LGB teen pregnancy where it was feasible in some adolescent health surveys since 2000, where studies examined the issue, they consistently found higher rates of teen pregnancy among sexual minority youth than heterosexual teens. In Canada, in addition to the 2003 British Columbia Adolescent Health Survey (Saewyc et al. 2008b), the 2007 Toronto Teen Sex Survey found that 28 % of sexual minority youth reported pregnancy involvement compared to only 7 % of youth who identified as heterosexual or straight (Flicker et al. 2009). Similarly, in the 2007 New Zealand national youth health survey, 22 % of

youth with same-sex or both-sex attractions had been pregnant or gotten someone pregnant, compared to 9 % of opposite-sex-attracted youth (Rossen et al. 2009).

Some studies focused on more diverse populations of LGB youth in examining the risk for pregnancy involvement. For example, one analysis of the 2003 British Columbia Adolescent Health Survey examined rural and urban differences in health risks among LGB youth (Poon and Saewyc 2009). Rural gay and bisexual boys were nearly three times more likely to have caused a pregnancy compared to urban gay and bisexual peers; however, there were no differences in pregnancy among rural and urban sexual minority girls. Another study of the multi-ethnic sample of the Toronto Teen Sex Survey also found higher teen pregnancy involvement among sexual minority youth (Pole et al. 2010).

There have been very few studies that have looked at pregnancy involvement among ethnocultural minority groups in any country. Likewise, with the exception of New Zealand, the majority of surveys that have explored teen pregnancy among LGB youth have been from North America. There are no studies available that have identified whether this same phenomenon occurs in Europe, Asia, or South America, despite surveys documenting sexual minority youth in these populations, and some surveys identifying risk behaviors that increase the chance of pregnancy. For example, a recent study of cities in Sweden found that 5 % of boys and 3 % of girls report same-sex or both-sex attractions, similar to populations in North America, but the published research does not examine pregnancy involvement compared to opposite-sex-attracted youth (Haggstrom-Nordin et al. 2011). Other recent studies have documented same-sex attractions in Northern Ireland (Schubotz and O'Hara 2011), and same-sex sexual contacts in Slovenia (Pinter et al. 2009), and cities in Asian countries, specifically Hanoi, Taipei, and Shanghai (Feng et al. 2012), that may not have asked about pregnancy involvement.

Thus, we have evidence for more than 20 years of higher risks of pregnancy involvement among LGB adolescents in North America, and more recent evidence in New Zealand, but a lack of studies in other parts of the world to determine whether this is as universal a health disparity for LGB youth as abuse or suicide.

Why the Higher Risk for Pregnancy Among LGB Youth?

How might we explain this higher risk for teen pregnancy involvement among LGB youth? As with most such population outcomes, it is difficult to establish the "causes," beyond the basics of how pregnancy occurs, i.e., unprotected penile–vaginal intercourse when a female is ovulating and a male has adequate sperm levels for fertilization to take place. Public health observational research of this type usually is limited to considering potential contributing factors, or risk factors that appear to increase the likelihood of pregnancy involvement, and possibly protective factors that decrease those odds. The first step in helping to understand this phenomenon is to consider how lesbian, gay, and bisexual adolescents may experience the causes of pregnancy, and whether any of the contributing factors that are known from general population research are also an issue for LGB youth.

When it comes to the "cause" of teen pregnancy, unprotected sex between opposite-sex partners at a fertile moment, it is important to remember that sexual orientation is primarily defined as sexual attraction, or the gender(s) toward which a youth has romantic and erotic attractions (Saewyc 2011). Although another dimension of sexual orientation is the actual sexual behavior with the gender(s) the young person is attracted to, sexual behavior may not always be concordant with desires. Half or more of adolescents have not had sexual experience, although they may recognize their sexual attractions clearly enough to self-identify their orientation. There are many reasons that young people will have sexual intercourse when they

are not particularly interested in doing so, or not interested in the particular person they end up having sex with; some of these reasons include social pressure to be sexually active, a desire to keep a romantic relationship, even being forced or coerced into having sex. It is possible that LGB youth may engage in opposite-gender sexual behavior because of these reasons. If they are more likely to be sexually active than their heterosexual peers, this may help explain their higher risk for pregnancy.

What is the evidence for LGB youth around sexual intercourse? A number of studies over the past few decades have documented that LGB youth are more likely to report ever having sexual intercourse compared to heterosexual adolescents. This has been documented in Canada (Saewyc et al. 2008b), in several regions of the USA (Blake et al. 2001; Goodenow et al. 2008; Kann et al. 2011; Robin et al. 2002; Saewyc et al. 2006) as well as in New Zealand (Rossen et al. 2009) and Northern Ireland (Schubotz and O'Hara 2011). Some studies have found that they are not only more likely to be sexually experienced, but also to have sexual intercourse more frequently than heterosexual adolescents (Saewyc et al. 1999).

Although penile–vaginal intercourse is required for pregnancy among adolescents, the key risk is actually unprotected (or inconsistently protected) intercourse. In all of the population-based surveys that have examined condom use or contraception the last time a youth had sexual intercourse, they all have noted LGB youth are less likely to use condoms or hormonal contraception than their heterosexual peers. For example, in the study of the YRBS data from the 13 different US states and cities where they included a measure of sexual orientation, heterosexual teens in most regions were more likely to report using a condom the last time they had sex than LGB youth and were also more likely to report using birth control pills (Kann et al. 2011). There were sometimes differences between bisexual youth compared to their lesbian and gay peers as well, but generally heterosexual youth were more likely to use contraception. This was also found in Minnesota (Gallart and Saewyc 2004), in British Columbia (Saewyc et al. 2008b), and in New Zealand (Rossen et al. 2009). One of the limitations of using such measures is none of the surveys actually asked whether their sexual partner at last intercourse was the same or opposite sex, so it is possible that LGB youth were less likely to use contraceptives because they did not need to prevent pregnancy.

There are several other risk factors associated with teen pregnancy involvement in the general population, and all of them have some evidence that LGB teens are more likely to experience that risk factor than heterosexual teens. One such risk factor is early sexual initiation, for example before the age of 13 or 14. In several studies, LGB youth were more likely to report early sexual initiation (Goodenow et al. 2008; Kann et al. 2011; Saewyc et al. 2008b). Early sexual initiation may be associated with sexual abuse or coerced sex, and sexual abuse itself is strongly associated with teen pregnancy involvement for both girls and boys (Saewyc et al. 2004a; Homma et al. 2012). There is extensive evidence that LGB youth are more likely to report a history of sexual abuse or assault than heterosexual youth; Friedman and colleagues (2011) conducted a meta-analysis among existing population-based studies that documented the higher rates of sexual abuse among LGB youth.

Other forms of violence, such as physical abuse, bullying in school, sexual harassment, and dating violence, have been linked to teen pregnancy involvement in the general population (Saewyc et al. 2010). Here again, there is extensive evidence from the meta-analysis in North America (Friedman et al. 2011) that sexual minority adolescents are more likely to report physical abuse and bullying. Other studies in Canada have documented higher rates of dating violence among LGB youth compared to heterosexual teens (Smith et al. 2009).

One of the potential causes of inconsistent contraceptive use is having sex under the influence of alcohol or other drugs. Many but not all of the surveys in North America have found that LGB youth are more likely to have sex under the

influence (Kann et al. 2011). In fact, Herrick and colleagues (2011) recently conducted a meta-analysis comparing sexual minority youth and heterosexual youth on prevalence of sex under the influence. They found that sexual minority youth were nearly twice as likely to report having sex while intoxicated than heterosexual adolescents.

Having sex more often, with multiple partners, also increases the chances for pregnancy, provided that they are opposite-sex partners. The surveys from across North America have consistently found that LGB youth are more likely to report multiple sexual partners, either lifetime prevalence or in the past 3 months (Goodenow et al. 2008; Kann et al. 2011; Saewyc et al. 2008b). However, very few studies have actually assessed the number of sexual partners by gender of sexual partner. The Minnesota Student Survey and BC Adolescent Health survey are two of the rare surveys that include questions about the number of male and female sexual partners, and both have found higher numbers of sexual partners among LGB youth (Saewyc et al. 2008b).

Certain groups are more vulnerable to pregnancy involvement, in part because of their higher exposure to all of the above risks and others. For example, runaway, street-involved, and homeless youth have high rates of pregnancy involvement (Saewyc et al. 2004a; Smith et al. 2007), as do young people who have been in foster care (Smith et al. 2011). Extensive evidence documents LGB youth are disproportionately found among runaways, street youth, and homeless adolescents (Cochran et al. 2002; Smith et al. 2007). This may be because they come out and are kicked out, or leave home to escape family rejection; however, once on the street, they may experience sexual exploitation or be forced to engage in survival sex. Research among street youth in multiple cities in western Canada has found that LGB youth more likely to be sexually exploited than heterosexual street youth (Saewyc et al. 2008a). The analysis of teen pregnancy and sexual orientation in the 1986 Minnesota adolescent health survey also identified that lesbian and bisexual girls in school were more likely to have run away and were more likely to have been involved in prostitution than heterosexual girls in school (Saewyc et al. 1999).

In the general literature on teen pregnancy, there are protective factors associated with lower risk for pregnancy involvement. Two that have been most consistently linked to lower pregnancy rates are family connectedness, or supportive and caring relationships with parents and other family members, and school connectedness, which can be defined as a sense of belonging and being part of school along with feeling cared about by teachers and other school staff (Kirby et al. 2005). Even among youth who have key risk factors like sexual abuse, family and school connectedness appear to lower the odds of pregnancy involvement (Saewyc and Chen 2012). Do LGB youth have the same levels of protective factors? Data from both British Columbia and Minnesota document lower levels of family and school connectedness among LGB youth compared to heterosexual teens (Saewyc et al. 2009). Other research in Ontario, Canada, found lower levels of family relationships, but not school connectedness for LGB youth, most markedly for bisexually attracted youth (Busseri et al. 2006). Research among younger adolescents in the Netherlands, those who recognize same-sex attractions but may not be publicly self-identified as LGB yet, found that same-sex-attracted youth reported poorer relationships with fathers, lower social acceptance among peers, and lower school belonging (Bos et al. 2008).

Potential LGB Specific Reasons for Teen Pregnancy Involvement

Beyond the risk and protective factors that are generally associated with teen pregnancy, are there reasons that LGB youth give that explain their teen pregnancy involvement, or their higher rates of teen pregnancy that are specific to LGB youth experiences? To answer this question, large-scale population research studies are not as useful. They seldom include specific questions about LGB experiences. Instead, we

must turn to the small number of qualitative LGB-focused studies to shed light on the reasons for teen pregnancy involvement.

Qualitative research about the experience of teen pregnancy among LGB youth is rare. To date, only two studies in the published literature document discussions of the meaning of teen pregnancy to LGB youth. One study was limited to interviews with Black lesbians from a homeless shelter in the USA (Reed et al. 2011). The other study involved focus groups of LGBTQ youth and adults who worked with them in Toronto, Canada; although, it should be noted that few of the youth in that study had actually been involved in pregnancy (Travers et al. 2011). In addition to these published studies, a masters project from the University of Minnesota provided information from 10 female-born sexual minority youth who had been pregnant, several of whom were also parenting (Fletcher 2011). All three of these studies found similar, as well as quite different, reasons for pregnancy involvement among LGB youth.

One of the reasons described in the study by Travers et al. (2011) was the ways in which heterosexism, and the pressures around being heterosexually active, contributed to risk for teen pregnancy involvement. They suggested the invisibility of sexually diverse examples of relationships, and the pressures to conform to heterosexual norms, led to LGB youth engaging in heterosexual sex as “proof” of heterosexuality, or to hide same-sex attractions. In addition, the groups felt there was a lack of awareness that opposite-sex sexual behavior can lead to pregnancy, in part because so much of the focus for gay and bisexual males is on HIV and STI prevention. These two ideas of heterosexual camouflage and lack of awareness about one’s own risk were partly supported in Fletcher’s study (2011), where many of the pregnancies had been unintentional, and some participants from small towns actually suggested that they provided a counter to being perceived as gay or lesbian. However, this invisibility or camouflage was not always perceived as positive, as several of the young women expressed frustration with beliefs among their social groups that one could not be LGB and pregnant at the same time, and that the assumptions of heterosexuality that went with pregnancy and parenting limited their opportunities for same-gender relationships, or being included in LGBTQ space.

In contrast, in the study among Black lesbians (Reed et al. 2011), their narratives contradicted the idea of getting pregnant as a way of accessing heterosexual privilege, or as camouflage, although some of the young women identified heterosexual dating and sexual behavior as a form of camouflage, and this led in some cases to unintentional pregnancy. However, in their social circles, pregnancy and childbearing were not considered mutually exclusive with their lesbian identities, as it was quite common; it was only unintentional pregnancies that appeared to create stress around identity. These qualitative studies also supported additional risks for pregnancy such as sexual abuse and homelessness, especially being kicked out due to coming out; indeed, in Fletcher’s study (2011), two of the pregnancies were a direct result of sexual abuse or sexual assault.

The idea of using heterosexual intercourse or pregnancy as stigma management or camouflage to deflect further homophobic violence and discrimination has some population-level support in a study from the British Columbia Adolescent Health Survey (Saewyc et al. 2008b). Sexual minority youth who had experienced higher levels of discrimination and harassment were more likely to be involved in a pregnancy. This is, however, indirect evidence, as it is unclear whether youth were becoming pregnant to deflect violence, or to cope with existing homophobia, or for other reasons; when one cannot ask directly about reasons for pregnancy, or decisions around parenting, it is difficult to know how people make sense of their experiences.

Another possible explanation for teen pregnancy involvement has to do with both the impact of homophobia and potentially positive changes in status that can come with parenting. Given in most societies motherhood and fatherhood are positive roles—in the Western world, there are even annual holidays for fathers

and mothers—there is a thought that LGB youth who are exposed to constant negative messages about being lesbian, gay, or bisexual might choose to become pregnant as a way to reach for a more positive self-concept (Saewyc et al. 2008b). This idea was supported, in part, by the study by Travers et al. (2011), and the study by Reed and colleagues (2011).

Does LGB Teen Pregnancy Involvement Result in LGB Teen Parents?

One area that is not well documented is whether higher risk for teen pregnancy involvement among LGB youth actually leads to LGB teen parents. For the most part, the surveys that ask about sexual behaviors and pregnancy do not ask about the outcomes of those pregnancies, and surveillance around births or abortions does not usually include asking about the sexual orientation of the pregnant woman or her partner. To date, only two adolescent health population surveys that ask about sexual orientation have included measures of teen parenthood, the Minnesota Student Survey of 1998, and the Seattle YRBS of 1999. In both cases, sexual minority youth were disproportionately more likely to be teen parents (Forrest and Saewyc 2004). There have been no population studies documenting teen parenthood among sexual minority youth since 2000.

Teen Pregnancy Prevention for LGB Youth

With a clearly documented disparity in teen pregnancy for LGB youth, it would be useful to develop programs to prevent unintended pregnancy among these young people or incorporate LGB-specific content in prevention initiatives already developed for the general population. At present, the only program that has any evidence of effectiveness is a study that examined the effectiveness of gay-sensitive sexual education in preventing risky sexual behaviors among LGB students in Massachusetts, although not specifically focused on pregnancy involvement (Blake et al. 2001). This program found that inclusive education was associated with fewer sexual risk behaviors, including those that could lead to unintended pregnancy.

While there are no intervention studies that focus on pregnancy prevention among LGB youth, research that examines risks and protective factors for teen pregnancy involvement among LGB youth may provide some suggested areas for intervention. A study examining the protective factors linked to lower odds of pregnancy involvement among bisexual youth in British Columbia and Minnesota, drawing on 3 surveys in each region from the 1990s and early 2000s, found most of the same protective factors that are linked to reduced sexual risk and lower rates of teen pregnancy in the general population were also linked to the same positive outcomes among LGB boys and girls (Saewyc et al. 2008c). Family connectedness and perceptions that parents care were strong protective factors for both males and females, in both British Columbia and Minnesota, in all cohort years, with age-adjusted odds ratios of .01 or lower for the highest family connectedness. School connectedness was also a strong protective factor in most years for both boys and girls, with age-adjusted odds ratios of .10 or lower at high levels of school connectedness. Extracurricular activities, such as sports involvement, groups and clubs, arts and music, and community volunteering, were all significantly associated with lower odds of pregnancy involvement. Religious involvement or spirituality, however, which is often associated with lower levels of sexual risk behaviors and teen pregnancy among heterosexual teens, was not a protective factors for bisexual adolescents of either gender in any cohort, and in a couple of the years, high levels of religiosity or spirituality increased the odds of pregnancy involvement (became a risk factor, not a protective factor).

Thus, although sexual minority youth generally have lower levels of these important developmental protective factors, those who do have positive relationships with parents and

families, who feel supported and connected at school, and who are engaged in their community, appear to have lower levels of risky sexual behaviors and teen pregnancy involvement. To the extent that interventions can focus on reducing the risk factors (preventing sexual abuse, homophobic bullying, sex under the influence, etc.) and foster these protective factors among LGB youth, they may contribute to reducing the higher rates of teen pregnancy involvement.

Implications for Research and Practice

Given the state of the evidence about teen pregnancy among sexual minority youth, documented in several countries, across more than 20 years, what are next steps for narrowing the gap between LGB youth and their heterosexual peers? How might we prevent unintended pregnancy among this relatively hidden population of young people?

One of the first priorities is identifying how common this issue is in countries where they have begun to document same-sex attractions, behaviors, or LGB identities among young people, but where they have not examined sexual risk behaviors and teen pregnancy involvement. The stigma linked to a sexual minority identity is pervasive throughout the world, and in the same way that higher levels of suicidal thoughts and suicide attempts have been noted among LGBT youth populations in such diverse parts of the world as Guam, Turkey, Norway, New Zealand, and Canada, it seems likely that teen pregnancy rates are higher for LGB youth in various countries throughout the world, too. However, teen pregnancy rates vary widely throughout the world, and LGB youth are influenced by their culture and context, social norms and opportunities in addition to stigma; perhaps this higher risk for teen pregnancy only manifests in some countries and not others. Until we routinely monitor the sexual and reproductive health of all youth, including LGB youth, we cannot be sure how common teen pregnancy occurs for this subset of the population.

Another important area for research is tracking the outcomes of teen pregnancy among LGB youth, even in countries where they document pregnancy involvement. What percent of pregnant teens give birth, miscarry, or terminate their pregnancy? And, among those who give birth, what percent choose to parent, place for adoption, or make other arrangements for their offspring? Until we understand pathways to and decisions after pregnancy, we will not be able to address the reproductive health needs of LGB youth. Nor will we be able to support them as young parents when children are born. The lesbian and bisexual teen mothers interviewed in Minnesota mentioned how difficult it was to find support networks who understood both being LGB and parenting, rather than one or the other (Fletcher 2011).

More research is needed to understand the reasons that LGB youth decide to become pregnant, and the outcomes of those pregnancies, as well as the differing contexts that might influence their pregnancy involvement. So far, the research about the meaning of pregnancy and the lived experiences of those who have been pregnant have been focused almost exclusively on young women, among ethnic minority young women, and among those who have experienced homelessness. Yet the wide array of population studies have identified higher rates of pregnancy involvement among both boys and girls, of all ethnic groups, among young people in school, and thus far less likely to be homeless youth. It is unlikely the reasons and experiences of pregnancy for the varied groups of LGB youth are going to be wholly consistent and that one size will fit all in pregnancy prevention interventions.

When it comes to interventions, we need to develop innovative interventions that address the key contributors to higher rates of pregnancy involvement: stigma, sexual violence, a lack of social support from families, schools, peers and community organizations, and the lack of sexual minority content in sexual health education. With the exception of the latter, most of these interventions are not likely to fall within the scope of practice of sexual health educators

(Kirby et al. 2005). Effective interventions to change these risk factors could also address a wide array of health inequities for sexual minority adolescents beyond sexual risk behaviors and pregnancy, such as higher rates of suicide attempts and substance use. Public health nurses and other health professionals, as well as principals, teachers, and counselors in schools and staff in various community organizations, could all bring a wider lens of prevention interventions to the issue of pregnancy involvement among LGB youth.

Beyond developing innovative interventions, we need to rigorously evaluate those programs and initiatives to determine their effectiveness in reducing key risk factors, or in promoting protective factors, and ultimately we need to know whether they influence the sexual risk behaviors among LGB youth that lead to unintended pregnancy. Some of these strategies may involve adapting existing evidence-based initiatives to ensure they are appropriate for LGB youth experiences; others may need to be developed from the beginning, in very different approaches, to be effective. Understanding what works, and equally importantly, *how* it works, are also important elements to changing this health inequity.

Conclusion

Teen pregnancy is an issue for lesbian, gay, and bisexual adolescents, both boys and girls, in several countries, and appears to be a higher risk among sexual minority youth compared to heterosexual teens. Some of the common risk factors that are linked to teen pregnancy involvement in the general population appear to occur at even higher rates among LGB young people, which may help explain their higher risk. LGB youth also report lower levels of some of the supportive factors that reduce the odds of pregnancy involvement in the general population, yet when they do have these protective factors at high levels in their lives, they are less likely to become pregnant or cause a pregnancy. We still know very little about why LGB teens become pregnant, or what their lives are like if they decide to parent, and there are almost no interventions developed to prevent teen pregnancy among sexual minority adolescents. More than twenty years after this phenomenon was first empirically documented, it remains a relatively hidden issue, with limited attention among LGBTQ communities or among the wider society focused on addressing this health issue.

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Teenage Pregnancy in Argentina: A Reality

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Keywords

Argentina: adolescent abortion · Adolescent pregnancy · Conceptualization · Maternal mortality · Sexual abuse · Sexual and reproductive health · Risks in teenage pregnancy · Social cost of adolescence pregnancy · Sexual abuse

Introduction

Adolescence is the period of time during which a series of developmental modifications take place, not only physical but also psychological and social development, which directly influence the individual, her life trajectory, and her social and family behavior. Therefore, when a girl becomes pregnant during adolescence, it creates a complex situation for the adolescent and her relatives. As such, teenage pregnancy that is often unintended may at times represent a hidden wish by the teenager to start her own family. No less important, however, it may represent a hidden sexual abuse that has not been reported. These are conditions that may have different outcomes depending on the personality, the environment, and sociocultural background of the teenager, as well as the professional care she receives during her pregnancy.

Even though sexual maturity among females begins at different times after menarche, the age in which women decide to have their children, apart from individual reasons, is conditioned by the culture and society in which they live, the degree of development of the country and the educational level of its residents. Health and education of teenagers, and young people are a key element in the social and economic development of a country. Nevertheless, their needs and rights frequently are not taken into account in public policies or in the health sector agenda. This neglect is a current reason why teenage pregnancy has become a priority health issue. It is an issue not only because of the number of adolescent pregnancies, but also for its repercussions in the public health of many countries in the world, especially in developing countries. In this chapter, the most important aspects related to pregnancy during adolescence in Argentine will be discussed.

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Conceptualization

The World Health Organization (WHO) defines adolescence as the period of life between the age of 10 and 20, during which individual reproductive maturity is acquired, psychological development goes through a transition from childhood to adulthood, and where her socioeconomic independence is established.

This period of life may be subdivided into three periods, each of which has its own characteristics:

Early Adolescence (10–13 years old): The prepubertal period is characterized by important physical and functional (menarche) changes. The young show interest in their parents and belong to groups of friends of their own sex. Their fantasies increase and they cannot control their impulses. They show great uncertainty about their physical appearance.

Middle Adolescence (14–16 years old): Adolescence itself. Youngsters have completed their growth and development. Their relationship with their peers is in its maximum splendor, and there are frequent conflicts with their parents. This is the age range when sexual activities begin. They feel invulnerable, omnipotent, and very concerned about their physical appearance (fashion).

Late Adolescence (17–19 years old): They accept their bodily image and they often come closer to their parents again. They develop values and a more adult perspective. They value intimate relations and their groups of peers start losing hierarchy. True vocational goals appear.

Therefore, according to the definition, during adolescence, deep biological, psychological and social changes are experienced and in many cases, they set the initial footstep to sexual activity. Each young person will go through this period in different ways, and this will be subject to his or her singularity, own characteristics, family, peer group and community.

Biological maturity and reproductive capacity are the most important achievements in puberty. They are related with maturity, growth and sexuality and will be experienced accordingly to how sexuality has been constructed and transmitted in each family. Knowing the characteristics of these stages is important to be able to interpret attitudes and behaviors of teenagers during pregnancy, bearing in mind that "a teenager that gets pregnant will behave as any other person that is going through that stage, without maturing into later stages simply because she is pregnant" (Issler 2001).

Table 1 Estimated average of pregnancies according to ethereal groups, with intervals ranged within 5 years (2000–2005)

Continents	Births (total)	15–19 years old	Total %
Africa	31,458	4,9851	15.8
Asia	77,985	6,039	7.7
Europe	7,064	494	7
LAC[a]	11,662	1,904	16.3
North America	4,565	558	12.2
Oceania	549	40	7.3
Total	133,283	14,020	10.5

[a] *LAC* Latin America and the Caribbean. OPS (Organización panamericana de la Salud)

Although the developmental rhythm moves faster than the growth of emotional relations, this does not imply that the young are apt to assume maternity or paternity. An increase in teenage sexual activity and a decrease in the age at which sexual relations begin have been shown worldwide to increase adolescent pregnancy. Because of the above, we may define *teenage pregnancy as a pregnancy that takes place within the two first years after menarche age and/or when the adolescent is still dependent on her origin family nucleus* (Coll 2005).

Adolescent Pregnancy in the World

In order to understand the situation of adolescent pregnancy in Argentina, it is necessary to locate it in a worldwide context to be able to compare it with countries, which share the same characteristics. Table 1 shows the results of percentages for each continent, observing that 10.5 % (14

Table 2 Relationship between number of births and degree of development

Countries	Total of births	15–19 years old	Total %
Developed	13,092	1,079	8.2
Developing	92,558	8,192	8.9
Underdeveloped	27,633	4,748	17.2
Total	133,283	14,019	10.5

Table 3 Births, discriminated by age in South America and Mexico

Countries	Births (total)	15–19 years old	Total %
Argentina	726	99	13.6
Bolivia	256	36	14.1
Brazil	3,492	629	18.0
Chile	285	29	10.2
Colombia	975	165	16.9
Ecuador	296	43	14.5
Mexico	2,299	334	14.5
Paraguay	172	23	13.4
Peru	628	73	11.6
Uruguay	57	9	15.8
Venezuela	581	119	20.5
Total	9,767	1,559	16.0

million) of the 133 million pregnancies around the world are to mothers between 15 and 19 years old. The higher concentrations are in Africa, Latin America and the Caribbean.

Analyzing adolescent pregnancy in relation to the degree of the development of the country illustrates the differences (see Table 2). Worldwide, approximately 10 % of the children born per year are born to adolescent mothers. In developed countries, 8.2 % of births are to adolescent mothers. While in the underdeveloped countries, 17.2 % of births are to adolescent mothers (United Nations Population Division 2011). This figure represents double births to teenage mothers than in developed countries.

Lastly, in Table 3 the percentage of births in South America and Mexico are presented. These percentages show that 16 % of the children born were born to adolescents ranging from 10.2 % (Chile) to 20.5 % (Venezuela) (Coll 2005; United Nations Population Division 2011).

Another method to approach this issue is through the adolescent fertility rate (AFR). This is the number of births per thousand among adolescents in a given country. Using this definition, *it is estimated that 49 per thousand births in the world from 2000 and 2005 were to adolescents* (Coll 2005). The story, of course, is in the range of the variation of births to adolescents, country by country.

The countries with the highest levels of adolescent fertility are located in Africa, such as Liberia, Niger, Sierra Leona, Somalia and Uganda. Additionally, in these countries, the average ATR exceeds the 100 per thousand. On the other hand, among countries in Asia, the AFR is estimated to be 35 per thousand. This is significantly below the World average ATR, but a closer examination shows even among countries identified as Asia, there are major differences in ATR. Conspicuous differences can be found. Afghanistan, Bangladesh, Nepal and Yemen report AFRs that are over 100 per thousand. Conversely, countries such as Japan, China, North and South Korea, and Singapore have the lowest AFRs in the world. Rates in these countries are similar to the ones in some European countries such as Holland, Switzerland, Italy, Spain, and Sweden (among others), which have rates from 3 to 6 per thousand of adolescent-mother births. In the U.S.A., the birth rate for teenagers ages 15–19 fell from 42.5 in 2006 to an all-time low of 31 births per 1,000 teens in 2011, down 8 % from 2010 (CDC statistics 2012).

In Latin America, the birth rate for teenagers was 72.4 per thousand in 2007. Thus, similar to what is found in other continents, there are countries such as Guatemala (97 per 1,000, data from 2006), Honduras (108 per 1,000, data from 2003), or Nicaragua (108 per 1,000, data from 2005), with high rates and countries such as Guadalupe (20.5 per 1,000, data from 2004) and Martinique (20 per 1,000, data from 2007) with a relatively low rate of adolescent fertility. Argentina, with an estimated level of adolescent fertility of 60.6 per thousand is rated below most of its neighbors: Bolivia (88.7 per 1,000, data

from 2005), Brazil (71.4 per 1,000, data from 2008), Paraguay (63 per 1,000, data from 2007) and Uruguay (59.7 per 1,000, data from 2007), and above of Chile (54 per 1,000, data from 2008). Another way to look at the number of adolescent pregnancies is to note that *one out of every six births in Argentina* is to a girl between 15 and 19 years of age (Downes 2005). Given these numbers, adolescent pregnancy, as a problem is not an illusion, but a cruel reality. Among the 700,000 babies that are born annually in Argentina, 100,000 are children born to mothers that are younger than 20. These 100,000 babies are not even their firstborn. Some 30 % of these mothers give birth to their second or third child before their 20th birthday (Lovera 2010).

Epidemiology in Argentina

According to official statistics, in Argentina, 14.6 % of the babies born alive are born to parents that are under 20 and most of them come from impoverished families. The numbers are unprecedented, 17 of every 18 teen moms live in poverty, a difference that reflects serious social inequity (3–15) (Lovera 2010; Coll 2005). This socioeconomic disparity is a barrier to these adolescent girls accessing their sexual and reproductive rights in our country.

For Cecilia Correa, from the foundation for the study of women (FSW), "one of the facts that has the incidence in adolescent pregnancies is poverty." But, inevitably, the difficulties for the development of a responsible sexuality and the prevention of unintended pregnancies are more complicated in a country where 66.7 % of the people under 18 are poor (Permanent Home Survey; INDEC: National Institute of Statistics and Census May 2003).

The AFR, in Argentina shows an average of 60 per thousand since 2000–2005 (Salvo 2011) (Table 4).

The fertility rate varies from one jurisdiction to the other within our country. Thus, the early fertility rate in the autonomous city of Buenos Aires was 0.6 per thousand while in Chaco, it was 5.2 per thousand in 2001. The fertility rate in the city of Buenos Aires in the year 2005 was 23.9 per thousand, and in the province of Misiones, it was 100.4 per thousand. Even though the economic development and the culture shape the regional differences, the northwest provinces have similar levels of poverty, yet the fertility rates in the northwest are significantly lower than provinces in the south of the country. Typically, fertility rates in the south are as high as the ones found in Misiones.

In our country as well as in the rest of the world, teenage maternity has an inverse relation with the level of education. The proportion of mothers with low levels of education is almost three times higher than in the case of mothers with higher level of education (Coll 2005). See Table 5.

Table 4 Variations in the fertility rate in early- and late-adolescence from 1960 to 2005

Year	Fertility rate per thousand	
	Age: 10–14	Age: 15–19
1960	1.0	58.4
1970	1.9	65.5
1980	2.3	78.3
1991	1.9	69.9
2001	1.8	62.2
2005	1.6	62.8

(Pantelides y col. Revista Argentina de Sociología 2013)

Table 5 Relationship between educational level and the age in pregnant adolescents

Age group	14	15–17	18–19	Total
No instruction	7.8	20.3	39.7	26.3
Primary (incomplete)	4.6	18.9	47.6	20.1
Primary (complete)	7.5	23.9	146.3	35.0
Secondary (incomplete)	2.1	4.7	19.8	7.4
Secondary (complete) and higher			7.1	7.2

Adolescent Pregnancy and Level of Education

Teenagers that have had pregnancies or children born alive have a lower level of education. In fact, about 20 % of pregnant teens did not finish their primary level of education; while among girls who did not become pregnant only 4 % did not finish their primary level of education (Weller 2000). It is also noteworthy that related to the social characteristics of these girls up to 49 % of the adolescents that are mothers live in inadequate housing and only 27 % have health coverage (Pantelides and Binstock 2007).

Traditionally, adolescent mothers have been thought of as single parents or mothers that do not have a partner, but research shows that more than half are married. This suggests a relationship between becoming pregnant and getting married or at least living together as a consequence of the pregnancy, or that this union constitutes a family (see Table 6).

In relation to the partners of adolescent mothers, two different situations are typical. Adolescents between 18 and 19 years of age, usually live with males between 20 and 24 years of age (approximately one-third of the cases) or they live with male partners between 25 and 29 years of age (15 %). On the other hand, a completely different situation is found among "infant mothers," girls between 9 and 13 years of age. In this age group, 80 % of girls had children with males that were at least 10 years older than the adolescent mother. The remaining 20 % live with males that are at least 20 years older than they are. The age of the young mother suggests the possibility of the presence of cases of sexual abuse, rape, and even incest (Pantelides and Binstock 2007; Weller 2000; Coll 2005).

Finally, it is important to note that a great percentage of Argentine adolescent mothers are not first-time mothers. Some 31.9 % of the adolescents in 1995 were mothers for the second time, 9.2 % were mothers for the third time, and 2.5 % were mothers for the fourth time (Pantelides and Binstock 2006).

Table 6 Relationship between age group and marital status among adolescent parents

Marital status	Age: 14	Age: 15–17
Single	1.9	3.9
Illegal union	35.8	56.4
Married	66.7	62.1
Others	15.4	21.0

Pantelides and Binstock. INDEC National Institute of Statistics and Census. Data from 2013

Pregnancy and birth among young girls are of concern because giving birth at a young age and short-term intergenesic intervals are the main risk factors related to poor birth outcomes of both the mother and the child. These data give additional information about two facts: first, adolescent girls who get married or live with a man at a very early age and have children as a "natural" part of the couple's life. The second situation is adolescent girls who had not been sufficiently educated about the risks associated with adolescent pregnancy, rapid repeated pregnancy, a lack of motivation and resources (material and also cognitive) to use a contraceptive method (Weller 2000).

Adolescent Sexual Initiation

A research study carried out in 2003, by the Argentinian Society of Infant-Adolescent Gynecology named, *Exploratory research on the characteristics of growth development and sexual and reproductive health care in the adolescent population in the different regions of the country* showed that the average age at which sexual relations start in Argentina was 15.6 ± 1.7 years old. Of the 1,034 adolescents who participated in the study, 146 (14.1 %) were pregnant at the time of the study and 318 (30.8 %) girls had been pregnant in the past. The average age of the first pregnancy was 16.6 ± 1.6 years ranging between 10 and 20 years of age (Oizerovich 2011).

Why Do Argentine Teenagers Get Pregnant

There are predisposing and determinant factors involved in adolescent pregnancy that help identify teenagers at high risk. Related to these factors, it is probable that the reasons an adolescent girl does not end her pregnancy are the same reasons she became pregnant (Issler 2001; Ashkenazi 2011; Coll 2005).

A. Predisposing factors:

1. *Early menarche*: Reproductive maturity before the adolescent is ready to handle situations of risk is a contributing factor.
2. *Precocious beginning of sexual relations*: Lack of emotional maturity to make decisions that take into consideration pregnancy prevention and the consequences of not using contraception is a factor.
3. *Dysfunctional family*: Adolescent promiscuous behavior is often an indication of family dysfunction. Typically, it is the lack of a protective and supportive family. The lack of love within the family often drives a young woman to look for attention and affection rather than true love.
4. *More tolerance*: Girls from social backgrounds where adolescent motherhood is more acceptable, especially among low-income families with low educational level.
5. *Low educational level*: The existence of a life goal that prioritizes the completion of their education and a plan to delay maternity until reaching adulthood increases the probability that the adolescent will use an effective contraceptive method.
6. *Recent migrations*: The effect is often a loss of family bonds.
7. *Magic thoughts*: Common to adolescence, this is a stage of life when they believe they will not get pregnant because they do not want it to happen.
8. *Fantasies of sterility*: Some adolescent girls who do not use contraception when they begin sexual relations, and when they do not get pregnant by chance, they think they are sterile.
9. *Lack or distortion of information*: "Myths" circulating among adolescents can have a major impact. Sexual education can modify myths such as: You can only get pregnant if you have an orgasm or when you are older, or when you do it when you are menstruating, or when there is no full penetration.
10. *Conflicts between adolescents and parents' value system*: Severe restraints within the family *against sexual relations between adolescents* may provoke young people to have sex just to rebel. At the same time, as a way to denying that they are sexually active, they do not implement contraceptive measures.
11. *Demographic factors*: Adolescent girls make up some 50 % of the female population.
12. S*ociocultural factors*: The sense of sexual freedom that is overvalued in the media has a profound effect on adolescent sexual behavior. Evidence of a change in adolescent sexual attitudes has occurred at all socioeconomic levels.
13. *Sexually transmitted infections*: Adolescent sexual activity increases when there is less fear of venereal diseases.

B. Determinant factors:

1. *Sexual relations without contraception.*
2. *Sexual abuse*.
3. *Rape*.

A Psychosocial Perspective on Argentinian Adolescent Pregnancy

Analyzing adolescent pregnancy from a psychosocial point of view, it is clear that adolescent pregnancy is a phenomenon that takes place in all the social strata. However, it is also clear that adolescent pregnancy is experienced differently at different social strata levels. In the middle or higher strata, Argentine adolescents have several options if they decide to interrupt the gestation. Girls from the middle and higher strata tend to have more control over the decision to terminate the pregnancy or have the

child. In either case, these adolescent girls will have access to adequate reproductive health care. In contrast, girls from the lower social strata may continue with the pregnancy and have the child because either they cannot afford interrupting the pregnancy or because there is more tolerance of adolescent maternity among her peers and community.

Adolescents from poor or repressed communities, who have few opportunities to get an education and improve their lives economically, frequently see maternity as a way to increase their own value. Many times, adolescent pregnancy is unintentional. It was not a conscious decision. With some girls, the pregnancy is a conscious decision. It might be a girl's only reason to live. The girls often believe the expected child will fill the emptiness they feel in their lives (Coll 2005).

In their fantasies, the pregnancy may represent a reaffirmation of their corporeal integrity, of their value as a person, of their identity, and of the possibility of leaving their family group (generally, dysfunctional) and acquire an adult pseudo-identity. On occasions, it is this child to whom they give their affection and of whom they take care of, the one that offers them that feeling of belonging that is so important for their self-assessment (Issler 2001).

The effective use of contraception is also complicated by tradition values and ideas of sexual freedom. The conscious and planned use of contraception is considered an admission of being sexually active. For many girls admitting that they are sexually active is difficult because it is in conflict with the traditional view of a young woman. Meanwhile, many of these girls want to be certain they are adults and fertile. A pregnancy confirms their fertility. This form of magical thinking also interferes with the adoption of preventive measures that would protect them in sexual relations and would also help to protect them from sexually transmitted diseases, drug addiction, etc. (Ashkenazi 2011; Weller 2000).

Adolescence: A Balance Between Risk and Protection

In a cross-sectional study (carried out in Argentina in 2003 by the Argentinean Society of Infant-Juvenile Gynecology), fundamental problems faced by adolescents, and thus, Argentine society was explored. Interviews were conducted with 1,477 young people across Argentina. To the question about occupation, 80.1 % said they did not work, 13.1 % said they did work, 6.8 % occasionally worked or worked part-time.

In relation with schooling, 67.3 % were in the educational system and 32.7 % were not. When asked about their group of coexistence, 53.4 % lived with their biological family (mother and father). Some 25.18 % lived with a single biological parent. There were 20.3 % living with a partner and others, 0.6 % lived alone with a child (ren), and 3.92 % lived in other situations (Oizerovich 2011).

The degree of exposer to risk factors (such as dangerous behavior) and the presence of protective factors will fundamentally affect the health of a teenager (Ashkenazi 2011).

Risk Factors that Adolescents are Exposed to may be Classified as:

Personal—such as alcohol, drugs, depression, frustration, chronic diseases, spending time in jail, living in the streets, the lack of future plans, lack of education, being physically or mentally handicapped, etc. As a consequence, in Argentina statistics show that about 75 % of the young people are under 25 years of age, consume alcohol on weekends, and they view drinking as a synonym for fun (Torresi 2001). The Secretary of Planning for the Prevention of Drug Addiction and Narco-trafficking (Sedronar) show that during the year of 2001, 3 % of the young people between 12 and 15 years of age had some kind of contact with drugs. Specialists point out that young drug users, alcohol abusers, and adolescents who dropout of school have become a normal part of society. In

Argentina in 2001, more than 1,200,000 young people were not studying or working and many of them were involved with alcohol and drugs at an earlier age (Calvo and Sayoia 2004).

Relative—conflicting and dysfunctional families, domestic violence, sexual abuse and maltreatment, and immigration are risk factors. In Argentina, one in every three couples gets divorced after an average of 12 years of marriage. The most common reasons are slanderous allegations (46 %), abandonment of the home (34 %), and adultery (13 %). Some 93 % of the children are left under the custody of the mother (Fourcade 2008).

Social—involvement with peers, friends, or groups that participate in high-risk behaviors, or lack of acceptance by their peers, and lack of a positive role model.

There also are Protective Factors in the Life of Adolescents:

Personal—such as having good nutrition, practicing care of oneself in both hygiene and diet, having a future plan, and having developed critical thinking are protective factors.

Relatives—a stable family where the adolescent receives positive attention, emotional support, and families with access to health care services are protective factors.

Social—participating in social activities, formal education, having work opportunities, having access to health services, and respecting other people's rights are also protective factors. In 2008, the program "Young people with more and better jobs" was created and that benefits about 6,000,000 young people, especially those who have not completed their secondary school studies. The goal is to move these young people into the working world (Archivo.lacapital.com.ar).

In the management of health and social characteristics of teenagers, it is necessary to involve the family. Families with teenage children must deal with three types of threats from the environment: (a) demands of school, work, peers, community, etc. (b) perceptions based on myths, traditions, the media, values, beliefs, etc., and (c) expectations, aspirations, or family's needs.

Each family goes through different situations throughout their existence: becoming a couple, the birth of the first child, the birth of other children, school admittance, children going through adolescence, children leaving home, and the couple being alone again. Facing these changes inevitably supposes recognizing it as a change and requires the work of changing behaviors, attitudes, and roles. A lack of dealing with any of these areas may create pathological or dysfunctional behavior. Other situations that tests the family capacity to adjust and specifically the capacity of an adolescent within the family that may include working or economic changes, deaths, moving, supporting grandparents, accidents, parents menopause, diseases, etc. (Ashkenazi 2011).

Adolescent Pregnancy Risks

According to the UNICEF report, "The Global Situation of Children in 2009," the younger a girl gets pregnant, the higher the risks to her and her baby's health. Worldwide, each year, about 70,000 girls between 15 and 19 years of age die giving birth due to pregnancy complications, most of them in developing countries (UNICEF 2009).

If the mother is under 18, her baby has 60 % of chances of dying during its first year of life, risk that reduces dramatically if the mother is over 19 years of age (Coll 2005). The World Health Organization defines maternal mortality as:

> …the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.

Based on this definition, the WHO has calculated that more than 1,500 women and girls die every day as a result of preventable complications

Table 7 Rate of adolescent deaths in relation to the total of maternal deaths grouped into two groups [a](10–19 and 20–24 years old)—1999

Causes	Total of maternal deaths[a]	10–19 years %	20–24 years %
All the causes	282	13.5	16.6
Pregnancy ended in abortion	87	11.5	23.0
Direct obstetric causes	175	13.5	14.8
Hypertensive disorders	52	27.0	7.7
Previous placenta	20	5.0	15.0
Postdelivery hemorrhage	28	10.7	10.7
Sepsis & other complications	29	6.9	20.7
Other direct causes	46	6.5	21.7
Indirect obstetric causes	20	25.0	5.0

[a] Per thousand. *Source* Ministry of Health. Life Statistics. Basic Information. 1999

that occur before, during, or after pregnancy and delivery and that global maternal mortality, together with accidents, are the main reasons of death during the reproductive period of the lives of women and girls (United Nations Population Division 2011). Women under 20 that get pregnant cannot escape from the causes of global mortality. The percentages of maternal deaths during the year of 1999 differentiated by age groups in Argentina are depicted in Table 7 (Coll 2005).

After 2008, according to the Argentine National Ministry of Health, there were 296 maternal deaths, 39 of which were under 20, 20 % were abortions, and 74 % were due to direct obstetric causes. Highlighting the fact that these statistics showed no significant changes from earlier years and that the risk increases much more in under-15 patients, this makes this age group highly vulnerable.

There are social and biological aspects that make pregnancy during adolescence a high-risk condition:

- Pregnancies among girls, under-15 years should be investigated for the possibility of sexual abuse.
- Adolescent pregnancies, girls who are shorter than 1.50 m (about 5 ft tall) are more likely to present a premature or dystocia delivery.
- Weight is directly related to the nutrition of the mother and its progression. If the adolescent pregnant presents difficulties in gaining weight, then it may be suspected the possibility of a feeding behavioral disorder and/or sexual abuse.
- The educational level determines an adequate prenatal control and a better response and observance of medical instructions.
- Socioeconomical aspects are related with the equity of access to health systems and adequate treatments (Coll 2005).

Obstetric problems contributing to maternal–perinatal morbidity—mortality in this age group include:

Premature delivery: The earlier chronological or gynecological age of the adolescent is the higher risk of having under-weight children. Among the factors that may play a part and should be considered are genital tract infections, premature rupture of membranes, nutritional deficit, low height, use of noxious substances, multiple pregnancies, and/or inadequate perinatal care. Low weight newborns and longer stays in the hospital for the mother and child may lead to a higher risk of infections and neurological sequels (Ashkenazi 2011).

Anemia: In Argentina, 30–40 % of the pregnant adolescents are anemic and it is associated with poverty and their preconception nutritional deficiencies and with the lack of early prenatal care.

Hypertension induced by the pregnancy: The first delivery and the early maternal age are strong risk factors for developing hypertensive status.

Delivery and puerperium: Voto and associates in 1994 pointed out that labor and the delivery are particularly difficult for teenagers, both for the adolescents' attitude and for the lack of preparation of the physician to aid patients in such conditions. This study in the city of Buenos Aires shows that the duration of labor was similar in adolescents than in adults. However, the incidence of cesareans was 21.6 % in adults and 16 % in teenagers, and the incidence of forceps in patients under age 17 was twice that of adults (8 vs. 4 %) (Weller 2000).

According to the data published by the Pan-American Health Organization (OPS) within the same geographical area, it was found that the group between 10 and 14 years of age presented in most cases a total absence of perinatal controls and that in this group a greater incidence of complications was observed such as anemia, syphilis, pre-eclampsia, and premature deliveries. Furthermore, the younger the girl, the more serious and frequent the incidence of eclampsia (Pasqualini and Llorens 2010).

Abortion During Adolescence

Teenage pregnancy has become a serious concern for many sectors of society for more than 30 years, not only because of the implication for adolescent health, but also because of the bigger picture of unfavorable outcomes. The impact of abortion, psychosocial problems, and adverse consequences related to mental health issues are risk issues for the teenager and her family.

When a teenage girl becomes pregnant in Argentina, a complex process begins that will decide the course of the pregnancy, which includes the possibilities of an abortion (Issler 2001). To deal with the abortion issue in adolescence, it is necessary to take into account the cultural, social, and economic conditions that led to the young girl's unwanted pregnancy. Thus, abortion is not only a topic related to sexual and reproductive rights, but also a topic of gender dimension, social inequity, and health risks for the adolescents (Pons and Briozzo 2005). Thus, the circumstances that lead a girl or young woman to decide to interrupt a pregnancy are very complex. The reasons are associated with powerful influences of a social and cultural nature that varies widely all over the world.

Each year, 20 million unsafe abortions are performed in the world according to the WHO. Some 2.5 million abortions were performed on adolescents between 15 and 19 years of age. Of these, 97 % were performed in developing countries. Many die as a consequence of unsafe abortions. Around 68,000 women die and millions of others suffer from complications and permanent sequels. All these deaths are absolutely avoidable and perpetuate gender, social strata inequity, and injustice that separate rich nations from the poor (Vazquez 2011).

In Argentina, as in many countries in Latin America, abortion is an ongoing ideological debate. Abortion's *illegality* results in additional social control over woman's bodies. Women who seek an abortion or have abortions are stigmatized and ostracized. Even though the law allows for some exceptions (raped minor or mentally disabled person, life or a health threat to the mother), in the case of an adolescent, the law increases the likelihood of the girl having an unsafe abortion in unsafe conditions, which may severely compromise her future fertility and health (Pons and Briozzo 2005). According to Center of Estate and Society Research (CEDES), in the year of 2007, 450,000 unsafe abortions were performed per year, that is to say, almost one per each birth (0.64 abortions per birth) (Ashkenazi 2011).

During the last 20 years, the maternal mortality rate had been declining. However, in the year 2000 unsafe abortions began to increase once again, reaching 4.4 % of deaths per thousand born alive in 2007. In the same way, maternal mortality rates have remained unchanged during the last 15 years, with the complications of unsafe abortions as the main cause of mortality. Regarding adolescents, the figures have been increasing in the last few years in Argentina. In 2008, over 68 maternal deaths occurred as a consequence of an unsafe abortion, eight were adolescent (Ashkenazi 2011). According to the data collected for 2008, around

16 % of the hospital admissions for abortion complications were girls under 20 years of age.

In a research study, "abortion in minors under 16," conducted by the Institute of Maternity Nuestra Señora de las Mercedes, in the city of Tucumán, Argentina, it was determined that of the 647 pregnant adolescents admitted, there were 69 pregnancies (11 %) among girls between the ages of 10 and 16 years of age that ended in abortion. Approximately 15 % had had a previous pregnancy, 9 % did something to cause the abortion, and 7 % presented with complications most frequently, infections (Ciaravino et al. 2006).

Sexual Abuse and Adolescent Pregnancy

Sexual abuse during childhood is a risk factor for pregnancies during adolescence. Studies from different countries found that between 11 and 20 % of adolescent pregnancies are a direct result of rape; while 60 % of the adolescent mothers had at least a previous unwilling sexual experience before the pregnancy. Before the age of 15, most of the first sexual experiences had been against their will. The Guttmacher Institute found that 60 % of the adolescent mothers had been forced to have sexual relations with a man that was, at least, 6 years older than they were. One of every five fathers of the children of teenage mothers admits having forced the adolescent into having sexual relations with them (Wikipedia 2011; Guttmacher 2007).

In Argentina, there is no official statistical data on adolescent pregnancy due to sexual abuse, but it is known that in South American countries such as Chile, for instance, between 59 and 69 % of the rapes and between 43 and 93 % of sexual abuse, occur to minors under 20. In addition, it was found that among pregnant girls ranging from 16 to 19 years of age between 6 and 40 % had suffered from sexual abuse.

When these situations take place, associated facts reveal that 55 % of the adolescent rapes are intrafamily such as the father, the stepfather, and other relatives and people known by the family. Related characteristics that are frequently found include being an adolescent under 15, belonging to a low socioeconomic stratum, being a student, having partners older than 30 years of age, having negative attitudes toward the pregnancy and toward the child to be born, being a daughter of adolescent mothers, having a bad relationship with her parents, having a history of physical maltreatment, presence of a step-father or another coexisting man in the house, alcoholism in the family, and having a negative view of contraception (Issler 2001).

Sexual abuse in adolescence triggers a series of complications that often are not pondered such as:

- High frequency of unwilling pregnancies and children.
- High mortality of children under 5 years of age.
- High risk of acquiring STD's and HIV/AIDS.
- High frequency of post-traumatic stress disorder.
- High risk of repeated pregnancies.
- High risk of sexual assaults in adulthood.
- High risk of promiscuous behavior after a unique or repeated rape, especially when the rape is intrafamily and chronic.

All of these alter completely the perspective of integral health for the life of an adolescent (Mendez Rivas et al. 2005).

Adolescent Pregnancy: Social and Public Health Cost

Adolescent pregnancy has been and will be the topic of many studies and the focus of important social programs. However, the persistent nature of adolescent pregnancy in most of the world suggests the lack of effective interventions.

The major difficulty pregnant teens faced in Argentina are similar to those faced by pregnant adolescents worldwide:

- Globally, more than 500,000 women die each year of causes related to pregnancy and delivery and more than 20 million will suffer

from complications during their pregnancy and delivery.

- In general, 13 % of the maternal deaths are consequences of unsafe abortions. In developing countries, adolescents account for 2–4.4 % of abortions.
- Adolescent mothers do not complete their secondary studies; 80 % ends up without a partner and will need social programs to provide economic support for her child and herself.
- The children of adolescent mothers have a lower weight at birth, lower school development, and higher risk of abuse and maltreatment.
- The daughters of adolescent mothers also have a higher risk of being adolescent mothers themselves (Salvo 2010).

Moreover, young people represent a high proportion of the population in developing countries. It is well established that pregnancy among adolescents in these developing countries reduces the possibilities of social and economical progress. Unquestionably, the birth of a child in adolescence may alter the mother's, the father's, and the child's life, impacting their future not only in relation to their education, but also in relationship to their socioeconomic achievements.

Given these realities in Argentina, the national financial burden cannot be overlooked. According to the Latin American Center of Women and Health (CELSAM) (2003), "the risk of maternal death, eclampsia, puerperal infections, anemia, low birth weight, and premature birth are increased in the adolescent population." The Latin American Center of Perinatology and Human Development (CLAP) (2005) also stated among pregnant adolescents there is "a clear tendency of increment of preeclampsia, anemia, postdelivery hemorrhage, endometritis, percentages of cesareans, and a higher rate of maternal mortality." In addition, it should be noted that two of the most significant complications, premature birth and low birth weight are very costly in terms of extended hospitalization and in terms of long- and medium-term treatment of the sequels of these adolescent complications during pregnancy, birth, and postnatal care.

Follow-up data from the Hospital Posadas in Buenos Aires, Argentina collected over 11 years (1999–2009) showed that of the 44,086 children registered as born alive, 8,500 were children to mothers who were under 20 years of age. Some 1,043 (20 %) of the babies were premature, and 20 % were delivered by cesarean. According to the national medical insurance, a delivery module (that covers expenses for delivery and 48 h in hospital) costs $400 US dollars. This adds up to a cost of $45,588,400 US. Adding to the cost is the likelihood of an admission to a neonatal intensive care unit. This cost $480 per day. Taking into account that child may have to remain in a neonatal intensive care unit from a week up to a month, the costs are increased enormously. Moreover, the percentage of premature births in Argentina is 8.2 %. This translates into a total of 9,345 births to mothers under 20 years of age.

In addition to medical costs, there are the social costs. The burden born by adolescent mothers in Argentina is primarily related to the loss of educational opportunities in part because of prenatal or postpregnancy complications. Circumstances that reduce the chances of the adolescent mother obtaining an education and skills training put her and her child's future welfare at risk. Loss of educational opportunity and adolescent motherhood far too often leads to lower salaries and dependence on social programs or her family of origin. These economic realities can cause distress and frustration among adolescent mothers and can result in the maltreatment of her child.

The children of adolescent mothers are also negatively affected by the timing of their mother's pregnancy. These children tend to complete fewer years of formal education and as adults have lower incomes. And, children of adolescent mothers who are born prematurely or were low weight babies are also at risk of chronic lifelong health problems.

The Health Team and the Pregnant Teenager

Public programming to offset the disadvantages of adolescent pregnancy has to be comprehensive. This means programming must include biological, psychological, social, and spiritual support that promotes the personality development of the pregnant or mothering adolescent considering her personal characteristics and her life goals.

Working with the pregnant and mothering adolescent is complicated because of their immaturity, which is normal for an adolescent. They are less aware of what health and sickness means, less accepting of the responsibility to care for themselves, and more responsive to unfounded fears and magical thoughts.

Apart from all that was previously mentioned, the health team is hampered by preconceptions about the pregnant adolescent. Too often health team members view adolescent pregnancy as a problem. Many view the adolescent as deviant, irresponsible, and even immoral. Health team members often discount the ability and desire of the adolescent to participate in their own care decisions (Peña et al. 2011).

In order to better understand the unique nature of adolescent pregnancy as a sequel of health events, data on the differentiating characteristics among adolescents groups were collected and analyzed. It must be remembered that pregnancy in and of itself does not ensure adolescent maturity, especially in cases of early- and medium-age adolescent pregnancy.

Based on the study, there are some very important concepts that Health Teams working with pregnant adolescents need be taken into account.

Characteristics that differentiates adolescent pregnancy from adult pregnancy:

(a) Adolescents may have little knowledge or apprehension for health issues related to their pregnancy. They may have difficulties in accepting that they have to take care of themselves because of the maturity of their body and other circumstances under which the pregnancy occurs and the difficulties it implies. She may not remember to attend regular checkups or she may not want to go though the regular physical examinations. She may not understand the importance of complementary tests and sees them as a punishment. For all of these reasons, it is necessary to explain carefully what each procedure is for and how they will be carried out.

(b) The adolescent has not developed her gender identity yet. If she cannot understand thoroughly what being a woman is, she will understand even less the meaning of having a child. She may show happiness over her pregnancy or child, but it is more an idealization of maternity than a vision of what it actually is.

(c) A characteristic of infancy and of early- and medium-adolescence is magical thinking, that is, the belief that things will occur according to their wishes (For example, “the delivery will not hurt.” “We will move in together and we will live on his salary.” And, this type of thinking may endanger the adolescent and/or her child.

(d) She is afraid of invasive procedures; even routine procedures that are quite familiar to adult women.

(e) They have less information about the whole process because the different difficulties of pregnancy, delivery, and raising a child are not normal issues at that age. These girls have not talked with adults to compare symptoms, so the doctor will have to give all the information as clearly as possible.

Difficulties bonding with the child:

(a) Many adolescents have difficulties differentiating themselves from their babies and establishing symbolic bonds with their babies. When this bond interferes with the adolescent mother’s social activities, they may tire of the responsibility and neglect or even abuse their child.

(b) Adolescent mothers and fathers are likely to prioritize their needs over the child’s needs

because they are still developing both emotionally and physically.

(c) These young mothers often are easily frustrated. They do not understand that their baby is not like them. They do not understand why their baby cries or cannot be comforted. Or, why the baby does not return their love. They can get so angry at their baby that they may even put the baby at risk.

Professional knowledge and skills needed by health team members:

(a) Team members need to know perinatology and the biopsychosocial characteristics of the teenager.
(b) Team members need to know how to listen and be willing to allow the teenager to communicate her doubts and fears, encouraging her with respectful questions. Team members need to be good observers and know how to reframe teen questions and how to choose his/her words without turning off the teen.
(c) Team members need to show respect for the adolescent, accepting the adolescent's values even when they differ from team members.
(d) Team members need to be able to tolerate anger and rejection from the adolescent. At times, pregnant teens may become upset and distraught and take the anger out on team members. If a team member feels that the situation exceeds his/her tolerance, the target of the teen's anger should seek help of another member of the team. These situations become more critical during delivery, especially if the adolescent is very young or loses control. During these situations, team members need to de-escalate the situation and be supportive of the adolescents concerns and fears. The way these situations are handled can determine the degree of emotional damage and impact the mother and the child's future sequels.

Goals of the health team:

(a) Help the adolescent to accept her pregnancy.
(b) Strengthening family bonds.
(c) Educating health team members and institutional staff about adolescent developmental issues associated with adolescent pregnancy.
(d) Emphasize perinatal care strategies.

Strategies of the Health Team:

(a) Form interdisciplinary team (obstetrician, obstetric nurses, psychologist, and social assistant),
(b) Involve the child's father and other close relatives that the teenager asks for during prenatal, delivery, and postnatal care.
(c) Work with institutional staff (resident doctors, nurses, social workers, support staff, and others) that are involved in the adolescent patient's care, to improve attitudes and direct care.

Based on the above guidelines, adolescent pregnancy care cannot be provided by one discipline. Successful outcomes depend on an interdisciplinary team that may include obstetrician, obstetric nurses, psychologist, and social worker, and in some cases it may include justice personnel if there is a rape or sexual abuse involved. A team member from the girl's school may also be involved to ameliorate educational problems that may arise.

These strategies and trainings will assist health teams who work with pregnant adolescents during all phases of her pregnancy. The interdisciplinary team approach promotes healthy mothers and their children. It can promote prevention, family and parent involvement, and it can provide elements for the development of the adolescent-mother's potential (Peña et al. 2011).

In Argentina, the government depends on the National Ministry of Health, which has implemented several plans. Their strategies are the following: the implementation of guides and norms for the organization of the services structure in networks all over the country; training of the integrated health teams in order to be able to provide better perinatal, abortion, and maternal breastfeeding; and lastly, improving the surveillance of the maternal and infant mortality.

Nowadays, in Argentina, we also have a *birth plan*, which is a plan from the National Ministry of Health, which aims to give more and better

health opportunities to pregnant and puerperal women and children under 6 years of age with no health insurance. This program was created in the northwest in 2004 and was implemented in 2007 across the country. This plan addresses social challenges such as taking care and protecting the future of children and accompanying pregnant women from the first trimester of gestation. The aim is to reduce infant and maternal mortality in Argentina, increasing social inclusion, and increasing the quality of care for all Argentines. By August 2010, some 6,246 health institutions adhered to the plan and more had committed to follow this health management approach in our country.

Measures to Prevent Adolescent Pregnancy

Adolescent pregnancy epidemiology teaches us that the outcomes vary and change overtime, but it also gives us a vision close to reality that allows us to plan actions, makes policies, and designs and executes programs.

From a pragmatic point of view, there are interventions that have proved to be successful in diminishing obstetric complications, and therefore the maternal mortality at any age.

One of them is the CPN, which continues to be the most valuable strategy in the prevention of bad perinatal results.

There are fundamental measures that have to be implemented to improve the results and diminish obstetric complications and maternal deaths at any age, for example:

- Adolescent Pregnancy Prevention. The promotion of prescriptions for safe contraceptives or the promotion of sexual abstinence until the age of 20 or more. In our country, this policy is based on the Law 25673, in the year of 2002 (Appendix 1).
- Early and complete healthcare information useful for preventing obstetric problems that increase the risk of maternal mortality such as abortions or premature deliveries. This involves collecting additional medical record information using the CLAP (history of prenatal care) for pregnant teenagers.
- Education of the pregnant adolescent about risk events during pregnancy, delivery, and puerperium can help identify early signs of high-risk pregnancies (i.e., psychological disorders, rape, abuse, anorexia, and sexually transmitted infections).
- Ongoing evaluation of the health services that pregnant women receive can identify complex problems in individual cases and address issues accordingly to the care each case demands—referring not only to material resources but also to emotional needs. This includes permanent training of all the staff, professional, or nonprofessional that assists young adolescents.
- Assuring safe practices, adequate for safe abortions, and dealing with complications. In Argentina, abortions are not legal; they are only provided when the patient is admitted to a public or private institution because of serious complications.
- Norms for the adequate and appropriate prevention and treatment of hypertensive states during pregnancy (www.msal.gov.ar) to prevent postdelivery hemorrhage.
- Prevention and treatment appropriate for obstetric infections.
- Early detection and adequate treatment of HIV/AIDS in adolescent patients.
- Training of the services for a gestational diabetic patient.
- Creation of the epidemiological oversight committee to monitor all the cases of maternal mortality though the perinatal information system.

These critical goals can only be accomplished if the medical estate, health systems, provincial health services, and society work together to reduce pregnancy complications. In this way, we will also reduce adolescent maternal mortality.

Conclusions

Adolescent pregnancy in Argentina is and will continue to be very complex. There are many issues to consider when developing public

policy and programming related to adolescent pregnancy. There are other factors that are still not well understood. And, there are many questions still to be answered.

Adolescent pregnancy is considered a problem in Argentina because of the impact on the mother's health and psychosocial development. Additionally, the pregnancy can involve a penal code violation, for example, in the case of rape and incest. Unsafe abortions when performed under deficient hygienic, technical, and poor aseptic conditions (particularly at an advanced gestational age) compromises the health and the life of the adolescent mother, which, unfortunately occurs very often and results in a very high morbid mortality rate.

Adolescent pregnancy is considered a problem from the social point of view because the girl's pregnancy tends to interrupt her studies. Although, the adolescent mother has the option to return to school to continue her studies, in general, most young mothers do not return nor finish school. In too many cases, these young mothers are often unemployed and in other cases under employed. They lack training and the education needed to provide for their family. Moreover, the child of a teenage mother is at higher risk of maltreatment, abandonment, and the consequences of adoption.

To provide guidance and best practices to pregnant and parenting adolescents, interdisciplinary teams made up of health professionals, psychologists, social workers, and assistants who are trained to work with adolescents are needed to reduce the perinatal risks of the pregnant adolescent. What is needed is a comprehensive interdisciplinary team approach to work with pregnant and parenting adolescents.

Finally, there are two social policies that need resolutions. First, a solution must be found to deal with the provision in the birth plans that provides regular financial support to every pregnant mother from the third month of pregnancy. As a consequence of the financial incentive, there has been an increase in the rate of second pregnancies in mothers under 20 years of age. Second is the phenomenon of the high rate of repeat adolescent pregnancies over several generations in the same family.

Appendix 1

Law 26673: Argentina

Within the sphere of the Ministry of Health, the National Programme of Sexual Health and Responsible Procreation is created, sanctioned on October 30, 2002, enacted on November 21, 2002, and gathered in Congress, the Senate and the Chamber of Deputies of the Argentinian Nation sanction the Law 25673. ARTICLE 1—The Programme of Sexual Health and Responsible Procreation is sanctioned within the sphere of the Ministry of Health. ARTICLE 2—The aim of this Programme will be the following:

(a) To reach the highest level of sexual health and responsible procreation for the population to be able to adopt decisions, free of discrimination, coercion, or violence;
(b) To reduce morbid maternal-child mortality;
(c) To prevent unwilling pregnancies;
(d) To promote sexual health in teenagers;
(e) To contribute to the prevention and early detection of sexually transmitted diseases, HIV/AIDS and genital and mammary pathologies;
(f) To warranty the access to sexual health and responsible procreation information, orientation, methods, and social benefits for all the population;
(g) To foster female participation in the act of taking a decision in relation to their sexual health and responsible procreation;

ARTICLE 3—The Program is aimed at the population in general, without discriminating against any sector.

ARTICLE 4—The present law is recorded within the legal framework of the exercise of the parental rights and obligations. In any case, the satisfaction of the child's higher interests will be considered primary in full possession of the child's rights and guarantees imprinted within the spirit of the International Convention of the Child's Rights (Law 23849).

ARTICLE 5—The Ministry of Health, in coordination with the Ministries of Education and Social Development and Environment will be in charge of training educators, social workers, and all community operators to train apt agents:

(a) To raise the demand satisfaction of the health effectors and agents;
(b) To contribute to the training, improvement, and updating of basic knowledge related to sexual health and responsible procreation in the educational community;
(c) To promote spaces for reflection and action for the apprehension of basic knowledge related to this Programme;
(d) To detect properly risk behaviors and provide lawsuit to the risk groups, seeking to strengthen and improve neighborhood and community resources to educate, advise, and cover all the levels of sexually transmitted diseases prevention, HIV/aids and genital and mammary cancer.

ARTICLE 6—The transformation of the attention model will be implemented re-enforcing the quality and the coverage of the health services to give efficient answers on the grounds of sexual health and responsible procreation. In order to be able to accomplish all the previously mentioned we should

(a) Establish an adequate health control system to foster the early detection of sexually transmitted diseases, HIV/aids and genital and mammary cancer and to accomplish the performance of diagnosis, treatment, and rehabilitation;
(b) On beneficiaries demand, based on previous studies, prescribe, and provide contraceptive methods and elements that should be reversible, non-abortive, and transitory, respecting the criteria and convictions of the receivers, unless specific medical contraindication, having previously being informed about the advantages and disadvantages of natural and National Administration of Drugs and Food (NADF) approved methods;
(c) To make periodic controls after the selected method has started being used.

ARTICLE 7—The previously mentioned services will be included in the Obligatory Medical Programme (OMP), in the national nomenclature of medical practices, and in the pharmacological nomenclature.

The public system of health services, health social security, and private systems will add them to their coverage, on equal terms as other benefits.

ARTICLE 8—The present Programme must be periodically broadcasted.

ARTICLE 9—Educational institutions, public, private, confessional, or not will observe the present norm with their convictions frame.

ARTICLE 10—The private institutions of confessional character that provide themselves or through tertiary health services, may be excepted form the observance of the provided in ARTICLE 6, subsection b, of the present law.

ARTICLE 11—The application authority will have to:

(a) Accomplish the implementation, follow-up, and evaluation of the Programme;
(b) Subscribe agreements with other provinces and with the Autonomous City of Buenos Aires, in order to apply this Programme in every and each jurisdiction, for which they will receive consignments from the National treasure provided in the national budget. In case this Programme is not organized, the agreed consignments will be canceled. Within the frame of the Federal Council of Health, aliquots for each province and for the Autonomous City of Buenos Aires will be established.

ARTICLE 12—The expenditure for the public sector demanded by the accomplishment of this Programme will be charged to the 80-jurisdiction of the Ministry of Health, National Programme of Sexual Health, and Responsible Procreation, from the National Budget of the National Administration.

ARTICLE 13—The provinces and the Autonomous City of Buenos Aires are invited to adhere to the present law.

ARTICLE 14—Let it be known to the executive power.

As worded in the sessions hall of the Argentinian congress, in Buenos Aires, this 30th day of October 2002.

—REGISTERED UNDER No. 25.673—

EDUARDO CAMAÑO.—JUAN C. MAQUEDA.—Eduardo Rollano.—Juan C. Oyarzún.

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Adolescent Pregnancy in Australia

Lucy N. Lewis and S. Rachel Skinner

Keywords

Australian adolescent pregnancy • Birth outcomes • Domestic violence • Emergency contraceptive pill • First intercourse • Illicit and licit drug use • Indigenous adolescents • Low birth weight • Rapid repeat adolescent pregnancy • Sexually transmitted infection

Introduction

The Commonwealth of Australia's mainland is made up of six states and three territories. All states and two of the three internal territories have their own parliaments and administer themselves; the remaining territories are administered by the Federal Government. The total population of Australia is estimated to be 22.7 million. Indigenous people are classified as the original people of Australia and all first nation and Torres Straight Islander peoples, who are recognized as such by their communities (Australian Bureau of Statistics 2010). The Aboriginal and Torres Strait Islander population comprises around 2.5 % of the Australian population.

Adolescent pregnancy is a major health, social, and economic issue for Australia. Research over more than three decades has identified many risk factors for early pregnancy (e.g., poverty, disrupted family structure, low educational achievement), but not yet an understanding of the multiple systems of influence, mediating mechanisms, and trajectories leading to adolescent pregnancy.

Trends in Australian Adolescent Birth over Time

The Australian Bureau of Statistics is Australia's national statistical agency. In Australia, the Australian Bureau of Statistics provides information in relation to the rate of adolescent pregnancy. The incidence of adolescent pregnancy is defined as the number of pregnancies per 1,000 adolescent females per year. Although the birth rate among Australian adolescents (aged 15–19 years) has fallen in recent decades to a low of 15.5 births per 1,000 in 2010 (Australian Bureau of Statistics 2010) (see Table 1).

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Table 1 Age-specific fertility rates for 15–19-year-old women using data from the Australian Bureau of Statistics

Year	NT	TAS	QLD	WA	NSW	SA	VIC	ACT	AUST
1971									55.5
1977									32.1
1980	98.9	38.1	36.9	30.2	28	26.3	21	19.9	27.6
1992	90.5	29	26.5	25	22.8	18.7	14.7	14	22.0
1997	75.5	27.3	25.6	21.2	19.5	16.2	12.4	13.5	19.8
2000	68.8	26.3	223.0	21.2	16.9	15.2	11.0	10.6	17.7
2001	71.0	32.7	22.6	19.4	17.1	14.5	11.5	9.8	17.7
2002	63.3	28.3	22.3	18.8	16.5	15.5	11.3	11.1	17.2
2003	63.5	26.1	21.4	18.5	15.0	14.7	10.2	8.6	16.1
2004	56.4	24.9	21.6	19.6	15.0	13.5	10.3	7.8	16.0
2005	61.4	26.8	20.4	20.5	13.4	18.5	9.7	9.1	15.7
2006	63.5	26.5	19.7	19.6	13.2	16.7	9.7	9.1	15.3
2007	58.8	27.4	23.0	20.5	12.3	17.5	10.0	10.3	16.0
2008	51.9	27.5	24.7	22.7	13.9	18.3	10.6	8.0	17.2
2009	48.0	27.1	26.7	20.1	13.0	15.9	9.9	9.7	16.7
2010	48.1	21.5	24.0	19.1	12.9	15.3	8.5	8.9	15.5

Data from the Australian Bureau of Statistics, birth catalogs (Australian Bureau of Statistics 2004, 2005, 2008, 2010)

Australia continues to have an adolescent birth rate several times higher than other comparable countries and Organization for Economic Co-operation and Development (OECD) nations, such as the Netherlands (United Nations International Children's Education Fund 2001; Shaw et al. 2006; Singh and Darroch 2000).

The downward trend in adolescent births (since the 1980s) has been attributed to the fact that Australian adolescents have had increasing control of their fertility (Australian Bureau of Statistics 2005), especially in terms of access to the combined oral contraceptive pill (Fraser and Ward 1995) and abortion following the reinterpretation of the abortion law in 1971 (Drabsch 2005) in New South Wales (when nationally the rate of teenagers giving birth had peaked at 55.5 births per 1,000) (Table 1).

Birth Trends with Indigenous and Rural Adolescents

There is evidence that not all cohorts of Australian adolescents are mirroring the overall downward trend in adolescent births (Table 2). Especially, those living in rural (Robson et al. 2006), socially disadvantaged areas (Coory 2000), and Indigenous adolescents (Van der Klis et al. 2002) who experience a fertility rate of 76.3 per 1,000 (Australian Bureau of Statistics 2010), more than four times that of non Indigenous adolescent women.

This situation is particularly apparent in Western Australia which has the highest rate of Indigenous adolescent pregnancy in Australia at 103.5 per 1,000 (Australian Bureau of Statistics 2010), six times higher than the overall rate of Australian adolescent births (Table 1). In 2008, births to Australian adolescent women accounted for 4 % of all Australian births, with Indigenous adolescent women accounting for 20 % of all births (Australian Bureau of Statistics 2008).

Characteristics of Australian Adolescents Who Give Birth

Although it is clear that there is heterogeneity in the adolescents who give birth, especially in terms of ethnicity (e.g., Indigenous adolescents are more likely to be single and less likely to be married than non Indigenous adolescents (Westenberg et al. 2002), there are also important

Table 2 Age-specific fertility rates for Indigenous 15–19-year-old women in Australia

Year	NT	TAS	QLD	WA	NSW	SA	VIC	AUST
1998	117.9		69.5	96.9	70.4	77.2	50.3	77.6
2001	146.1	51.4	74.2	85.3	58.9	54.2	36.3	75.9
2002	127.8	53.0	74.6	72.5	69.4	62.6	47.3	76.2
2004	111.0		68.0	88.0				70.9
2005	105.8	45.6	69.5	99.6	53.2	84.1	51.6	72.1
2006	116.3	32.2	61.6	89.7	57.0	71.6	47.6	69.0
2007	110.8	27.0	73.5	101.6	47.7	70.9	44.9	70.0
2008	91.0	36.5	77.1	116.6	56.9	94.3	50.6	75.2
2009	87.6	38.2	99.7	103.4	56.0	82.0	53.0	78.8
2010	91.1	35.9	94.7	103.5	56.3	75.6	38.7	76.3

Data from the Australian Bureau of Statistics, birth catalogs (Australian Bureau of Statistics 2004, 2006, 2008, 2010). Empty cells indicate there was no data available

similarities. These include: patterns in sexual activity; contraceptive use at first intercourse; disadvantage as a result of lower socioeconomic status; family characteristics; illicit and licit drug use; and domestic violence.

Sexual Activity

In Australia, the median age of first intercourse for females is 16 years (Rissel et al. 2003). Indigenous adolescents are more likely than non Indigenous adolescents to fall pregnant at a younger age (Australian Bureau of Statistics 2010; Westenberg et al. 2002). Cultural norms and social context shape sexual activity and pregnancy in adolescents. Among the most influential sources of social influence are parents, siblings, friends, and sexual partners. Sexual debut has been linked to gaining friends' respect, being strongest in those adolescents who are highly involved with their friends (Skinner et al. 2008, 2009).

Pressure from partners also plays a role in earlier sexual activity (Skinner et al. 2009) with male adolescents often having higher levels of pregnancy idealization than their female counterparts (Condon et al. 2000; Larkins et al. 2011). This may influence their female partners' wish to conceive. Research suggests that increasing numbers of 16–17-year-old females are having sex with multiple partners (Agius et al. 2010).

Sexually Transmitted Infection

Sexually transmitted infection is a major contributor to overall morbidity in the Australian adolescent age group (Skinner and Hickey 2003). Sexually transmissible infections among young Australians increased dramatically between 1997 and 2007, with rates of Chlamydia increasing by 528 % and rates of Gonorrhea by 169 % among those 15–19 years old (Macbeth et al. 2009). Pregnant adolescents have been found to have a high prevalence of Chlamydia (27 %) (Quinlivan et al. 1998) reinforcing the findings of others that consistent use of contraception in this cohort is low.

Abortion

Almost one-third of adolescents who give birth have previously been pregnant (Van der Klis et al. 2002). Australian adolescents have a high abortion rate with approximately half known pregnancies, ending in abortion (Joyce and Tran 2011; Van der Klis et al. 2002). Younger adolescents have higher rates of abortion, between 2006 and 2009; West Australian adolescents

terminated 70–80 % of their pregnancies. In 2003, the estimated rate of induced abortion for Australian adolescents was 20.8 per 1,000 (Grayson et al. 2005). Although the rate of induced abortion in Australian adolescents is declining, it is still higher than many Western European countries.

Australian rates of induced abortion tend to mirror South Australian trends. High socioeconomic areas in South Australia have been found to have the lowest adolescent pregnancy rates, but the highest proportion of adolescent induced abortion (Van der Klis et al. 2002). A South Australian time series study from 1996 to 2006 (which used cases from a termination of pregnancy service provider) found there had been no significant changes or trends in induced abortion for those adolescents 19 years and younger. Indigenous adolescents are more likely to have a live birth than their non Indigenous counterparts and less likely to have an induced abortion (Westenberg et al. 2002; Lewis et al. 2009).

Only a small number of states (South Australia, Western Australia, and the Northern Territory) actually require notification of abortions to a central register. National induced abortion rates are therefore estimated from Medical Benefits Scheme item numbers and are likely to be underestimated (Walker et al. 2011).

Rapid Repeat Adolescent Pregnancy

Rapid repeat adolescent pregnancy (when a second birth occurs within two years of a first) in Australia is high, with an estimated one-third of adolescent mothers giving birth again. An Australian prospective cohort study of 147 participants found 49 (33 %) experienced a rapid repeat pregnancy (Lewis et al. 2010a, b). Sexual intercourse was independently significantly associated with: using an oral contraceptive; living with the birth father; intending to become pregnant; smoking marijuana; and using alcohol. Adolescents who used an oral contraceptive had a similar risk of rapid repeat pregnancy compared with those using barrier methods or no contraception. Use of long-acting contraceptives reduced the likelihood of rapid repeat pregnancy. The adversity for adolescent mothers is amplified when a second pregnancy occurs within this short time period.

Disadvantage as a Result of Low Socioeconomic Status

Australian adolescent mothers are up to four times more likely to originate from poor families (Coory 2000; Gaudie et al. 2010) and have been brought up in and currently live in an area of socioeconomic disadvantage (Quinlivan et al. 2004; Van der Klis et al. 2002). In addition, Indigenous adolescent pregnancy is associated with lower socioeconomic status and residing in remote areas (Grayson et al. 2005).

By the time adolescent mothers are in their early 1930s, they are less likely than older mothers to be purchasing their own homes (Bradbury 2006). Analysis of responses from 9,689 young participants in the Longitudinal Study on Women's Health was used to examine predictors of outcomes of early motherhood in Australia, finding social disadvantage predisposes women to become mothers early and to adopt unhealthy behaviors (Lee and Gramotnev 2006). Financial stress caused by exclusion from both education and employment that is caused as a result of being an adolescent mother compounds this situation.

Education

Adolescent mothers are more likely than their older counterparts to come from a family background in which their own carriers did not reach an age appropriate education (Gaudie et al. 2010). Adolescents who see childbearing as a threat to their educational goals are less likely to become pregnant, with young women who chose abortion being more likely to have completed secondary school to year 12 (Evans 2004). Pregnant adolescents often have age inappropriate education

with one study highlighting 65 % are one school year or more behind (Lewis et al. 2010a, b) and another, that only one-third of pregnant adolescents had completed schooling beyond year 10 (Gaff-Smith 2005). This has implications for targeting sex education at those adolescents in school. In addition, the children of adolescent mothers have been found to have poorer school performance and reading ability (Shaw et al. 2006).

Family Characteristics

One-fifth of Australian adolescents, whose mother had been an adolescent mother, become adolescent mothers themselves. Disrupted family structure with a history of parental separation is common in the families of adolescent mothers. Family violence has also been identified as an issue (Gaudie et al. 2010; Quinlivan et al. 2004).

Partners Characteristics

Adolescents are more likely to be single parent than older mothers (Bradbury 2011; Shaw et al. 2006). In one study of 147 adolescent mothers in Perth, Australia, 34 % were no longer in a relationship with the father of their child at the time of the birth (Lewis et al. 2010a, b). It is also unlikely that adolescent mothers will be living with the father of their child when the child is an adolescent (Bradbury 2011; Bradbury and Norris 2005; Shaw et al. 2006). The mean age difference between adolescent mothers and the birth father is more than two to three years (Tan and Quinlivan 2006). Inevitably, some of these pregnancies result from involuntary sex, but the exact percentage is hard to assess as these data are rarely collected.

Fathers of infants born to adolescent mothers are consistently found to have age inappropriate education with an educational inadequacy of around two years (Tan and Quinlivan 2006). Low educational attainment and employment opportunities are common in these men; therefore, it is not surprising that they are likely to be socioeconomically disadvantaged with one-third of birth fathers, of infants born to adolescent mothers, being homeless or living in unstable accommodation (Quinlivan and Condon 2005).

It is inevitable that educational achievement will increase employment and income opportunities, which in turn affects the financial support that can be given to the adolescent mother and their child. In addition, these men are at increased risk of being exposed to domestic violence and family dysfunction as children. Involvement with illegal activities especially illicit drugs is not unusual (Tan and Quinlivan 2006).

Domestic Violence

Domestic violence and adolescent pregnancy have been shown to be associated with each other. Recent research suggests that one-fifth of pregnant adolescents experience physical abuse before the age of 16 years with 9 % experiencing both sexual and physical abuse (Quinlivan et al. 2004). Data from the younger cohort of the Australian Longitudinal Study on Women's Health, comprising 14,776 young women in 1996 (of whom 9,683 were resurveyed in 2000), found women reporting adolescent termination of pregnancy were more likely to be a victim of partner violence (Taft and Watson 2007). Australian adolescents subjected to domestic violence have been shown to exhibit reduced attachment to their infants (Quinlivan and Evans 2006).

Sexual Abuse

Adolescents, who have a pregnancy, are more likely to report having had an unwanted sexual experience in the past. The fourth National Survey of Australian Secondary Students HIV/ AIDS and Sexual Health, surveyed almost 3,000 students in year 10 (aged 14–15 years), year 11 (aged 15–16 years) and year 12 (aged

16–17 years) in more than 100 secondary schools from every jurisdiction in Australia). It found the number of young women experiencing unwanted sex, had increased significantly between the 2002 and 2008 surveys (Smith et al. 2008).

Pregnant adolescents may require consideration as to whether they have been the victim of an abusive sexual relationship. If an adolescent has had a sexual relationship with an older person, then concerns regarding the possibility of sexual abuse or assault must be considered. Coercive relationships in this setting can be difficult to determine as most adolescent mothers who fall pregnant to an older partner, often describe a caring consensual relationship.

In Australia, sexual activity under the age of 16 is against the law. If a young pregnant adolescent presents to a health practitioner, there is a legal requirement to notify welfare authorities. Mature minor status of adolescent mothers less than 16 years (where the adolescent is deemed competent to choose or reject a specific health care treatment) needs to be carefully considered, and the pregnant adolescent's relationship often need to be monitored. A risk assessment based on the vulnerability of the young mother and the history of the partner should be made, hence the need for involvement of welfare services.

Smoking

Between 32 % (Lewis et al. 2009) and 42 % (Chan and Sullivan 2008) of Australian adolescents smoke during their pregnancy; while Indigenous pregnant adolescents are more likely to smoke than their non Indigenous counterparts. In addition, a retrospective study of 4,896 nulliparous pregnant women delivering in Western Australia found prevalence of smoking in pregnancy was associated with maternal ethnicity and age, with the youngest Indigenous adolescents (those aged 16 years and below) being the most likely to smoke (Lewis et al. 2009).

Using data from the New South Wales Midwives Data Collection (a population-based surveillance system administered by the New South Wales Department of Health that covers all births) for 1999–2003, 426,344 pregnancies were analyzed to explore the socio-demographic characteristics of women who continued to smoke during pregnancy. Smoking rates were highest in adolescents, Indigenous women, and those with a lower socioeconomic background (Mohsin and Bauman 2005).

A subsequent study by Mohsin et al. (2011) found that although the prevalence of smoking in Australian pregnancy had declined, the smallest declines were among adolescent and rural remote mothers. Maternal age, ethnicity, being Indigenous, living in an area of remoteness, and socioeconomic status were all independently associated with smoking in pregnancy. Smoking in adolescent pregnancy remains a public health issue especially for Indigenous women (Lewis et al. 2009), for whom tobacco use is a risk factor for premature morbidity and mortality (Australian Bureau of Statistics 2006).

Other Illicit and Licit Drug Use

Consumption of cigarettes, alcohol, marijuana, solvents, and heroin is higher in pregnant Australian adolescents than the general Australian adolescent population (Quinlivan et al. 1999). Use of alcohol is a risk factor for sexual activity in adolescents (Skinner et al. 2009) with 69 % of adolescent mothers found to use alcohol before they conceived (Lewis et al. 2010a, b). Use of alcohol reduces the perceived health benefits of protected sex with failure to use contraception being associated with the use of alcohol (Skinner et al. 2009). During pregnancy, alcohol and substance use drop off, but rates of smoking remain high. Postpartum, the use of cigarettes and alcohol and marijuana increases with time (Lewis et al. 2010a, b).

Contraception

Contraceptive counseling should be performed before adolescent females are prescribed contraception. Medico-legally, a young person who is a legal minor may need to be deemed competent to consent to treatment before contraception can be prescribed or administered without parental consent.

Australian research has identified that attitudes and beliefs of sexually active female adolescents have an impact on pregnancy risk. For example, those adolescents who perceive a low risk of pregnancy, or who consider that motherhood would have a positive impact on their lives, may be at higher risk of pregnancy. Some adolescent females believe they are infertile. These beliefs are usually based on their previous experiences of unprotected sex, which did not result in pregnancy. Adolescents may also hold false beliefs about side effects of contraception or of the limited efficacy of contraception (Skinner et al. 2009).

Where an adolescent perceives: pregnancy is low risk; that motherhood will have a positive impact on their lives; or that contraception has side effects; or is not effective, they are unlikely to have the motivation to use contraception consistently; their beliefs should be explored in a constructive way. For example, guiding the adolescent to consider how they and their family would feel if they fell pregnant may help. However, some adolescent females consider motherhood a logical and appropriate life choice, and it may not be possible or appropriate to change these beliefs. It may be more appropriate to ensure they understand the importance of good prenatal care (Lewis et al. 2010a, b).

In adolescent heterosexual relationships, the female partner usually assumes the responsibility for birth control. Many studies have found that pregnancy prevention is the main concern for both males and females who are sexually active, prevention of sexually transmitted infection concerns adolescents less. Couples should be encouraged to attend contraceptive counseling together, this provides an opportunity for the male partner to access sexual health clinical services and can help the couple to discuss contraception.

Contraceptive Use at First Intercourse

Consistent use of contraceptives in Australian adolescents is low, despite adolescents being aware of their contraceptive options (Larkins et al. 2007; Lewis et al. 2010a, b; Skinner et al. 2009). At first intercourse, most Australian teenagers only use condoms, or a less effective form of contraception such as withdrawal. Little Australian data are available in relation to patterns of contraceptive use at first intercourse in adolescence. Risky behaviors such as not using contraceptives consistently and doubting the need for contraceptives are increased by the developmental processes that adolescents are experiencing in conjunction with first sex (Skinner and Hickey 2003).

Over half adolescent pregnancies occur within six months of first intercourse (Marie Stopes International 2010) suggesting contraceptives were either not used or used inappropriately. Indeed, a recent study found although three quarters of female adolescents' did not intend pregnancy, just under half were not using contraception when they conceived (Lewis et al. 2010a, b). Therefore, adolescent females may present requesting contraception, some months after they become sexually active.

Australia has not implemented a comprehensive sexual health program to teach adolescents about their sexual health and the value of contraception to not only prevent pregnancy but sexually transmitted infection. This failure is perhaps based on the belief that education of children and young adolescents about contraception and safe sex may promote earlier sexual activity (Skinner and Hickey 2003).

Emergency Contraceptive Pill

Emergency contraception can be accessed through pharmacies in Australia without a

doctor's prescription; this provides for more rapid access and hence has the potential for greater efficacy. Adolescent females are the most frequent users of the emergency contraceptive pill at Australian Family Planning clinics (Mirzaj et al. 1998). However, recent research in relation to pharmacy access highlighted the finding that adolescents aged 16–19 years old were less likely than adults to access the emergency contraceptive pill (Hobbs et al. 2011). Despite this finding, an estimated 27 % of adolescents aged 16–19 years have used the emergency contraceptive pill (Smith et al. 2003).

Condom Use

Younger adolescents are more likely to use condoms than older adolescents. Younger adolescents tend to use condoms alone for pregnancy protection and then transition from condom use to hormonal contraception as their relationships become more established.

Studies exploring the knowledge and sexual health behaviors of secondary school students aged 14 to 17 years old repeatedly find 45 % of sexually active female Australian high school students do not use condoms consistently. An estimated 31 % of adolescents use condoms without another form of contraception, with those aged 14 to 15 years being more likely to use a condom than those aged 16 to 17 years (Agius et al. 2010; Lindsay et al. 1999)· Indigenous adolescents have been found to lack ability to negotiate with partners in relation to condom use, with condoms being associated with shame, a bad reputation and coercion (Larkins et al. 2007).

Oral Contraceptive Pill

Contraceptive methods which require daily action, such as the contraceptive pill and those which are coital-dependent such as condoms, have higher typical failure rates than methods which are administered less frequently such as the long-reversible contraceptives (Lewis et al. 2010a, b). Australian qualitative research has highlighted that pregnant adolescents experienced difficulties with the oral contraceptive pill particularly in relation to remembering to take it consistently (Skinner et al. 2008).

The National Surveys of Australian Secondary Students, HIV/AIDS and Sexual Health, have shown consistently that hormonal contraceptive use is more common in older adolescents than younger adolescents (Lindsay et al. 1997). Similarly among Australian high school students, only 50 % report use of hormonal contraceptives at last sexual encounter. A survey conducted in 2001 by the Australia Bureau of Statistics, used data from a nationally representative sample of 5,872 women aged 18–49. It found women aged 18 and 19 had increased their use of the oral contraceptive pill from 21 % in 1977 to 38 % in 2001 (Yusef and Siedlecky 2007). However, data from a 1997 national survey of 3,550 Australian secondary school students highlighted that of the 961 sexually active students, 45 % were using the oral contraceptive pill with some other method of contraception (mainly condoms) and only 10 % were using the oral contraceptive pill exclusively (Lindsay et al. 1999).

Long-Acting Contraception

Long-acting contraceptives have been demonstrated to be more effective in the prevention of rapid repeat adolescent pregnancy (when a second birth occurs within two years of a first) than other forms of contraception (Lewis et al. 2010a, b). They have also been shown to be appropriate options for adolescents with low motivation to use contraception, as such they are a good choice for those wanting to avoid unplanned pregnancy.

An Australian prospective cohort study compared repeat adolescent pregnancy over a 24 month period postpartum, among users of three contraceptive groups (Implanon; oral contraception or Depot Medroxyprogesterone Acetate

and barrier methods or nothing). At 24 month postpartum, 35 % of adolescents had conceived. Implanon users became pregnant later than other contraceptive groups, with those choosing Implanon significantly less likely to become pregnant and to continue with this method of contraception 24 month postpartum, compared with those who chose the other contraceptive methods (Lewis et al. 2010a, b).

Birth Outcomes for Adolescent Women and Their Infants

Antenatally, Australian adolescents have been found to experience anemia, urinary tract infection, and pregnancy-induced hypertension more often than adults. Although most Australian studies report that adolescents' babies are at greater risk of adverse outcomes (Lewis et al. 2009; O'Leary et al. 2007; Van der Klis et al. 2002; Westenberg et al. 2002), it has been suggested both nationally and internationally (Raatikainen et al. 2006) that these associations can be minimized if high-quality antenatal care is provided. Therefore, it is concerning that Australian adolescents attend fewer antenatal visits (Van der Klis et al. 2002). Encouragingly, they are less likely to deliver by cesarean section and have fewer instrumental deliveries (O'Leary et al. 2007; Quinlivan and Evans 2004).

Neonatal Outcomes

Australian adolescent pregnancy is considered to be high risk for adverse neonatal outcomes specifically: preterm delivery; low birth weight; stillbirth; and neonatal death.

Indigenous adolescents are over represented among Australian adolescents who give birth, their babies are more likely to experience preterm birth, low birth weight, and childhood death than their non Indigenous counterparts (Freemantle et al. 2006a; Westenberg et al. 2002). Although it is encouraging that live births have increased and stillbirths decreased for the Indigenous population as a whole, from 2001 to 2004, infants born to Indigenous adolescents continued to have a higher incidence of death, especially those caused by infection (Freemantle et al. 2006b; Grayson et al. 2005). Despite obstetric advances in Australia in recent years, Indigenous adolescents remain one of the most vulnerable cohorts of women giving birth in Australia today.

Low Birth Weight and Preterm Delivery

Low birth weight (<2,500 g) and preterm labor is associated with Australian Adolescent pregnancy especially in association with smoking (Chan and Sullivan 2008) and being Indigenous (Lewis et al. 2009; Van der Klis et al. 2002; Westenberg et al. 2002).

Although the mechanisms associated with preterm labor are often not known, numerous factors have been found to be associated with preterm labor and adolescent pregnancy. These factors include: being l6 years of age or younger (Van der Klis et al. 2002); living in a rural/remote area (Robson et al. 2006); having limited access to adequate antenatal care (Quinlivan and Evans 2004); smoking (Lewis et al. 2009) and Indigenous status (Van der Klis et al. 2002; Van der Klis et al. 2002). Smoking is a modifiable factor which can be targeted to prevent low birth weight and decreased preterm delivery.

Stillbirth and Neonatal Death

Although the rate of stillbirth is decreasing among Indigenous adolescents, the stillbirth rate is consistently higher among Australian adolescents than Australian adults. A recent Western Australian study found the increased risk of stillbirth in adolescent mothers was completely explained by socio-demographic factors (O'Leary et al. 2007).

The risk of neonatal death (between birth and the first 28 days of life) is also higher in Australian adolescents than Australian adults (Van der Klis et al. 2002). This increased risk could be attributable to the higher risk of preterm birth

and low birth weight that the babies of Australian adolescent mothers experience. There is controversy in relation to whether this association can be explained by biological immaturity, lifestyle, inadequate prenatal care, or a combination of these factors (Freemantle et al. 2006b).

Welfare

Australian adolescents have numerous welfare benefits they can access. The most common are family tax benefits, youth allowance, and living away from home payments. In addition, Indigenous adolescents can receive help with their medical expenses.

The baby bonus is a cash payment introduced in 2004 by the Australian Federal Government to increase fertility. The initial 2004 payment was a one off payment of $3,000 (Australian dollars); this was increased to $4,000 (Australian dollars) in 2006 and $5,000 (Australian dollars) in 2008. In 2008, following media and public pressure, the one off payment to adolescents was reviewed and broken up into installments, for those mothers 18 years or younger at the time of their child's birth.

In the adolescent population, this bonus continues to cause concern because there is evidence that the baby bonus has had a negative impact on the declining rate of adolescent pregnancy (Lain et al. 2010) Although there is no evidence that births to first time adolescents have increased, second births to adolescents from disadvantaged or average socioeconomic status have increased since its implementation, along with a relative increase in rural and remote adolescent pregnancy (Lain et al. 2009).

Recommendations for Further Research

There is a need to build on the existing Australian research in relation to adolescent pregnancy. The following suggestions for further research are made:

- Research to investigate the value of sustained contraceptive support for adolescents.
- Further investigation in relation to pregnancy intention in adolescent pregnancy. Especially, how pregnancy intentions are assessed in this population, as the current research provides limited evidence for recommending clinical practice, and it is clear that this information would be useful for those caring for this population.
- Further research in relation to Indigenous adolescent pregnancy. This research may need to be performed by Indigenous researchers as they will be aware of the unique perceptions, values, and beliefs about pregnancy and parenthood that their culture holds.

Summary

Although there has been a downward trend in the number of Australian adolescents giving birth since the 1980s, the rate of Indigenous adolescent pregnancy is declining at a slower rate and is high compared with the average rate of Australian adolescent pregnancy.

In comparison with international data, research into Australian adolescent pregnancy is limited. We know that adolescent mothers in Australia are more likely to be: single, smoke, have high levels of illicit and licit substance use, live in an area of socioeconomic disadvantage, have pregnancies with uncertain dates, have partners at increased risk of exposure to domestic violence and family dysfunction as children, and partners who are often involved with illegal activities especially illicit drugs.

Over the last few decades, the median age of first pregnancy has increased significantly for non Indigenous women, while this has not occurred in the Indigenous population. When Indigenous adolescents are compared with non Indigenous adolescents, they are more likely to smoke, have anemia, and experience pregnancy-induced hypertension. Addressing Indigenous social disadvantage is complex. Providing Indigenous adolescents with culturally

appropriate and accessible contraceptive services should be an integral part of this process. This is important in terms of reducing Indigenous adolescent mothers exposure to the increased social inequality associated with adolescent pregnancy.

Adolescent parents and their children are vulnerable to adverse outcomes. It is likely that there are a number of maternal risk factors (e.g., smoking and being an Indigenous adolescent) which may precipitate medical and obstetric conditions resulting in adverse birth outcomes such as preterm delivery, low birth weight, and stillbirth. These maternal risk factors may be individual, psychological, or behavioral and identifying the individual pathways of the association between these maternal risk factors and adverse birth outcomes is difficult as they are likely to be multifaceted.

Greater understanding of the issues that surround adolescent pregnancy should be a high priority for Australia, especially in terms of evidence to assist with the development of effective intervention programs.

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Adolescent Pregnancy in Canada: Multicultural Considerations, Regional Differences, and the Legacy of Liberalization

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Keywords

Adolescent pregnancy in Canada · Abortion barriers · Canada's health care system · Developed countries · Ethno-cultural diversity · Gender inequalities · Human rights · In-hospital births · Sexual health education

Introduction

This chapter explores adolescent pregnancy among Canadians. Canada enjoys a relatively low teenage pregnancy rate compared with other Western nations, but aggregate statistics mask regional variations. As a vast nation with two European colonial settler populations and diverse Aboriginal peoples, Canada has historically been a diverse country. Canada's multicultural policy has further diversified the population, making large urban centers like Toronto, Montreal, and Vancouver among the most diverse cities in the world. Federally funded health care is managed at the provincial level making each province's priorities and delivery different. While a human sexual rights perspective broadly frames reproductive health and national guidelines for sexual health education, local programs are not bound to them. Women generally enjoy high levels of access to health care, abortion, and reproductive health information, but there is variation in access, attitudes, and behaviors. The ethno-cultural diversity of Canada's population, its regional differences, languages, and religions challenge aggregate analyses and social service implementation. These concerns are reflected in the body of research about adolescent pregnancy in Canada.

In this chapter we describe variation in, and attitudes toward, adolescent pregnancy and sexual behavior, with emphasis on adolescents and young women. These issues remain strongly influenced by Canada's extensive geographical realities as well as political, social, and economic values that reflect dedication to upholding multicultural differences, social justice, and freedom. Widely sanctioned reproductive choice and sexual education programs exemplify how Canadian values translate into rational and health promoting policies rather than punitive and restrictive agendas which lead to less effective health and mental health care for women and their newborns (Grimes et al. 2006;

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Singh et al. 2009). We discuss these issues in this chapter but first we begin by providing a brief description of Canada's history and its population.

Canadian History and Population

Canada is largely a nation of immigrants with two founding colonial nations: England and France. Remnants of Canada's first peoples, referred to as Aboriginal peoples (usually includes First Nations, Metis, and Inuit) remain today, but sadly colonization by the founding nations decimated most Aboriginal peoples. Canada's dedication to respecting the legacy of both founding European countries has resulted in an officially bilingual country and a predominantly Francophone Quebec population. Canada became the Dominion of Canada in 1867 retaining strong symbolic, familial, and political links to England. Canada is a constitutional monarchy with a democratic parliament and multiple political parties. Since confederation, Canadian governments have attempted to integrate elements of socialism and liberalism into a parliamentary model.

Canada is a vast country with a landmass of 9.9 million km, the second largest country by area in the world next to Russia. It is divided into ten provinces and three territories and stretches across six time zones. The geography is diverse ranging from temperate in the south to arctic in the north. Its only neighbor is the United States (USA) with which it shares the longest, largely undefended border in the world at over 8,000 km. It is bordered by three oceans: the Atlantic, the Pacific, and the Arctic and boasts the longest coastline in the world at just over 200,000 km.

Despite its large area, Canada's population density is 3.3 people per square kilometer with over 90 % of population living within 100 km of the Canada-US border. Population estimates in 2010 were just over 34 million (http://data.worldbank.org), or approximately 1/11th that of the United States, with 81 % of residents living in urban areas (http://www.who.int). Canada is a wealthy country, categorized as a high-income nation by the Organization for Economic Co-Operation and Development (OECD) standards with a Gross Domestic Product (GDP) of $1.5 trillion, 10.9 % of which is spent on health care (http://www.who.int). Infant mortality rates in 2007 were 5.1 per 1,000 live births (http://www.oecd-ilibrary.org). The percentage of Canadians who use antenatal care services (4+ visits) was 99 % in 2005. Similarly, births attended by a skilled health professional were also 99 % (http://www.who.int).

Canada is good place to live by health and wealth indicators and seems particularly so for women whose life expectancy at birth is 83 years (http://www.who.int), one of the highest in the world.

Pregnancy Rates, the Decriminalization of Abortion, and Emergency Contraception

In 2006–2007, the average maternal age in Canada (excluding Quebec) was 29.3 years. Some 13,000 births were to adolescents. This accounted for almost 5 % of in-hospital births (CIHI 2009). Teenage pregnancy statistics began to be collected in 1974. Since then, trend data show that adolescent pregnancy rates have declined overall, with minor fluctuations over that time span (Dryburgh 2000; McKay 2004; Wadhera and Millar 1997). In fact, adolescent pregnancy rates among Canadian females age 15–19 years have declined steadily since the 1990s from 49.2 per 1,000 females in 1994 (McKay and Barrett 2006) to 29.2 per 1,000 females in 2005 (Statistics Canada 2008a). While comparable declines are reported from other developed countries, Canadian rates are roughly half those of the United States and England and Wales (CIHI 2009). More recently, in 2009, total live births registered in Canada were 380,863 (Statistics Canada 2012). Of these, 104 births (or 0.03 %) were registered to mothers under 15 years of age and 15,534 (or 4.08 %) births were registered to mothers aged 15–19 years. Reasons for the decline are

speculative and include decreased social stigma associated with out-of-wedlock pregnancy, increased availability of contraceptives, and increased awareness of risks of unprotected sex associated with the AIDS epidemic (Dryburgh 2000).

Qualitative research among western Canadian women suggests that motherhood at a young age is less socially acceptable (Benzies et al. 2006). The American media, which most Canadians have full access to, have been accused of glamorizing teenage pregnancy, but the long-term impact of this glamorizing on the shame associated with teenage pregnancy has yet to be determined. At the same time, there appears to have been a concurrent increase in the number of abortions among teenagers between 1974 and 1994 (Wadhera and Millar 1997). Indeed, recent work by Al-Sahab et al. (2012) indicates that 50 % of teenage conceptions result in abortion. This is discussed in the next section.

Abortion Access

Until 1988, abortions were only legal in Canada for cases deemed dangerous to the life or health of a woman by a hospital-based "therapeutic abortion committee" (Kaposy and Downie 2008). In a landmark 1988 ruling, *R. v. Morgentaler*, the Supreme Court of Canada struck down the criminal law on abortion on the grounds that it violated a section of the Canadian Charter of Rights and Freedoms (Kaposy and Downie 2008). Most of the justices used a harmed-based rather than a choice-based analysis for their vote, citing the delays caused by abortion committees and the increased risk associated with delay in performing abortions. Canada is one of a handful of nations in the world, and the only Western nation without any punishment for performing abortions (United Nations 2007). Despite this extremely liberal position, abortion rates in Canada are comparable or lower than most Northern European countries, as well as the United States, which have slightly more restrictive abortion policies (United Nations 2007). The abortions that are performed are either done in private clinics or hospitals, but there are relatively few physicians whose livelihood is based solely on abortion. There are illegal abortions performed in Canada but estimates vary and assessing prevalence is clearly problematic (Wadhera and Millar 1997). Therefore, despite an absence of punishment in this area, other ethically based codes of conduct would apply to those who perform abortions. For instance, the Canadian Medical Association's Code of Ethics prohibits discrimination on several levels including medical condition and physicians who prevent access to abortion services are in breach of this code, risking lawsuits, and disciplinary action (Canadian Medical Association 2004; Rodgers and Downie 2006). Lower abortion rates in Canada compared with the United States may indicate a more tolerable climate for teenage pregnancy and parenthood (discussed below). Teenage pregnancy does not necessarily mean an end to an adolescent girl's dreams or quality of life and there seems to be increasing access to specialized education and social services for those who do not abort.

The decriminalization of abortion, however, has not resulted in uniform acceptance of abortion nor services and practices associated with the procedure. The *Morgentaler* ruling left open the possibility to challenge the legalization of abortion based on protecting the fetus (although few attempts to do so have occurred). Funding for abortions has been a contested issue since *R. v. Morgentaler*, which impacts access to services for pregnant adolescents and others. Some provinces have refused to fund the entire cost of the procedure; other provinces refuse to cover the cost of abortions performed in private clinics (Kaposy and Downie 2008). Two cases pertaining to the provinces of Manitoba [*Jane Doe 1 v. Manitoba*, 2004 MBQB 285, 248 D.L.R. (4th) 547 (Q.B.) and *Jane Doe 1 v. Manitoba*, 2005 MBCA 109, 260 D.L.R. (4th) 149 (C.A.)] and Prince Edward Island [Morgentaler v. Prince Edward Island (Minister of Health and Social Services) (1996), 144 Nfld. & P.E.I.R. 263, 139 D.L.R. (4th) 603 ((S.C. (A.D.)) Morgentaler (1996)] have upheld the province's decision to refuse public funding for abortions

performed in private clinics. In a 2006 class action suit [*Association pour l'access a l'avortement c. Quebec* (*Procureur general*), 2006 QCCS 4694, (2006) R.J.Q. 1938], the province of Quebec was ordered to reimburse 45,000 women who had paid additional fees for abortion services because the public system could not provide the necessary services (Carroll and Dougherty 2006; Kaposy and Downie 2008).

More recently, the majority conservative government of Prime Minister Stephen Harper presented a motion (M-312) before parliament to grant personhood to the fetus. This motion was debated in April 2012, with a second round of debate scheduled for September 2012. The vote is scheduled for September 19, 2012 and, if passed may lay the legal groundwork to challenge *R. v. Morgentaler* (Abortion Rights Coalition of Canada 2012).

Abortion Barriers and Geographical Variation

Despite the large number of adolescent pregnancies that end in abortion, numerous barriers remain for Canadian women, some of which may differentially affect teenagers. Access to abortion varies regionally. For instance, most abortion clinics and hospitals which offer abortion are located within 150 km of the Canada-US border, effectively isolating roughly 20 % of the population (Royal Canadian Mounted Police 2010).

There are provincial differences in age and consent processes as well. But, legal precedent upholds a mother's autonomy even when she is young. For instance, in a 1990s case, the parents of a pregnant 14-years old contested her decision to have an abortion. The region's Children's Aid Society sought and was granted custody of the girl in order to enable her to have an abortion [*Children's Aid Society of the Region of Peel v. S.* (1991), 34 R.F.L. (3d) 157, [1991] O.J. No. 1388 (Ct. J. (Prov. Div.))]. The adolescent was found to have made a competent and informed choice and the Children's Aid Society was found to be acting in her best interests (Kaposy and Downie 2008).

Decriminalizing abortion in Canada, however, has not necessarily led to universal access to services. Downie and Nassar (2007) call access to a safe and legal abortion as "illusory" as it was in the 1970s. By contextualizing this choice through a discussion of potential barriers, geographical and age-related differences emerge. For example, hospital–based abortion services are declining. The percentage of general hospitals offering abortion services declined from 35 % in 1986 (Tatalovich 1997) to 15.9 % in 2006 (Shaw 2006). The recent 2005 deregulation of the emergency contraceptive pill, Plan B®, from prescription-only status to availability from pharmacists without a physician's prescription may mitigate some of these barriers and will be discussed further below.

Despite the declining percentage of hospitals that offer abortion services, most abortions in Canada are still performed in hospital (http://abortionincanada.ca/). Many such services are predicated on family physician referrals but with a physician shortage estimated at 3,244 (Buske 2009), a shortage more acutely felt in remote areas, referrals could cause serious delays to service. Furthermore, some antichoice physicians have resisted their patients' attempts to seek a legal abortion in several ways: by allegedly refusing to give referrals for their patients; actively blocking patient attempts to secure referrals from other sources; threatening to withdraw services if abortion is pursued (Downie and Nassar 2007).

Private clinics are not spread evenly across the country and require financial resources for services, travel to the clinic, and accommodation, decreasing their accessibility for many women. For instance, clinics are absent in Prince Edward Island, Nova Scotia, Saskatchewan, the Territories, and Nunavut (http://abortionincanada.ca). Many clinics do not offer information about their practices over the telephone for fear of harassment (Downie and Nassar 2007). Violence against abortion service providers is prevalent with over 15,000 reported incidents over 30 years and three shootings in the 1990s (Downie and Nassar 2007). Service providers are often personally targeted and because of a lack of

training many are reluctant to perform abortions beyond certain points in the pregnancy. Less than one hour of training on performing an abortion in four years of medical school is all that is required (Koyama and Williams 2005). Lack of newly trained abortion practitioners is exacerbated by retiring physicians and hospital downsizing which increases the demand for operating rooms and surgical personnel often wait-listing pregnant women until they are forced to seek services elsewhere due to delays (Downie and Nassar 2007).

Increasingly, abortion services are located in urban areas, adding financial burdens to rural women seeking services (Downie and Nassar 2007). Clinic abortions in Canada range in cost from $400 to $1425, with added costs of transportation, lost wages, accommodation, and possibly childcare. Not only are these costs more difficult to meet for poor women, and more costly for women living remotely, they are more problematic for adolescents and may necessitate the involvement of adults to facilitate abortion. Adolescents living remotely would need to secure more resources and then be separated from family and friends and a familiar environment in order to secure abortion services. This excess burden may account, at least in part, for the high live-birth rate among teenage mothers living in Nunavut. It certainly seems logical that the provinces with the highest rates of live births to adolescent mothers also have large rural populations and few or no abortion services. Nunavut has no private clinics and the only practitioner willing to perform abortions worked in a hospital that has lost its accreditation (Downie and Nassar 2007).

Age of consent legislation is a barrier specific to pregnant teens seeking abortion services. Some provinces (Ontario, British Columbia, Saskatchewan, Prince Edward Island, Quebec, and Manitoba) have specified an age at which minors can consent to treatment. Others use the age of majority that is either 18 or 19 years depending on the province. Complicating the issue are variations in hospital policy, which often requires parental consent, driving many adolescents to private clinics that believe that consent from those aged 14 years and older is necessary and sufficient. Those least capable of managing the financial costs of abortion services are those most likely to seek uninsured options.

Emergency Contraception

The earlier adolescents become sexually active, the longer they are at risk for unwanted pregnancies and exposure to sexually transmitted diseases. Large-scale Canadian surveys are performed periodically and offer data for comparison over time concerning teenage sexual behavior. Not all these instruments are identical but often have enough overlap in fields for comparative purposes. For instance, Rotermann (2008) found that fewer adolescents aged 15–19 years reported being sexually active in 2005 compared with 1996/1997. As with most national data in Canada, there are provincial variations. The proportion of teens in Nova Scotia reporting they had had sexual intercourse rose from 31 % in 1996/1997 to 49 % in 2005 whereas the figure fell from 41 to 37 % among Ontario adolescents (Rotermann 2008). Unfortunately, Rotermann does not offer any potential explanations for these data. Provincial differences in immigration settlement or sexual health education may explain some of this variation, but this remains speculative.

Approximately 75 % of teenagers reported using condoms the last time they had intercourse (Rotermann 2008). The odds, however, of not using a condom were higher for females who started having intercourse at the beginning of their teens (Rotermann 2005). The prevalence of oral contraceptive use among 15–19-year olds was 27 % in 1996/97 (Wilkins et al. 2000) and rose to almost 67 % by 2006 (Black et al. 2009).

On December 1, 2000, British Columbia became the first province of Canada to grant independent prescriptive authority to pharmacists allowing them to issue emergency contraception (known as "Plan B®") without a physician's prescription (Shoveller et al. 2007). By 2005, it was scheduled to be available to women across the country in this manner, and by 2008, the

National Association of Pharmacy Regulatory Authorities (NAPRA) recommended it be made available as an over-the-counter drug to increase accessibility (http://www.cmaj.ca). As with so many issues in Canada, the recommendations of NAPRA needed to be approved by the pharmacy regulatory authorities of each province and territory before implementation. Quebec, however, is not a member of NAPRA, so the recommendations are moot within that province. Currently, Plan B® is available in every province and territory. It is still kept behind the counter in Saskatchewan and available in Quebec with a pharmacist's prescription (http://www.planb.ca). However, in Ontario where pharmacies were surveyed before and after deregulation, Plan B® became more widely available post-regulation, although rural access remained constrained by more limited pharmacy hours than in urban centers (Dunn et al. 2008).

Research based in British Columbia compared the use of emergency contraceptive pills before and after pharmacists were authorized to dispense without a prescription and found that availability expanded and there was an increase in provincial use post-policy compared with pre-policy (Soon et al. 2005). Likewise, despite deregulation removing one barrier to access, another has been created, namely a fee for "counseling" or administration that is charged by some pharmacists. This fee is typically about $20 in addition to the drug, which is roughly $26 (Eggertson 2008), but the extent it may vary in price and application across the country is unknown. Although some provinces cover such fees, most women will be faced with this additional cost (Pancham and Dunn 2007).

Sexual Health Education: A Human Rights Perspective

Sexual health education began in the 1970s in Canada and has evolved considerably since that time. Initial aims focused on reducing teen pregnancies but by the 1980s had evolved to incorporate growing concerns about HIV/AIDS (Martinez and Phillips 2008) and more recently to pilot programs among elementary school children (Wackett and Evans 2000). From an information only approach in the early days, the focus changed in the 1990s to incorporate strategies for behavior and decision-making skills. The Public Health Agency of Canada has periodically published national guidelines for sexual health education since 1994 (http://www.phac-aspc.gc.ca). Its 2003 version recognized the environmental and social determinants of sexual health that included discussions of sexual pleasure and was built around international recognition of sexual health as a rights issue (Martinez and Phillips 2008). These values are reflected in the text below taken from the recommended sexuality education program to help parents talk to their children about sexuality called "Talk to Me"—Sexuality Education for Parents made available in Canada's Public Health Agency Web site (www.phac-aspc.gc.ca/publicat/ttm-pm/index-eng.php):

Parents will become more knowledgeable of the different methods of contraception and the benefits of dual protection. They will have a chance to discuss each method and explore the advantages and disadvantages, as well as what may make one method more appropriate for their teen than another. The participants will also become more familiar with the main difficulties teenagers face related to birth control methods and will have the opportunity to assess the impact of their own roles and values in matters of contraception.

The above recommendations encourage parents not only to become informed of the various contraceptive options but also to discuss these with their children so that young people can make informed decisions. These recommendations build upon Canada's 2008 Guidelines for Sexual Education (Public Health Agency of Canada 2008), which happen to be the revised guidelines from 2003, have the following two goals (p. 8):

1. To help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, and informed reproductive choices); and

2. To avoid negative outcomes (e.g., STI/HIV, sexual coercion, and unintended pregnancy).

It is not difficult to appreciate the perspective that human sexuality should be viewed as a human right when the philosophy and educational elements of the Canadian guidelines are considered (Public Health Agency of Canada 2008, pp. 11–12). We list these below. As stated in the report, effective sexual education:

- does not discriminate on the basis of age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities, and religious background in terms of access to relevant, appropriate, accurate, and comprehensive information.
- focuses on the self-worth, respect and dignity of the individual.
- helps individuals to become more sensitive and aware of the impact their behaviors and actions may have on others and society.
- stresses that sexual health is a diverse and interactive process that requires respect for self and others.
- integrates the positive, life-enhancing, and rewarding aspects of human sexuality while also seeking to prevent and reduce negative sexual health outcomes.
- incorporates a lifespan approach that provides information, motivational support and skill-building opportunities that are relevant to individuals at different ages, abilities and stages in their lives.
- is structured so that changes in behavior and confidence are developed as a result of non-judgmental and informed decision-making.
- encourages critical thinking and reflection about gender identities and gender-role stereotyping. It recognizes the dynamic nature of gender roles, power and privilege, and the impact of gender-related issues in society. It also recognizes the increasing variety of choices available to individuals and the need for better understanding and communication to bring about positive individual health and social change.
- challenges the broader and often invisible dynamics of society that privilege certain groups (e.g., heterosexuals) and identifies those dynamics, which marginalize or disadvantage others (e.g., sexual minorities, people with disabilities, and street-involved youth).
- addresses reasons why antioppressive (sexual) health education is often difficult to practice.
- recognizes and responds to the specific sexual health education needs of particular groups, such as seniors, new immigrants, First Nations, Inuit and Métis communities, youth, including “hard to reach” youth (e.g., street-involved and incarcerated), sexual minorities (e.g., lesbian, gay, bisexual, trans-identified, two-spirited, intersex, and queer) and individuals with physical or developmental disabilities, or who have experienced sexual coercion or abuse.
- provides evidence-based sexual health education within the context of the individual’s age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities, religious background and other such characteristics.

It is indeed striking the comprehensiveness of the health promotion aspects and extent to which the guidelines focus on the wellbeing of the individual while taking into considerations macro issues. These guidelines, firmly framed within a social welfare perspective, rely on evidence-based research to promote sexual wellbeing.

There is some evidence and concern, however, that despite the well-articulated human rights perspective evident in the guidelines, the implementation, and consequent impact may be less than adequate. For instance, Martinez and Phillips’ (2008) study of Ottawa area teachers and young adults document some of the tensions between the risk-focused biomedical approach and the inability to address inequities based on race/ethnicity, gender, or sexual identity. Although professionals serving teenagers such as educators, counselors, and others may use but are not bound to these guidelines these provincial curricula are the basis for the implementation of sexual education in Canadian classrooms. A more detailed discussion of geographical variation is presented later in the chapter in the section entitled *Regional Variation*.

Adolescent Pregnancy as "Risky Business"

Risk discourse is a common vehicle used among claims-makers to influence public opinion. In the public and professional literature related to adolescent pregnancy, a *risk discourse* is commonly used by researchers, educators, and service providers. Researchers often link risk with increased health care costs for services to adolescent mothers. The economic burden of teenage pregnancy to the health care system (see Al-Sahab et al. 2012, for instance) is another way of framing discussions about teenage pregnancy as a problem not limited to the individual and the families in which the pregnancy occurs, but for all taxpayers. By framing the discourse to include the population at large the business of risk verses cost moves from the individual (private) to the collective (public).

Currently, Canadian hospitals spend 1 dollar in 10 on health care for all mothers and babies (CIHI 2006). In 2002–2003, hospitals outside Quebec and Manitoba spent $1.1 billion on pregnancy and childbirth services for typical maternal inpatients and typical newborns (CIHI 2006). Furthermore, adolescent pregnancy can be placed as many Canadian health care initiatives are, as a risky, costly problem that is to be prevented.

Prevention is a key trope within Canada's health consciousness and it fits without conflict within two strong social imperatives: *individually focused health concerns and collective health care agendas like keeping costs low*. Researchers cite risk of low birth weights and associated health problems among babies born to teenage mothers (Al-Sahab et al. 2012; Dryburgh 2000; Health Canada 1999; Shrim et al. 2011; Wadhera and Millar 1997). Similarly, pregnant adolescents are at greater risk of anemia, hypertension, renal disease, eclampsia, and depressive disorders (Combes-Orme 1993; Dryburgh 2000; Turner et al. 1990). Risky sexual behavior has been associated with substance use and unplanned sexual intercourse among Canadian adolescents (Poulin and Graham 2001). Some researchers cite more "upstream" sources of this disparity such as poverty (Al-Sahab et al. 2012, for instance). Al-Sahab et al. (2012) compared teenage mothers with average aged mothers. Their robust sample size of 6,188 respondents to their Canada-wide survey revealed that teen mothers were more likely to have low socioeconomic status, be non-immigrant, have no partner, reside in the prairies, have experienced physical or sexual abuse, and would have preferred to have had their pregnancies later in life. Some researchers cite low pregnancy rates as indicators of young Canadian women's ability to control their reproductive health (McKay 2004). The argument is that if Canadian youth had less control, the pregnancy rates would be higher, closer to rates in the United States and United Kingdom. Shoveller and Johnson (2006) have argued that the assumption of teen agency and control may be overestimated in these models.

Given this climate of risk and prevention, government reports about the health of Canadians indicate that mothers younger than 20 years are associated with the highest rate of "small for gestational age" (SGA). SGA babies are born with a birth weight below the 10th percentile for gestational age and sex at 10 % (CIHI 2009). The authors of that report maintain that understanding the factors related to SGA births can help reduce costs. Teenagers are more likely to give birth to a SGA baby due to their physical immaturity and the inability of their bodies to adapt to the physiological demands of pregnancy (CIHI 2009). So there is physical risk for both the teenage mother and the SGA baby, but government reports also link these medical concerns with the approximately 1.6 times higher hospital costs for SGA babies (CIHI 2009). It is important to note that data in this report exclude the province of Quebec because of data unavailability. From a population health perspective, this may be a significant oversight because roughly ¼ of the country's population reside in Quebec. However, English language publications rely heavily on Statistics Canada datasets and failure to report (or record) in Quebec makes national claims difficult.

Socioeconomic status is associated with many adverse health outcomes including teenage pregnancy (CIHI 2009) and other possibly linked issues including substance and tobacco abuse (Jacono et al. 1992). Langille et al. (2003) reported that lower SES was significantly associated with drinking excessively among both adolescent males and females surveyed in rural Nova Scotia. As well, SES was significantly associated with driving after drinking among males and marijuana use among females (Langille et al. 2003). An earlier unpublished manuscript by Curtis demonstrated that adolescents living in low-income families were more likely to drink and smoke regularly (Langille et al. 2003). Studies indicate that despite universal access to health care, women living in poor neighborhoods may not use health care resources "effectively" (Dunlop et al. 2000). Unfortunately, this language blames individuals for not accessing services and may indicate a possible need for increased effects toward health literacy among Canada's poor. Small for gestational age babies (SGA) rates are highest among poor neighborhoods (CIHI 2009). Though the majority of teenage births do occur in low-income neighborhoods, 22 % occur in high-income neighborhoods suggesting the need to address these issues widely (CIHI 2009).

As one can imagine given Canada's vast geography, aggregate national statistics mask the variation that exists across the country. Within Canada's vast and varied geographical landscape, the ethno-cultural, social, political, and health "scapes" are equally varied and in flux. The total picture is, perhaps, difficult for educators and health professionals to apply locally. This is reflected in focused research projects that attempt to grasp local complexities. Aggregate statistics do tell us that the composition of new Canadians (recent immigrants) is changing and may mean constant shifting of resources and supports for emergent communities such as in some pockets of Toronto. The next section explores this variation.

Regional Variation

Although health care in Canada is "universal," payments from the federal government are transferred to provincial governments for management and distribution. This results in a patchwork quilt of health care services, policies, and priorities among and within provinces. Registration of some vital statistics may also vary by province/territory and over time (CIHI 2009). Similarly, adoption of new services such as emergency contraception, available without a physician prescription from pharmacists, or over the counter has been adopted at different times across the country (Shoveller et al. 2007). This geo-economic variation overlay the complexities of rural–urban variation and ethno-cultural differences over vast geographical spaces. People who live in small remote towns may rely on health services located in different towns, sometimes hundreds of kilometers away. In the far north, there may not be roads or railways that link a place of residence to the nearest health care services. This becomes a problem of access predicated on geographical isolation and the severity of climatic conditions associated with it and the economic burdens of remote air transportation for people among the poorest in the country.

These challenges are reflected in Canada's vital statistics. For instance, Nunavut and the Northwest Territories had the highest proportion of babies born to teenage mothers at 22.7 and 11.2 %, respectively (CIHI 2009). Of the provinces, Saskatchewan and Manitoba had the highest babies born to adolescents at 10.3 and 9.1 %, respectively. While very few (0.0–1.7 %) fetal deaths (stillbirths) occur out of hospital in most provinces, non-hospital fetal deaths in Manitoba were 14.7 % in 2009 (Statistics Canada 2012). Canadian adolescents are also very diverse with behaviors ranging from very sexually active to abstinent, with a multiplicity of cultural, social, and religious circumstances that may contribute to those behaviors (McKay 2004).

The higher prevalence of teenage pregnancies among those living in the Prairie Provinces and Territories is sometimes linked with an elevated proportion of Aboriginal peoples in these regions. Aboriginal peoples comprise 85 % of the populations of Nunavut, 50 % of the Northwest Territories, 25 % of Yukon, 16 % of Manitoba, and 15 % of Saskatchewan (Statistics Canada 2008b). Aboriginal youth are four times more likely to have teenage pregnancy (Murdoch 2009). There are hints of cultural differences with Al-Sahab et al. (2012) citing research that Aboriginal communities do not consider teenage pregnancy a tragedy (Best Start 2007). This ethno-cultural variation, specifically related to Aboriginal communities, has been cited by others (Bissell 2000; McKay 2004).

Live births registered in Nunavut account for 20 % of the live births registered to mothers age 15–19 years old. Manitoba, Saskatchewan, and the Northwest Territories also have higher proportions of live births among this age cohort with 8.9, 8.9, and 8.6 %, respectively (Statistics Canada 2012). Interestingly, 14.3 % of these births are recorded by Statistics Canada with "unknown" geography. While no explanation is offered concerning this ambiguity, it may reflect regional variation in health care access that forces many people to travel across provincial borders for services.

Research tends to focus on local experiences and implementations of national guidelines and policies. For example, Ninomiya's recent study (2010) of the experiences of junior high school sexual educators in Newfoundland and Labrador explored the topics, comfort levels, and opinions about curricula and professional practice. Langille et al. (2003) focused on high school students in rural Nova Scotia and numerous articles are based solely on the Toronto Teen Survey. It is difficult to extrapolate local results to the wider population due to regional variations of economics, environment, access to services, laws, funding, knowledge and attitudes, and ethno-cultural landscapes.

Multicultural Policy and Ethno-Cultural Variation

The Pearson government of the 1960s appointed a Royal Commission on Bilingualism and Biculturalism (the B&B Commission) in response to a perceived national crisis originating in Quebec. The report emphasized Canadians' desire to feel united as one, rejected the perceived duality of the Canadian identity legitimized and disseminated through popular phrases like "two founding nations" (Mansur 2011). The commissioners thought that the overwhelming presence of the United States obscured Canadian identity. The term "multiculturalism" was used by non-Francophone Canadians who expressed a desire to have all ethnic groups recognized as equals rather than just the "equal partnership" of "two nations" that privileges people of British and French descent. On the heels of the B&B Commission, Liberal Prime Minister Pierre Trudeau introduced the Official Languages Bill, which was passed into law in 1969 making Canada an officially bilingual country (Mansur 2011). The next step came in 1971 with the Multicultural Policy that was formally presented as a policy of multiculturalism within a bilingual framework (Mansur 2011). The Multicultural Policy had the support of all political parties with the only notable voice of opposition coming from Quebec Premier Robert Bourassa who was concerned with the defense of the French language and culture if the federal government was assuming responsibility for the cultural freedom of all Canadians. The Canadian Multiculturalism Act was passed in 1988 under Conservative Prime Minister Mulroney, making Canada the first Western liberal democracy to use multiculturalism as a defining characteristic of the nation and a directive principle for the government to abide by and promote.

With these policy changes came what has been dubbed a "polite revolution" (Ibbitson 2005), a dramatic refashioning of the Canadian

society. Changes came in many areas including immigration, education, and employment equity policies. Discourses of identity emphasized Canada as a "cultural mosaic" (often juxtaposed with America's "melting pot") and dubbed immigrants "new Canadians." Certainly, the demographic profile of Canada has changed dramatically over the last 40 years, and large cities like Toronto, Montreal, and Vancouver have very large proportions of their populations who are born outside of Canada. Fifty percentage of Torontonians for instance were born outside Canada, making it one of the most diverse cities in the world. Only 26 % of Torontonians were born in Canada to two Canadian-born parents (Schellenberg 2004). There are over 140 languages and dialects spoken there. It is not uncommon to find schools in Toronto with dozens of mother tongues that are not English or French. Of course, there are rural–urban differences, north–south differences, variation within the Canadian-born population, and differences in the spectrum of cultures between Canadian cities. Further, the countries of origin for immigrants are dynamic, making culturally appropriate policy, services, and education an ongoing challenge, with concerns about adolescent pregnancy and sexual health education illustrative of these challenges.

These cultural variations that result from multicultural policies are reflected in the research variation about fertility and pregnancy that emerges from Canada. For instance, some research focuses on specific cultural groups such as Chinese reproductive behavior in Canada and their decreased fertility rates associated with relative economic insecurity that accompanies minority membership and the immigration process (Tang 2004). Other work highlights cultural comparison. For example, Mitchell's (2001) work compared attitudes toward heterosexual cohabitation among ethno-culturally diverse young adults living in the Greater Vancouver Regional District. Studies vary in approach, theoretical lens, and disciplinary focus. "Culture" is widely used but rarely defined. Sometimes, the word "culture" is used interchangeably with ethnicity; sometimes, this includes or overlaps with religious affiliation; and, sometimes, the culture in question is youth itself. In Netting's study (1992) of the "youth-culture" among university-aged students, three sexual "subcultures" were identified: celibacy, monogamy, and free experimentation. Qualitative work by Shoveller et al. (2003) situates adolescent sexual development within sociocultural contexts and emphasizes the embeddedness of teenagers and their experiences within family, peer, community, and broader social contexts. This work is increasingly plentiful as local practice demands more information, but interestingly, the authors of this chapter note that this growing literature appears to represent a mosaic of stories that so far loosely hang together. It may be that another decade of research is needed for findings to tie these various studies together and allow for more universal generalizations.

Multicultural policies are aimed at assuring equality among numerous cultures, and they may have, at least theoretically, created a space in which Aboriginal cultures can also be discussed as components of the Canadian mosaic. Many might argue that special consideration ought to be given to Canada's First Nations given a history of genocide, relocation, and structural violence. Certainly no discussion of adolescent pregnancy in Canada is complete without research that touches on this topic despite problems of poor and incomplete data, and a lack of population-based linked data of Aboriginal births, stillbirths, and infant deaths (Luo et al. 2004). Rotermann (2007) points out that provinces and territories with high rates of second of subsequent births to teens tend to have relatively large numbers of Aboriginal residents. Unlike other Canadians, Aboriginal peoples have not seen a trend toward delayed first births (Rotermann 2007). For instance, in 1999, more than 20 % of First Nations babies were born to mothers aged 15–19 years (Health Canada 2005) compared with 5 % of non-Aboriginal babies (Rotermann 2007).

The Toronto Teen Survey is a community-based participatory research project that engaged 1,216 ethno-culturally and sexually diverse youth aged 13–18+ years in Toronto (Flicker

et al. 2010). Youth older than 18 years were not excluded from the survey if they wanted to participate. The partnership between the Toronto Teen Survey team, a Youth Advisory Committee, and Planned Parenthood Toronto administered surveys in 90 community workshops (Flicker et al. 2010). Care was taken to include populations who experience increased vulnerability to poor sexual health outcomes such as queer youth, young parents, and newcomers. Ninety percentage indicated their sexual orientation was heterosexual, 65 % were born in Canada, and 22 % were born outside Canada but had lived in Canada for four years or more. The sample was racially diverse with 14 % identifying as White, 14 % as Black, 38 % as East/Southeast Asian, and 13 % as multiracial. Several analyses have been derived from these data and offer an interesting glimpse into the challenges of implementing culturally appropriate services to adolescents.

Pole et al. (2010) explored the associations between sociodemographic factors and sexual behavior. Aggregate statistics are consistent with national statistics: 3 % of Torontonian teenagers experience their first sexual intercourse by age 13 and 28 % of teens aged 15–17 years report having had sexual intercourse at least once (Pole et al. 2010). East/Southeast Asian youth, Muslim youth, and newcomers were less likely to report high levels of sexual behavior. The authors suggest that professionals targeting these three groups ought to pay particular attention to issues of acculturation and intergenerational ideas about sex and sexual behavior (Pole et al. 2010). These data challenge some racially based stereotypes of sexual behavior with 32 % of Black adolescents reporting having had intercourse compared with 49 % of White adolescents. Risk for intercourse sexual activity was doubled among respondents who identified as LGBTQ. Young men who have sex with men are at increased risk for HIV/AIDS and young women who have sex with women were more likely to report intercourse activities compared with their heterosexual peers (Pole et al. 2010). Other studies indicate higher rates of pregnancy among sexually diverse young women (Saewyc et al. 1999).

Causarano et al. (2010) used data from the Toronto Teen Survey to assess exposure to sexual health education topics and teens' desire for more information about specific topics and associations with religious affiliation. They found that youth most frequently reported having learned about HIV/AIDS, STIs, and pregnancy and birth control but would like to learn more about healthy relationships, HIV/AIDS, and sexual pleasure (in that order) (Causarano et al. 2010). Lower age of respondent was associated with less desire for more information and higher age was associated with increased desire to learn more. Muslim youth were significantly less likely to desire more information on any topic than those youth who reported no religious affiliation. Protestant youth were more likely to have learned about STIs than those who reported no religion (Causarano et al. 2010).

Gender Inequalities

Unfortunately, as successful as Canada has been in preventing and reducing inequalities, gender inequities are still present. Varcoe et al. (2007) point out that women die prematurely from largely preventable conditions; they die in the prime of their life in greater numbers than men (largely due to cancers); and they experience higher levels of disability compared with men. In fact, violence against women in Canada persists as a major social problem despite declining reported rates of spousal homicide and violence (Statistics Canada 2006). Statistical trends are difficult to estimate accurately due to the private nature of the problem and the stigma that is associated with it. As well, the complexity of interpersonal violence is appreciated by researchers who are quick to point out that a significant number of people accused of spousal homicide do so in self-defense (Statistics Canada 2006). Nevertheless, several things remain clear from the available data, both men and women experience intimate partner violence. However, the severity of violence experienced by women is far greater than that for men. Surveys conducted in 1993, 1999, and 2004 indicate

a statistically significant decline in the rate of violence against women; in 1993, 12 % of respondents indicated they had suffered violence in the preceding five years compared with 7 % in 2004 (Statistics Canada 2006). The economic cost of violence against women has been estimated by several studies. For instance, a study by Greaves et al. (1995) estimated the economic burden of criminal justice, compensation, medical, shelter, and other services and lost productivity at $4.2 billion annually. Women under 25 years are at greater risk of sexual assault (6 %) and criminal harassment (9 %) than women in older age groups over a one-year time period (Statistics Canada 2006). Similarly, women between 15 and 25 years experience spousal homicide at higher rates than older age groups (Statistics Canada 2006). Psychological, physical, and social costs are readily acknowledged but more difficult to assess (Statistics Canada 2006). Also, Canadian men experience intimate partner violence at significantly lower rates than their female counterparts (Statistics Canada 2006). Rates vary within the country with rates of spousal violence (referring to both marital and common-law unions) against women in the territories higher than the provincial average (12 and 7 %, respectively) (Statistics Canada 2006). Increasing awareness of the problem, and programs and policies to combat it are expanding. The number of shelters available to women survivors of intimate partner violence is increasing, specialized domestic violence courts have been established, and discussions of what constitutes healthy intimate relationships have been worked into sexual and reproductive health curricula.

Despite these changes, there is a growing concern that nationally focused strategies may not be equally appropriate given the cultural diversity of the country (Shirwadkar 2004). For instance, consistently lower rates of partner violence in Quebec compared to the rest of Canada has led researchers to ask questions about Quebec's "culture" of male partner violence against women compared with the other provinces and territories (Brownridge 2002). Brownridge's analysis indicated that the rates of violence against women in Quebec were lower than rates from the rest of Canada and that men in Quebec who hold more rigid patriarchal attitudes were more likely to be violent than those who did not (Brownridge 2002). A telephone survey among the 2,120 female Francophone Quebecers indicated victimization rates of 6.1 % for physical violence and 6.8 % for sexual violence with significantly higher rates in the presence of controlling and humiliating behaviors by their partners (Rinfret-Raynor et al. 2004). A representative sample of 7,115 immigrant women in Canada demonstrated that women from developing countries had the highest rate of violence and that the sexually proprietary behavior of their partners was the key explanatory variable (Brownridge and Halli 2002). There is also concern about specific ethno-cultural groups of women and their considerations and concerns about accessing services or seeking help. For instance, a qualitative study among East Indian immigrant women in Ontario revealed that Canadian policies and services were inadequate to meet the complex needs of this community. Understanding the power dynamics of family, the caste system, and community pressures were central to the behaviors and potentially impactful interventions (Shirwadkar 2004). The author emphasizes the tremendous diversity *within* the Indian-Canadian community that was beyond the scope of her study. Many of these concerns are generalizable across many ethno-cultural groups in Toronto and other diverse cities in Canada.

When a Canadian Teenager Becomes a Parent

When a teenage girl becomes pregnant in Canada, she can access (at least theoretically) emergency contraception or abortion services assuming she has the resources and the inclination to do so, as discussed above. But what about those teenagers who choose to have their babies? Some will opt to place the baby for adoption, although research indicates that adoption is the

least discussed potential resolution for pregnant teens. Adoption as a resolution to an unplanned pregnancy in Canada had declined to 2 % in 1989 (Daly 1994). Daly (1994) administered questionnaires to 175 Ontario students between 15 and 19 years old to explore their values, attitudes, and knowledge about adoption. The author found that although adoption was viewed favorably, there was concern among respondents about how friends and family would feel (Daly 1994). For those who raise their babies, it may not be as limiting as it once was. A few high schools for teenage parents have been opened in Canada, giving adolescent parents a chance to complete their education in a less isolating and stigmatizing environment. The Louise Dean School in Calgary, Alberta, is one such school dedicated to educating pregnant and parenting teens. The school falls under the auspices of the Calgary Board of Education, is easily accessible by public transportation, and offers on-site daycare for 40 babies with nursing and social worker services. A glimpse into the experiences of an adolescent mother, her pregnancy, and how her pregnancy impacted her relationships and life is partially reproduced below. These excerpts are based on interviews conducted by Macleans magazine, a Canadian national news magazine and are available online at macleans.ca (Lunau 2008).

Kayla Clark, 18, got pregnant at age 16. Clark's baby, William, will be two years old in April. She is now a student at Louise Dean Centre. Here, Clark tells Macleans.ca *what it's really like being a teenage mom.*

***Macleans*.ca: Talk about when you found out you were pregnant.**

Kayla Clark: I took two home pregnancy tests, and they came back negative. Then I went to the hospital because I was having really bad pains. And they did a pregnancy test, and it was negative. So a week later, I went to my family doctor, and he did a pregnancy test and it was negative. He sent me for an ultrasound, to see what was causing my pains. [That's when] I found out I was pregnant.

The first thing that went through my head was, "This has to be a mistake." There was no way I could be pregnant, after multiple pregnancy tests all being negative. I thought, "I have no idea what I'm going to do." I'm alone—I broke up with the father. I had no one, and I didn't know what my parents would do. Finding out I was pregnant was one of the hardest things, because me and my dad were best friends. And when I told him I was pregnant, his heart broke. He didn't even talk to me for a week; every time I came into the room, he'd just leave. He couldn't stand to be around me.

***M*: Did you seriously consider abortion or adoption as options?**

KC: My mom looked into abortion at first for me. But because I found out in an ultrasound, the first thing they did was show me the baby's heartbeat. And right then, I knew I couldn't get rid of him. I knew it would be too hard. I made a pros and a cons list, and the cons side was huge—how to go to school, raising him by yourself, no housing, no support, everything. But the pros were I'm having a baby, I'm bringing somebody into the world. Somebody that I should be able to take care of.

***M*: Has having a baby been different than what you expected?**

KC: While I was pregnant, I lived with my parents. They weren't supportive at the beginning, but as it got closer and closer to the time I was going to have him, my mom came around. It took my dad until he was born to come around. My parents really helped me with buying the crib, buying clothes, the car seat, and all that. The school was helpful too. If I needed stuff, the social workers there were always looking, keeping an eye out. Teachers would bring in donations from their house.

When I was pregnant, my dad told me that if I kept the baby, I would have to move out. It really got my butt in gear to find a place. I have two little twin brothers, they were 15 when I was pregnant. So it was really hard, because they wanted all the attention. They couldn't have another baby in the house. Now I live in subsidized housing. It's a lot more work being on your own.

***M*: Some people say teen pregnancy is more accepted today than it was years ago. Do you think there's still a stigma out there against pregnant teens?**

KC: I don't think [teen pregnancy] is as taboo. Parents, and society, are more accepting of the fact that young people are having children. Some older people will ask me, "Why now? Why wouldn't you let someone adopt your baby?" It's hard, because you want to explain to them why you couldn't. But at the same time, the way they were brought up, [they were taught] it was wrong to have sex before you were married. So I can understand where they're coming from. You get your licks from them, and you get your licks from teenagers—they say, "Wow. She must be easy. She had sex, and didn't use protection." But it's not like that. I was on two forms of birth control, and I still got pregnant.

***M*: With all the images of pregnant celebrities in the media, do you think that impacts teens and the way they see having a baby?**

KC: I think it's huge. Angelina Jolie, or JLo—they all seem to get pregnant now, and it's turning into a fad. The younger generation thinks everyone's having babies, and they don't realize it's not *just* the nine months that you're pregnant. It's forever.

***M*: What's next for you?**

KC: I start at [the University of] Lethbridge in September. My major is exercise science—it's kinesiology. I want to do sports medicine.

These excerpts reflect several predominant ideals in Canada regarding health and welfare. The young woman had access to reproductive health care during and after her pregnancy. Her experience was a family matter. She is attending a school specifically designed for teenage parents that assists with childcare and life coaching, and she is looking forward to a career. Arming a teenage mother with an education and the necessary support in the short term in order to assist her self-sufficiency in the future reflects the values that guide Canada's health care system. Unfortunately, the statistics about teenage pregnancy reflect other realities not reflected in these stories such as a history of childhood abuse, increased use of alcohol and drugs among teenage mothers, and lower socioeconomic status that may impact access to reproductive health services. Also, this story is a southern Canadian story. For adolescent teenagers living in Canada's arctic, culture, geography, and economic considerations that shape teenage pregnancy experiences are very different. Consider the following quotes taken from a qualitative study of teenage pregnancy in Inuit communities (Archibald 2004). Interviews and focus groups were conducted with 53 teenagers and adults. When asked about the ideal age to start having children, respondents said between 13 and 20 years, either when menstruation began or when they were socially mature enough to care for a family (Archibald 2004).

Question: When is it ideal to start a family?

Elder Response: "I had my first child at 14… My grandchildren live in another world entirely… Thirteen- or 14-year olds today are still babies."

Response: "The methods that parents used were, when a young woman or man could sustain or look after themselves, and learn to sew for a woman and learn to make snow houses for a man. These were used as indicators that they could look after themselves or others."

Q: Is pregnancy a problem?

R: "Young ladies are getting pregnant too early, not living with their boyfriends, not living together. Grandparents cannot always help out with the necessities like milk and diapers and the whole family suffers, especially the baby." "I see kids in school who are hungry, poor, not dressed properly. I also see children in school having difficulties because the mother took drugs during her pregnancy."

Q: Why do teenage girls become pregnant?

R: "They look for love, for someone to love them." Some girls "come from homes where there are alcohol and other problems so they have been denied the nurturing care themselves and they may be looking for something that's their very own…" [Many pregnant teenage Inuit girls leave the community to have their babies, which would effectively distance them from abusers. Being pregnant enables them to have a modicum of financial independence with access to the child tax credit (Archibald 2004)]. "Some

Inuit teenagers get pregnant by older men. Young girls sometimes get used by older men…" "…just to sleep with a white man…"

R: "Now, there are many people in the community whereas before there were only a few families living together. The families had more control." [This refers to a shift in community organization in the 1950s and 1960s when Inuit peoples were settled into communities from smaller-scale camps composed of a few families (Archibald 2004)]. "In bigger communities and with schools, they tend to take away the role of the parents, then they should start teaching things the parents used to teach…. Put more elders in the schools."

Q: Regarding contraception…

R: "I approve of contraception such as birth control pills, but if the young woman is healthy and strong and able to bear a child, then I prefer to use the body well."

Q: regarding talking about sexuality…

ER: "Not only mothers and daughters, but the whole world."

Q: What are the challenges of teenage pregnancy?

R: "Their education ends up suffering if they planned to finish high school or they might give up plans to go to university." "…a lot of young women will keep their babies in the beginning but when they start struggling and have more problems, they give them up to social services. They know that social services will put the baby in a good home, and that the baby will be provided for." "…the mother is usually the one who ends up with the responsibility. Girls are faced with this more to the point where they're not afraid to die or kill themselves." "If family is not well off financially, everybody will suffer. We are not a society that can just say "okay, go get an abortion." ….the mother and baby will both suffer."

Concluding Remarks

The provincial funding formula, a long-standing national focus on policies of "multiculturalism," the emergence of cities classified as "super-diverse" such as Toronto, and the vast social geographical variation beg questions about teenage pregnancy national aggregate statistics and their utility at a local level. Canada's enormous diversity and public health care system is an interesting research crucible to explore social determinants of reproductive health. But it also raises questions about "cultural competence" of both educators and health care professionals involved with pregnant teenagers or attempting to reduce the "risk" of adolescent pregnancy. How can professionals possibly be "competent" in a city such as Toronto? Perhaps the notion of "cultural humility" is a better "best practice" aim than cultural competence (Ortega and Faller 2011). Large cosmopolitan cities such as Toronto are not static, but rather constantly evolving and altering; therefore, it calls for flexibility to meet the changing needs of the community, rather than to gain mastery over discrete populations. Furthermore, research focused on points of delivery (classroom, religious institutions, community centers) might be a more applicable stream than research that focuses on one or several distinct groups of adolescents. This is especially poignant if we are to consider long-term sustainable care and service delivery.

If Canada is to stand behind the antidiscrimination guidelines mentioned earlier, then the true challenges will be measured in how to implement and sustain their commitment to human rights. We have noted that Canada has decriminalized abortion throughout its provinces; however, there remain widespread issues including lack of access to safe affordable clinics especially for young women who live in non-urban settings. Continued gender inequalities taint the private and public domain when it comes to female sexual health, which translates into ineffective sexual education and interventions. Sadly, these discriminatory practices infect the social structures, which provide preventive and treatment health care services for women and more vigilance needs to be made in this area.

Finally, although Canada has shown attention to these issues, we caution that funding streams, education, and access to services should not be hampered by ideological debate and grandstanding. Adolescent female health is vital to the

future of families and communities throughout Canada. The outcomes not only affect the young women themselves, but their children, families, and communities. Researchers, intervention strategists, and policy makers therefore would benefit from the cultural humility of constantly re-evaluating self-knowledge rather than relying on political rhetoric in dealing with female adolescent sexual health. In this way, Canada could be an even greater leader and innovator for better access to services and overall health outcomes for their young population.

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Adolescent Pregnancy in Chile: A Social, Cultural, and Political Analysis

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Keywords
Chile · Adolescent pregnancy · Reproductive health · Cultural · Gender · Sex · Sexuality · Abortion · Infant mortality

Introduction

The Republic of Chile boasts a spectacularly long coast line of 2,700 miles long but only about 100 miles wide. It defines the southwestern border of Latin America. Chile's geographic boundaries, to the west the Pacific Ocean and to the East the Andes mountains, have contributed to its perception as isolated and insular. By July 2011, the population of Chile is estimated to be close to 17 million. This country's rich and complex history is marked by great economic advancement yet tempered with serious political and social repression such as the Augusto Pinochet military dictatorship that lasted 17 years (1973–1990). Today, Chile maintains a democratically led government and claims to be the most economically and socially stable country in Latin America. These changes have dramatically changed the social and political climate for all Chileans, and especially for adolescent females. Young Chilean girls and boys must not only manage the changing hormonal and social pressures of their adolescent lives, but they must also navigate a current reality marked by historical, religious, cultural, economic, and political processes. This chapter posits that the complex social realities of Chilean history and present social and political realities contribute to the country's failure to properly address issues concerning adolescent sexuality, sexual and reproductive rights, health, and education, and teenage motherhood.

History: A Story of Conflicting Paradigms

Chile, similar to other countries in Latin America, was colonized by Spain in the 1500s. Indigenous populations (such as the Incas and Mapuches) lived throughout Chile prior to European arrival. The country's social and political structure altered

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to mimic the European feudal organization was centered on the 'hacienda.' This system defined 'a vertical and authoritarian structure of total domination by the landowner' (Falabella 1997) and filtered down through the family structure with the patriarch lording over both land and family. In the early nineteenth century, Chile began its bid to gain independence from Spain with the proclamation of independence signed in 1818. Freedom from Spain, however, did not mean freedom for all especially indigenous populations and women.

With independence, the responsibility of running a nationwide educational system emerged (Yeager 2005). The Roman Catholic Church took over the primary role of public school educators, and Yeager 2005 argued that this shift and consolidation of power resulted in deleterious effects especially for girls, who felt the historical sting of structural oppression permeate their educational experiences:

> …Catholic female gender training, often referred to *marianismo* and characterized as an ideology female submissiveness internalized by most Latin American women, was not simply a legacy from the colonial past, but was systematically taught to girls in the public elementary schools (p. 210).

Thus, the social and political 'legacy' for girls in Chile has its roots in concurrence with the independence from Spain and the Catholic Church's integration into the social and moral fabric of the educational system. The Catholic Church's educational system supported restrictive gendered roles and opportunities which were in line with church ideology. Although the shift from secularism arose throughout the mid-nineteenth century, 'positivist reformers' were not very successful in advancing the highly gendered norms and expectations for girls and women. For example, women were not given the right to vote without restrictions until 1949.

Chile's precarious political history impacted women's health and economic status. Chile's political history and its nation attempts to develop evolved through a series of various coups, revolts, and economic depressions. In 1970, Chile elected its first Socialist president, Salvador Allende. By 1973, Allende was shot in a military coup backed by the Nixon administration and led by General Augusto Pinochet. Pinochet ruled as a dictator for 17 years. As a result of a national plebiscite in 1988 where a majority of the population voted against his continuing as president, he eventually stepped down in 1990 but continued to serve as Commander-in-Chief of the Chilean Army until 1998. He then retired and served as 'senator-for-life' based on the 1980 Constitution his regime had approved. The dictatorship managed to instill a modernized capitalistic economic structure that was further integrated by the work of the now famous 'Chicago Boys,' Chilean economists trained at the University of Chicago. In addition, the dictatorship brought back some highly repressive social policies that directly affected female sexual health. A government commission appointed by General Pinochet responded to the issue of abortion by enacting a 'right to life' clause in the constitution which in essence criminalized anyone attempting to get an abortion even if it threatens her life. This policy remains in effect despite more than two decades since the military dictatorship ended. Convicted of having an abortion, a woman could face three to 5 years in prison (Casas-Becerra 1997). These highly restrictive laws reflect not only the historical oppression of women embedded in the social political nation building of Chile, but also in the deeply rooted beliefs and enmeshed tendrils of the Roman Catholic Church. Still to this day, abortion is illegal in all circumstances even if the life of the mother is at risk (May 2011).

The 1990s returned to democratic rule with the hopes of cleansing Chilean history of its human rights violations. However, 'while Chile sees itself as a country that has fully restored human rights since 1990, sexual and reproductive health policies, programmes, and public discourse lack a consistent human rights and gender focus' (Casas and Ahumada 2009, p. 88).

Chile's efforts at nation building and stabilization are deeply intertwined with the subjugation of female sexuality. The early political system of the hacienda which limited women's freedoms carried through to the social policies of the dictatorship limited resources for women's issues. Unlike countries that experience paradigmatic

shifts due to human rights movements (such as the Women's Rights Movement in the United States), Chile maintains protective rather than permissive laws that promote motherhood within a paternalistic framework. Demanding maternalistic policies that protect women and children, the country also espouses highly oppressive anti-sexual health policies such as punishing abortion laws and meager sexual education in public schools. In addition, the economic sphere for women is ambivalent, wanting women to enter the workforce but only in particular ways which often include an over sexualizing of work appearance and conduct while at the same time limiting professional opportunities in managerial and upper wage opportunities.

A notable exception to these repressive policies did take place during the government of President Michelle Bachelet (years 2006–2010). Bachelet, a pediatrician, introduced legislation which received Congressional approval (though obtaining Congressional support was difficult), to allow minors (14–18-year-olds) to get emergency contraceptive or 'morning-after' pill in health clinics, pharmacies, and non-governmental organizations (NGOs) without parental consent if they suspected they were at risk of being pregnant after having had unprotected sex or by fearing the protection they used did not work. However, in 2008, 'the constitutional tribunal banned the free distribution of the morning-after pill in public hospitals or health centers, but not its sale. So women and girls of higher socioeconomic status (SES) had access to the pill, but poor uneducated women did not' (May 2011). The struggles to pass this law, its push back by the Catholic Church, and the conservative sectors are discussed later in the chapter.

Young female adolescents thus receive attention and treatment that is historically, politically, socially, and religiously interdependent. These competing epistemological stances converge and play out within the social space as both promoting sexualized behavior and admonishing it. These confusing and seemingly arbitrary messages (both explicit and implicit through the denial of sexual health education) are likely to have a confusing and negative effect on the lives and development of Chilean adolescents.

Vignette

When Josefa turned 13, she had an abortion. Since it is illegal to have this procedure done in Chile, she contacted a local woman who would help her for a fee. Josefa's father, a loving but poor man secretly asked his sister in the USA to send money. No one spoke about it after that. Two years later, Josefa got pregnant again and this time she decided to keep the baby. Her mother, who had raised Josefa and her two brothers, took on extra jobs cleaning houses while she helped raise her baby grandson at home; *this way*, Josefa's mother thought, *she can finish high school*. Josefa told no one who the baby's father was, no one pushed the matter. *What was the point*, thought Josefa's parents, *we are poor*, *and besides* (*as the Church says*) *children are a blessing*. About the time Josefa's grandfather, who also lived with the family, finished making an extra room for the baby by converting a closet, Josefa got pregnant again with her second child by another boy. She did not finish high school that year. When her mother pressed her to finish school, Josefa shrugged; she did not see much use in an education because there was no work to be found and *they don't teach you anything in school*, *it's boring*. None of her friends worked, they preferred to spend summer vacations camping on the beach. Josefa had never spoken to her parents or grandfather about sex, and they had never asked her. She was mostly left alone to hang out with her friends, check Facebook, watch TV, and go out to late night parties. She learned about sex from her friends and what she saw in the media.

When her third baby came around, she and her boyfriend decided to get married. Her boyfriend, Ignacio, moved in with her family because his parents were alcoholics, unemployed, and sometimes prone to violence. Eventually they married. When Josefa's third baby boy turned one, she separated from her

abusive husband, because *things just weren't working out*. They could not divorce at the time, because it was illegal, but they managed to live separately with limited visiting parental rights. Josefa's three boys were growing now, and taking up more space and food: Josefa's grandfather struggled to build a small attached room in an already crowded house. The two younger boys did not show much interest in school, but her oldest excelled. However, when the family saved enough to send him to a good school they had to dis-enroll him as Josefa announced she was pregnant again and would need the money for the baby. She was 20 now and had raised three boys as a teenager. Her mother had to take on another cleaning job, and her father finally found work as a construction worker, after years of struggling with finding employment. Money was scarce and came in through little jobs and remittances from relatives in the USA. Everyone in the family helped raise the children, even the older children helped raise the younger ones. Josefa never finished high school. They all still live together, although her grandfather has since passed on. The children are suffering from obesity since they have been raised on a diet of television, cola, and snack foods. Josefa is unmotivated to find work, and her options are limited because she does not hold a high school degree. Her parents love their grandchildren and consider themselves blessed with a loving family; and even though they are poor they give thanks to God for their lives, *it could be worse*, they say.

Trends in Pregnancy, Maternal and Infant Mortality, and Marriage Among Youth in Chile

In this section, we provide detailed statistics about trends and patterns of teenage pregnancy, live births, maternal mortality, and infant mortality among Chilean youth. These data are taken from several publications and comprehensive reports written on these topics available through mostly electronic resources. Some of these documents provide more recent data, while others provide interesting information about earlier decades. Some of the estimates differ because researchers have used different periods of assessment (late 1990s, early 2000s, and/or late 2000s), different age groups, and different datasets. Notwithstanding these differences, collectively, these data provide an extensive representation of these topics among contemporary Chilean youth.

Trends in Live Births, Maternal Mortality, and Infant Mortality—1990s

Using data from the *Anuario de demografía* (Demography Yearbook) volumes published by Chile's National Institute of Statistics (equivalent to the US Census Bureau) for 1990–1999, Donoso et al. 2003 found that between 1990 and 1999 there was a rise in live births rates among the two stratified groups of adolescents they studied (under 15 and 15–19 years old), but the rising trend was only statistically significant among those 15 years and younger. Among 20–34-year-olds, there had been a significantly declining trend in live births rates.

They also calculated the trends in the number of live births and in the rates of maternal mortality, late fetal mortality, neonatal mortality, and infant mortality among teenage mothers under 15 and among those 15–19 years old and compared these rates to women 20–34 years old. They found that between 1990 and 1999 there was a downward trend in maternal, fetal, neonatal, and infant mortality rates among 15–19- and 20–34-year-olds, whereas among those 15 years and younger only neonatal and infant mortality had declined. The authors speculated that the rise in the number of live births among adolescent mothers observed in their study could be explained by the fact that during that period only 21 % of Chilean youth had used contraceptives and only about 3 % had done so frequently (even though 87 % had received sexual education) and that about 57 % of the pregnancies were unplanned (Varas et al. 1999) as cited by Donose et al. (2003). Donoso et al. (2003) also found for the 1990–1999 period, in aggregate, that:

> '[For] mothers under age 15, the respective rates for maternal mortality, late fetal mortality, neonatal mortality, and infant mortality were 41.9 per 100 000 live births, 5.1 per 1000 live births, 15.2 per 1000 live births, and 27.4 per 1000 live births. For the adolescents from 15 to 19 years old, the corresponding percentage rates were 19.3, 4.1, 8.1, and 16.6; for the women 20–34 years old, they were 26.8, 5.0, 6.7, and 12.1' (p. 8).

When compared to women ages 20–34, adolescents under 15 years of age had significantly higher risks of neonatal mortality and of infant mortality and although they also had higher risks of maternal mortality and of fetal mortality these differences were not statistically significant (Donoso et al. 2003). On the other hand, those 15–19 years of age had significantly lower risks of maternal mortality and of fetal mortality but higher risks of neonatal mortality and of infant mortality when compared to women 20–34 years of age. These data suggest that in the 1990s adolescents had greater reproductive risks than young adults but they also demonstrate how trends and risks vary as a function of age and that not all outcomes are negative as demonstrated by the lower risks of maternal mortality and of fetal mortality exhibited by 15–19-year-olds when compared to women 20–34 years of age. The authors of that study speculate that this difference may be the result of adolescents having lower rates of abortions than older women, an entirely illegal activity in Chile as mentioned before due in part to legislation sanctioned by the influence of the Catholic Church. Abortions, therefore, are done in unsafe clandestine operations posing tremendous risk to the women, especially poor women or those with limited access to safe medical practices. Apparently, up to 1995, abortion was the leading cause of maternal death but since then the main cause has shifted to gestational hypertension (Donoso et al. 2003; Donoso 2000). Because data on abortions are practically unavailable, the conclusion that in the 1990s the lower rates of abortions may account for 15–19-year-olds having lower maternal mortality and fetal mortality rates than 20–34-year-olds remains quite speculative and more research is needed to understand these differences.

Based on work conducted by Dides et al. (2008) at the Latin American College of Social Sciences (FLASCO in Spanish, a UNESCO-funded organization to promote social sciences in Latin America and the Caribbean), presently there are roughly 871,000 adolescents between 10 and 19 years of age with approximately 51 % being males and 49 % females and where nearly 87 % of adolescents attend school (Dides et al. 2008). Data from the Chilean Government Ministry of Health and the Chilean Census (Dides et al. 2008) indicate that about 15 % of pregnancies (35,000–40,000) occur among adolescents between the ages of 15 and 19 and about 0.4 % among those younger than 15. They also estimated that among women ages 10–14 years old, in 2005 there were approximately 1.28 live births per 1,000 women from that same age range, a slight decrease from the rate of 1.47 in 2000 but no change in the rate of 4.1 (in 2005) total live births per 1,000 birth among all women compared to 4.2 in 2000. A larger decline is observed between 2000 and 2005 in the rate of live births among 15–19-year-olds (per 1,000 women 15–19 years old) with 48.8 in 2005 versus 60.2 in 2000. The rates of live births for both age groups, those 10–14 and 15–19 years old vary based on geographic location and tend to be higher among rural residents.

In sum, during the 1990s adolescent pregnancy rates increased, while rates for women from 20 to 34 decreased. This trend has fluctuated in the 2000s, with the rates decreasing slightly from 2000 to 2005. Still, the risks for pregnancy are the highest for the most vulnerable girls. These adolescents, whose ages are 15 years and younger, face higher rates of maternal, late fetal, neonatal, and infant mortality than 15–19 year olds, and women 20–34 years of age. For girls that live in rural versus urban areas and who have less education, these disparities widen. Access to safe abortions and reliable contraception are a barrier for these young women, who may not have the social support systems or adequate health facilities to address their prevention and intervention needs. Without adequate education and services, the health of both young mothers and their children are at greater risk.

Fertility Trends—2000s

Per Dussaillant's (2010) research using data from the Chilean *Registro Civil y de Identificación*, literally translated as the Civil Registry and Identification office, she found that in Chile every year approximately 35,000 children are born to adolescent mothers (under 20 years of age) which corresponds to about 15 % of all births. She indicates that many if not most of these pregnancies occur outside marriage or a stable relationship. More specifically, in 2009, nearly 54,000 children were born to women under the age of 21 (20.3 % of all births that year). She reports that in 2009, slightly over 25,000 were born to mothers between 19 and 20 years of age, over 24,000 to mothers between 16 and 18 years of age, and nearly 4,000 to those 15 years of age or younger. In the 1970s, Chile's fertility rates were somewhat similar to several other countries in Latin America (i.e., Colombia, Perú) with others having much lower rates (i.e., Brazil, Uruguay) (see Table 1). However, by the 1990s, the trend had reversed and Chile had become the country with the lowest fertility rates, in fact, considerably lower rates, than other countries in Latin America. This trend is expected to continue into the next decades (see Table 1).

Table 2 includes more specific information on fertility rates, stratified for the 2000–2005 years according to age group, and includes summary information for the more developed countries for comparison purposes. As shown in the table, fertility rates and average age of childbearing are more closely aligned with those of the more developed countries than those from other Latin American countries.

In fact, the decrease in fertility began to occur in the 1960s. In the 1950s, Chile experienced a moderate-to-high population increase mainly

Table 1 Fertility rates (# live births) among adolescents 15–19 years old per 1,000 women of the same age: Latin America, 1970–2025

Country	1970–1975	1990–1995	2000–2005	2020–2025
Argentina	68.3	69.7	60.6	52.4
Bolivia	94.7	82.4	75.3	57.0
Brazil	68.3	82.4	70.5	69.9
Chile	*84.1*	*55.7*	*43.6*	*30.3*
Colombia	89.9	99.6	79.5	62.4
Costa Rica	105.8	89.0	80.7	69.0
Cuba	140.7	67.2	65.4	74.4
Ecuador	120.0	79.4	65.5	51.8
El Salvador	150.6	110.6	86.7	66.0
Guatemala	143.0	126.4	110.7	75.5
Haití	65.7	76.0	64.1	44.5
Honduras	150.8	126.5	102.5	70.3
México	116.3	76.6	64.2	55.8
Nicaragua	157.9	167.6	138.1	86.7
Panamá	134.6	90.7	75.3	64.7
Paraguay	95.8	86.7	74.8	58.4
Perú	86.3	70.7	54.6	42.2
República Dominicana	116.7	102.6	93.2	80.7
Uruguay	65.4	70.5	69.6	68.0
Venezuela	102.6	101.4	94.6	82.6

Source United Nations Population Division. 'World Population Prospects. The 2000 Revision.' Retrieved from http://www.eclac.cl/mujer/proyectos/perfiles/comparados/beijing_nina2.htm

Table 2 Total fertility per woman, fertility rates for 15–19-year-olds (per 1,000 women), and mean age of childbearing for two time periods, 1970–1975 and 2000–2005

Country/region	1970–1975			2000–2005		
	Total fertility/ woman	15–19 yrs	Mean age at childbearing	Total fertility/ woman	15–19 yrs	Mean age at childbearing
Chile	*3.3*	*69*	*28.4*	*1.9*	*49*	*28.0*
South America	4.7	72	29.1	2.5	81	27.0
Central America	6.4	123	29.1	2.7	79	27.2
Caribbean	4.4	104	28.5	2.6	69	27.4
More developed regions	2.1	41	27.0	1.6	24	28.2

Notes '***Total Fertility per woman***' refers to the average number of live births a woman would have by age 50 if she were subject, throughout her life, to the age-specific fertility rates observed in a given year. The '***15–19 yrs***.' age-specific fertility rate refers to the annual number of births to women in that particular age group divided by the number of years lived by the women in that age group. It is expressed as number of births per 1,000 women in the age group considered. '***Mean age at childbearing***' is the average age mothers would have at the birth of their children if women were subject throughout their lives to the age-specific fertility rates observed in a given year. The '***More developed regions***' comprise Australia/New Zealand, Europe, Northern America, and Japan
Source United Nations—Department of Economic and Social Affairs—Population Division: World Fertility Patterns, 2007. Retrieved from http://www.un.org/esa/population/publications/worldfertility2007/WorldFertilityPatterns%202007_UpdatedData.xls

due to an increase in fertility rates and public health programs that reduced mortality rates (Donoso et al. 2009). Donoso et al. (2009) indicate that the reduction in births in the 1960s, when the total fertility rate was about 5.4 children per women, to 1.9 children in the last decade (2000s) is mainly attributed to women beginning to use contraceptives. The decline continued through the 1970s and then in the 1980s the trend was reversed with an increase in fertility rates and live births peaking in the 1990s, when the highest fertility rate was reached. Since then, there has been a slight tendency toward declining rates. An unanticipated consequence, as has been the case for some of the more developed countries such as Japan, is that the rate of 1.9 children per women is less than the 2.1 children per women it would require to replace the death rates in Chile. However, despite having the lowest fertility rates in Latin America, as is the case with the USA, unplanned pregnancies and lack of adequate sexual education and a progressive comprehensive policy on reproductive health continue to be a problem for Chile. These are discussed next.

Marriage Trends

Finally, consistent with the more liberal values toward sexuality, slightly over half of the 15–19-year-olds (51.6 %) who participated in the national survey of youth (Instituto Nacional de la Juventud 2009) supported the elimination of restrictions that exist for married individuals to get divorced (*Note*: Divorce only became legal in 2005) and less than half (49.4 %) consider marriage a life-long 'institution.' Thirty-four percent of 15–19-year-olds would support same sex marriage. Youth of higher SES and those living in urban areas were more supportive than lower-SES youth and those living in rural areas. As Alt (2009) describes, using data from the 2003, 2006, and 2009 national youth data, the percentage of never married youth is on the rise and the number of youth who marry is declining. Alt (2009) highlights that in 2003 about 15.9 % of youth (15–29 years old) had married versus in 2009 only 7.9 % had married. Also of interest is that in 2009, among those who married, 55.3 % did so only through the courts (civil matrimony), 40.9 % married by the courts and a church, and 0.5 % by a church only.

These data suggest that the concept and practice of marriage is changing for younger generations. Stripped of the oppressive anti-divorce laws, adolescents now see marriage as a less permanent option. Positive notions of marriage are waning, with marriage numbers declining over recent years. This may be a function of increased economic opportunities for both young men and women resulting in greater career focus and independence, influences of western liberal ideals, or the disenchantment youths perceive from older generations who were trapped in difficult social and religious contracts.

Sexual Behaviors and Attitudes About Sexuality Among Chilean Youth

Data from the 2009, sixth and most recent, national survey of over 7,500 youth by the *Instituto Nacional de la Juventud* (INJUV) in Chile, loosely translated as the National Youth Institute, indicates that 47.9 % of 15–19-year-olds said they had had sex, defined in the survey as sex where penetration occurred (does not include oral sex), the percent almost doubled among 20–24-year-olds. Based on this 2009 survey, the average age of first sex by males and females in Chile is 16.4 and 17.1 years of age, respectively (Instituto Nacional de la Juventud 2009). Interestingly, in a study conducted by the lead author of this chapter with over 1,000 adolescents from low-income neighborhoods in Santiago, between 2007 and 2010, he and his colleagues found the average age of first sex for males and females to be much younger than that reported in the 2009 national study (13.5 and 14.1 years old, respectively) (Sanchez et al. 2010). These differences likely reflect the fact that patterns of sexual activity, pregnancy rates, abortion, and other aspects of adolescent sexual behavior vary as a function of SES and geographic location (Dides et al. 2008; Dussaillant 2010; Instituto Nacional de la Juventud 2009). The 2009 survey also indicates that approximately 14.6 % of the study participants (18.1 for men and 10.9 for women) had had sex before age 15.

The first sex act of most 15–19-year-olds occurred with their boyfriend/girlfriend (Chilean: *pololo*/*polola*) (70.6 %) which was followed by 14.7 % having sex with a partner that is a non-exclusive boyfriend/girlfriend with less commitment to the relationship, a relationship defined as '*andante*' ('someone they go with') by youth in Chile. About 10.3 % indicated their first sex was with a friend and 2.5 % with someone they had just met. These data suggest that most youth have their first sex act with someone they are dating, with a boyfriend or girlfriend or with someone into a relationship that is not as serious as in the case of '*andantes*.'

Despite the high rates of sexual activity, when it comes to protecting themselves, over half of the youth are using protection. Results of the 2009 survey indicate that about 58.3 % of 15–19-year-olds used some form of protection during their first sex act, the number dropping to 44 % among 25–29-year-olds. It is interesting that younger individuals are more likely to report using protection. At present, we do not have an explanation for this difference. It could be a cohort effect or the combination of a number of interrelated factors. More research is needed to understand these differences.

Of the various methods utilized by 15–19-year-olds when they first had sex the main two are condom (90.5 %) and oral contraceptive pill (14.8 %). The next highest percentage is the use of the morning-after pill by 0.9 %, and then all other methods were mentioned by less than 0.7 % of the respondents. The main reasons 15–19-year-olds provided for using condoms is to prevent a pregnancy (92.4 %), protect against HIV/AIDS (42.4 %) and against other sexually transmitted diseases (39.5 %). When asked where they obtained the contraceptive, 63.7 % said the pharmacy, 13.6 % mentioned a health clinic, 10.8 % said it belonged to his/her partner, and 7.6 % a friend. These data highlight the importance that formal sectors, as opposed to informal ones (i.e., friends) play in helping adolescents prevent pregnancies and STDs.

Young people thus are having sex, and their sexual practices are becoming more liberal (i.e., *andantes*). In addition, the age of first sex may be a contested issue, but what remains is that Chilean adolescents are admitting to having sex at earlier ages. There is some good news here; though Chilean adolescents are having sex at earlier ages, the majority use some sort of contraception to protect against pregnancy and sexually transmitted disease.

It is also telling that the percentage of adolescents who have used some form of protection when they last had sex in the past 12 months (68.1 %) is higher than when they had their first sexual encounter (58.3 %, as reported earlier). As adolescents mature in their sexual identities, they may become savier about how to protect themselves from unwanted pregnancy and disease; still, it is troubling that first time sex had a lower rate of contraception use. This suggests that more education and access to contraception should be available, especially for young teens that are at high risk for unwanted pregnancy and STDs.

It is also interesting that most youth appear to have an adequate knowledge of HIV/AIDS transmission (i.e., sex without condom, blood transfusion, sharing objects that can cut with people with HIV/AIDS) though a high proportion still believes that one can acquire HIV/AIDS by sharing objects for personal hygiene with people who have HIV/AIDS or by sharing public bathrooms with homosexuals and those with HIV/AIDS. These data also point to the need for more effort at educating youth.

When 15–19-year-olds who did not use a contraceptive when they had their last sexual activity were asked to indicate the reason(s) for their decision, 30.3 % said it was due to their being irresponsible, 16.7 % stated they do not like to use any of the methods they know about, 12.9 % could not obtain it, 7.5 % did not have money to purchase it, 7.1 % did not dare ask, 5.9 % their partner did not want to use it, 4.0 % did not know where to get them from, 3.1 % wanted to become pregnant, and 20.4 % indicated another reason. Unfortunately, no information is available on what the 'other' reasons may be which could be the result of the youth being under the influence of alcohol or other mood-altering substances. (*Note*: These percentages are not mutually exclusive. That is, survey respondents could provide multiple answers.)

Finally, over two-thirds of the 15–19-year-olds had sex with one person in the past 12 months, but 12.2 % and 9.2 % had sex with 2 and with 3–5 persons, respectively, and about 3.1 % had sex with 6–10 persons, with males generally having a tendency to be overrepresented among those having sex with more than one person. Also when asked about their sexual partners in the past 12 months, 4.7 % of men indicated they had had sex only with men and 1.7 % of women indicated they had sex only with women. Less than one-percent (0.6 % for both men and women) had sex with both men and women. These data are for the entire sample of 15–29-year-olds as data by age group are not available.

Although young people appear to have access to contraception and education about the risks of unprotected sex, the prevalence of sex without protection is startlingly high. Also, males have a disproportionately higher number of sexual partners, which may be an indication of the prevalence of the machismo culture. Finally, although adolescents do understand the risks, there remain some deeply entrenched myths about sexually transmitted diseases and sexuality in general that continue to plague decision making. Persistent mythologies are made problematic when environmental forces act upon Chilean adolescents. For example, parties where alcohol and drugs are available diminish the decision-making capabilities of youth. In addition, social networking sites have contributed to the rise of high-risk sexual activity. There have also been reports of subgroups of youth who, gathering and organizing on the web (via blogs and websites), plan public orgies where the goal is to engage in anonymous sex with as many strangers as possible:

The teens call their public orgies *Ponceo*. On a typical Friday afternoon in the Chilean capital of Santiago, hundreds gather in a leafy urban park for a few hours of sexual experimentation.

Surrounded by passing strollers, they trade partners multiple times—mostly engaging in anonymous rounds of oral sex. When the party is over, no contact information is exchanged. Same gender interactions are commonplace, as the lines between hetero- and homosexuality are blurred, partly by the alcohol and drugs consumed, but also by shifting social mores held by Chilean youth, in contrast to their conservative parents. 'Ponceo is about having fun,' says Natalia Fernandez, a 15 years old with pink hair and a pierced chin. 'This time I had seven partners' (Steinberg 2008).

These gatherings have inspired Facebook picture postings, YouTube video accounts, and countless cell phone texts that broadcast the event and any given adolescent's sexual conquests. An examination of these sites revealed that youth were also referring to 'Ponceo' as the act of 'making out/kissing publicly' and not necessarily through their involvement in orgies suggesting a broader use of the term for different types of behaviors. In sum, these gatherings highlight the large swath of difference between what adolescent's are given as tools to navigate their transition to adulthood, and their very present needs for higher standards of sexual education in schools and in the home.

Abortion, Contraception, and Reproductive Choices Among Youth in Chile

In the early 1900s, abortion was legal and considered a private matter. It was practiced across all socioeconomic levels (Shepard and Casas Becerra 2007; Fuentes 2010). Because of its frequency and associated high mortality rates among women, over time it became a public health concern. In the late 1960s, therapeutic abortion, termination of a pregnancy when the mother's health was in danger, was authorized and required the authorization of two doctors (Dides 2006). This policy resulted in a decrease in maternal mortality associated with abortion from 107 per 100,000 live births to 5 per 100,000 in 2000 (Shepard and Casas Becerra 2007). This policy existed up to just about the last year of the military dictatorship.

In 1998, in response to a request by a Chilean Bishop to the military government that abortion should be made illegal, the military government passed a law that made any abortion a criminal activity, a homicide, punishable with incarceration for the woman and anyone assisting her. It does not matter if a woman is a victim of incest, her life is in danger, or the fetus shows signs of severe abnormalities, if she undergoes an abortion she will be prosecuted. Hospitals, clinics, and health care providers are supposed to inform the authorities if a woman is seen showing signs of complications from having had an abortion. This law was the culmination of the conservative values brought about by the military government and those of the Catholic Church during the 1970s and early 1980s when the topic of abortion took on pro-life arguments (González et al. 2009).

Despite the end of the dictatorship and more than two decades of a democratic government with numerous changes to laws and policies enacted during the military dictatorship, the abortion law remains unchanged. As mentioned earlier, only recently (since 2005) has divorce been made legal, further reflecting the conservative and Catholic Church influences. The discussion of abortion in the public sphere remains conspicuously concealed in Chilean legislation. This is not due to women's popular opinions. A majority of women in the country are in favor of therapeutic abortion. Over 65 % of the general population is in favor of abortion if the pregnancy is the result of rape or the fetus shows a possible malformation (Serventi-Gleeson 2010). Two-thirds of youth 15–29 years of age are in support of abortion if this procedure will prevent health problems or save the life of the mother (Instituto Nacional de la Juventud 2009). Thus, the silence on this issue may be an indication that women still do not hold significant social, economic, or political power in order to enact policies that directly affect their lives such as the important area of reproductive rights.

Even during the government of President Bachelet (2006–2010), when the morning-after pill was made available to teens, she declared

that she would not change the abortion law despite its continued occurrence and human/sexual rights violations of women and health care providers. During her government, a law was passed, which encouraged health providers to provide 'humane' medical assistance to women who experience complications due to an abortion. However, the implications of this policy were not clear due to its conflict with existing laws that criminalize abortion and forces medical practitioners to report patients in need of care from complications due to abortions. Failure to make progress in changing anti-reproductive rights legislation is the result of the strong influence of the Catholic Church in people's lives and government, a weakened feminist movement resulting from the military dictatorship where more attention has been paid to addressing human rights violations and socio-economic inequalities than to gender discrimination and women's issues such as those involving reproductive rights. The hypocrisy and discrepancies of these laws indicate a larger social problem and ambivalence with female sexuality: the desire to maintain antiquated Puritanism-like values to appease religious and cultural beliefs versus facing the reality of necessary and inevitable reproductive choices that are already taking place. Chile has yet to resolve its conflicting relationship with modern female sexual health practices and choices.

It is within these social, political, and cultural considerations that approximately 30 % of youth ages 15–29 had an unplanned pregnancy with about 60.4 % among those under 20 years of age and that 6.7 % of those who had an unplanned pregnancy indicating having had an abortion (Instituto Nacional de la Juventud 2009). When asked to indicate the reasons for taking the decision to have an abortion, 53 % indicated it was the result of an illness or accident. About 20.4 % indicated the decision to have an abortion was made by the mother only, 15.3 by both partners, and 8.3 % by the youth parents.

Adolescents' attitudes toward abortion can shed light into the way they may behave. Although 43.4 % of 15–19-year-olds are in support of 'therapeutic abortion' (defined in the Chilean study as abortion that is conducted when the life of the mother is in danger), only 9.8 % would approve of abortion for any reasons (Instituto Nacional de la Juventud 2009). Interestingly, the percentage of men and women who approve of therapeutic abortion (50.4 and 51.1 %, respectively) and abortion (11.5 and 11.2 %, respectively) are quite similar, but these data are for the entire sample of youth (15–29-year-olds) as no data were available for 15–19-year-olds.

In an analysis of the Chilean national survey of youth with cluster analysis, Fuentes (2010) identified seven clusters of characteristics that distinguish youth (15–29 years of age) who support therapeutic abortion and those who do not. The first group, about 15 % of the sample, indicated being supportive of abortion under any of the six circumstances asked in the survey. These youth tend not to be religious, similar percentage of males and females, live in the capital Santiago, and do not belong to the lowest SES levels.

These circumstances were as follows:

- If the woman does not want to have a child.
- If the couple jointly decides not to have a child.
- If the health of the mother is in serious danger due to the pregnancy.
- If the baby has a serious defect [*Note*: It is interesting that the wording of the survey was 'baby' (bebé) and not 'fetus.' The choice of words could lead to different rates of agreement or disagreement among respondents.]
- If the woman became pregnant because of rape.
- If the woman or the couple does not have the economic means to raise a child.

Those in the second group, about 14 % of the sample, were in agreement with abortion for all circumstances above except the last one, if the woman or couple does not have the economic means to raise a child. These individuals tend to live in cities and regions other than Santiago, are not among the lowest SES levels, and are similarly represented by men and women. Those in the third group, about 13.6 % of the sample, are in agreement with a woman having an abortion

if there is a risk to the health of the mother, if the baby has a serious defect, or if it is the result of a rape. These individuals tend to be of higher SES and are similarly distributed among men and women. Individuals in group four, about 17.7 % of the sample, are in support of abortion only if the mother's health is in danger or the pregnancy is the result of a rape. The only characteristic that distinguishes this group from the others is that these youth tend to belong to a religion but are not Catholics. Youth in group five, about 9 % are in support of abortion only when the pregnancy is the result of a rape. These youth tend to be equally represented by men and women and across SES levels. Youth in group six, about 10.3 %, are only in support of an abortion if the mother's life is in danger. These youth tend to belong to lower-SES and educational levels and are represented equally by men and women. Finally, those in group seven, about 20 %, tend to be youth who oppose abortion in all circumstances. These youth tend to be from lower-SES and educational levels, tend to be older youth, are religious, and the groups are equally represented by men and women. As the author indicates (Fuentes 2010), these are the youth whose opinions match the country's present policy on abortion.

These findings highlight two important aspects of the country's position on abortion that Fuentes (2010) discusses. First, that there is considerable heterogeneity in opinions and that most of the youth ages 15–29 (about 80 %) are in agreement with supporting abortion under certain circumstances. Second, there is a disconnect between public opinion and political/religious doctrine. Sadly, although most Chilean youth do understand the importance of reproductive choice, there seems to remain little support for any substantive change in this regard.

Approximately 51.2 % of 15–9-year-olds believe the 'morning-after pill' should be made available by health service providers without any restrictions, which is, without youth having to ask parents for permission, for example. Interestingly, among the entire population sampled (15–29 years old), a higher percentage of men (56.2 %) than women (49.8 %) indicated being in favor of the distribution of this emergency contraceptive pill (ECP) without restrictions. Unfortunately, data by sex for the adolescent sample (15–19-year-olds) are not available. Also of interest is the greater support for ECPs by individuals of higher SES and those with a university education. These approvals may stem from the fact that this is a non-surgical procedure and that there is no certainty that a pregnancy has in fact occurred. Therefore, the higher ambiguity and the less invasive procedure may illicit higher approval, especially from individuals with higher education and SES, who are already more accustomed to pharmaceutical interventions.

Sexual Education in Chile

In a report presented to the government of Chile, Olavarría and colleagues provide a comprehensive description of the history of laws concerning school-based sexual education in Chile and include data that describe the implementation and effectiveness of these programs (Olavarría et al. 2008). They indicate that the first formal policy concerning sexual education took place in the 1960s when the Ministry of Education established a policy on sexual education under the rubric of Family Life and Sexual Education. The purpose of this program was to incorporate sexual education in public schools. What is remarkable about this policy is that it was introduced by then President Frei Motalva a conservative Catholic. Despite his personal beliefs, he saw the need to establish such a program in Chile. We mention the policy introduced in the 1960s not only because it was the first time such a policy to incorporate sexual education in public schools was in place but also because it served as the antecedent to a more comprehensive policy on sexual education established in 1993 under the Ministry of Education which systematically targeted pregnant adolescents with the intention of preventing high school dropout rates. The policy views sexual education as a basic human right that should

include all the appropriate information about human sexual development and to encourage youth to think of their relationships from a perspective of collaboration, respect, responsibility, and equity. Furthermore, the policy states that this basic right should be guaranteed by the state. This is important because the Chilean national survey of youth conducted in 2009 indicated that non-attendance in high school for about a third of the young women and men was due to a pregnancy, getting married/creating their own family, and taking care of their children. Approximately 11 and 7.9 % of 15–19-year-olds indicated that they were not attending school because they were caring for a child or it was due to a pregnancy, respectively. These numbers are much higher among women than men (Instituto Nacional de la Juventud 2009).

Olavarría et al. (2008) indicate that several evaluation studies conducted between 2000 and 2004 by the Ministry of Education found a considerable number of schools that had incorporated sexual education in their educational plans along with a number of workshops and training programs on sexuality for teachers. Unfortunately, the problem with these programs was the lack of a more detailed plan that would guide each school's program resulting in vast differences in the program's implementation varying in the extent and quality of information presented to students. These programs also varied on the extent to which resources were available to prevent pregnant youth or those that recently gave birth from dropping out of school. In fact, being pregnant or becoming a father remained the primary reasons for adolescents dropping out of school in Chile in 2009 (Instituto Nacional de la Juventud 2009; Olavarría et al 2008). Additional laws passed in the early 2000s aimed specifically to guarantee assistance to pregnant adolescents or those who became mothers. Law No. 19.688 states 'Pregnancy and motherhood will not constitute impediments to enroll and attend schools of any level. In addition, schools should provide the necessary academic support' (http://chile.justia.com/nacionales/leyes/ley-n-19-688/gdoc/). A modification to the law, Article 2, Law No. 18.962 essentially asserts that it is the duty of the State to guarantee that schools enroll and prevent drop outs among students who are pregnant or who have become mothers as well as provide the necessary academic assistance.

As a result of these policies, many schools developed well-intentioned principles, goals, and objectives about sexual education but unfortunately fell short in their ability to implement. As a result of evaluations conducted in the early 2000s, in 2005, the Ministry of Education came up with a new plan that addressed the concerns of these earlier evaluations. The goals for the students, listed in the report by (Olavarría et al. 2008), are notable because of their progressive agenda. Below we list six (pages 17–18):

'All boys, girls, and youth in the country, during and at conclusion of high school education, will accomplish the following goals:

- To recognize, identify, and accept themselves as sexual beings… and that they understand and carry on their sexuality freely, without violence or coercion in any case or circumstance.
- To recognize the value of relationships and the mutual affective components that are part of human relations and that they establish respectful relationships with others guided by values that promote fair relationships, respects of rights, and fulfillment of responsibilities and common good.
- To develop a growing and adequate knowledge of their bodies… and attention to self-care, self-esteem, health, and prevention of abuse and sexual violence.
- To develop a positive and critical perspective toward sexuality and sexual behavior….
- To make responsible decisions to prevent sexually transmitted diseases …, and to understand the mechanisms of transmission, and risky behaviors to self and others.
- To become sexually responsible individuals taking into consideration the planning of pregnancies, paternity and maternity, and the rearing of children….'

The emphasis on mutual respect and accurate sexual information are notable. They seek to recognize the importance of acknowledging an

individual as a sexual being, but also as a positive social being capable of having healthy sexual experiences. These goals are notable and helpful in guiding adolescents to mature adulthood. What remains to be seen is whether the implementation can effectively address earlier concerns of incomplete and ineffective strategies, or whether a more comprehensive vision can truly improve the sexual experiences and outcomes for adolescents.

Violence Against Women

Any discussion of human rights, sexual and reproductive rights would be incomplete without a discussion about violence against women. Although progress has been made, more publicly addressing gender bias and discrimination against women in Chile and, the harsh, punitive, law against abortion can be considered a state-sanctioned form of violence against women. According to the national survey of youth, approximately the same percentage of young men (90.4 %) and women (93.5 %) were in agreement that men and women should receive the same salary for the same type of work and these percentages were about the same among 15–19, 20–24, and 25–29-year-olds. However, a higher percentage of women (94.2 %) than men (88.1 %) indicated that women were equally capable of taking on leadership positions and a greater percentage of women (92.2 %) than men (85.3 %) indicated men and women had the same skills to take on political leadership positions. Sharing of domestic labor among men and women was slightly higher among women (91.7 %) than men (84.5 %). Differences on these answers among the younger and older individuals are negligible, discarding cohort effects. A greater percentage of men agreed with the question that it is the man's responsibility to be the main provider (31.8 % of men vs. 21.8 % of women) and that the role of caring for children should be more of a woman's 'job' (23.6 % of men vs. 19.6 % of women). Approximately 8 % of men and 4.5 % of women said that in a relationship the man has the right to have control over the woman (Instituto Nacional de la Juventud 2009).

There is overall recognition that in Chile there still exist abuse of power and violence against women with 77.9 % of men and 80.7 % of women agreeing with this statement. About 30 % of both men and women believe that there is no longer discrimination against adolescent mothers. The percentage of youth who do not believe there exists discrimination against women is higher among youth of lower-SES and educational status and among those living in rural areas.

In response to questions about their experiences of psychological (i.e., discounts what the person says, does, or thinks), physical (ever pushed, shaken, or hit), and sexual violence (unfortunately, a definition of sexual violence is not presented in the report or the authors of this chapter were unable to find it) within the confine of the relationships with their partners, the rates are lower among men and much lower among 15–19-year-olds when compared to older youth (Instituto Nacional de la Juventud 2009). For example, among those who were in a relationship, 14.2 % of men and 19.2 % of women 15–29 years old had experienced psychological violence from their partners. When broken down by age, 10, 17.1, and 21.4 % of 15–19, 20–24, and 25–29-year-olds reported experiencing this type of violence. The extent of psychological violence is also much higher among lower-SES youth. Physical violence from their partners was reported by 5.4 % of men and 9.6 % of women. As was the case with psychological violence, a much smaller percentage of younger youth (4.6 % of 15–19-year-olds) than older youth (9.5 % of 25–29-year-olds) reported physical violence with much higher percentages among those of lower-SES and educational levels. In terms of sexual violence, about 1.0 % of men and women ages 15–19 reported sexual violence, but among older youth, a much greater percentage of women reported sexual violence (1.0 % of women vs. 0.3 % of men).

Social, political, and economic views among young men and women mostly align with regard to opportunities for women in the workforce, family responsibilities, gender tasks and roles, and leadership opportunities. Still, power and violence against women remains important areas

of concern. Though violence against women does exist, adolescent teens report less reports of physical and psychological violence than individuals 20–29 years old. Factors that increase reports of violence include geography (rural higher than urban) and SES (the lower the SES, the higher the incidence of violence). A disconnect remains between the attitudes and behaviors in Chilean culture. With claims that there is more equality and opportunities for women, still the issues of violence against women remain a significant fissure in the psyche of the Chilean population.

Discussion

Adolescent pregnancy in Chile is deeply linked to historical, political, and religious ideologies that affect social policy inception and implementation. Chile experienced a feudal society brought from the Spanish that privileged a patriarchal social order. With the increasing deep influences of the Catholic Church and economic social reforms, women were unable to attain many meaningful social and political gains for decades. For women to advance socially and politically in any social system, they must have access to affordable and safe methods for family planning. In a struggling developing country, aiming to become one of Latin America's most stable economies, Chile privileged economic reforms (such as those implemented by the Chicago Boys) versus embracing social change policies that would get rid of oppressive policies such as anti-abortion laws. In some ways, adolescent pregnancy in Chile and the policies that surround this issue are indicative of larger social realities. The need to establish a country as a stable economic power, especially one colonized by a major European power is of vital interest. But how do women, and especially young adolescent females, navigate their place in this particular nation-state building process? To enforce the strong paternalistic and machismo power of a developing country necessitates the subjugation of women who otherwise would be competitors for seemingly limited resources such as leadership positions and employment opportunities. A simple way to do this is to create ineffective reproductive right policies including sexual education programs for youth that have little long-lasting effect and maintaining antiquated abortion laws that result in the criminalization of sexuality. These initiatives thus not only legally create an atmosphere of repression but communicate to young Chilean men and women, but particularly women, what they can expect from their lives; fear and expulsion from accepted society.

Conclusion

The most vulnerable are those youngest adolescents who live in rural areas of Chile, and who have lower SES. This group has the highest maternal, late fetal, neonatal, and infant mortality rates, as well as the highest rates of reported violence against women. Despite these health disparities, attitudes and behaviors across demographics are changing for adolescents. Ideas of marriage are becoming less rigid, sexual practices are more widespread, use of prophylactics and pharmaceutical interventions is tolerated on a larger scale, and among some urban youth at-risk behaviors may be more prevalent than initially believed (i.e., those engaged in '*ponceos*'). In order for Chilean policies and practices to align with the changing social realities, a new radical approach needs to be considered (one that may be in conflict with entrenched social and religious ideologies), especially for those young women who are the most vulnerable in society.

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Adolescent Pregnancy in Colombia: The Price of Inequality and Political Conflict

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Keywords
Abortion Colombia · Colombian adolescent pregnancy · Colombian fertility rate · Colombian maternal mortality rate · Contraceptive use · Catholic church · Sex education · Sexual and reproductive health · Prenatal · Partum and postpartum care

Introduction

For two decades, the reproductive behavior of adolescents in Colombia placed the country in the middle range among countries in Latin America, the Spanish-speaking Caribbean, Haiti, and Jamaica (Guzmán et al. 2001) in terms of adolescent fertility rates. This was due to an upwards tendency during the 1990s and 2000s. Since 2005, Colombia ranks in the lower range of AFR, along with Perú, mainly because the adolescent fertility rate in other countries of the region is higher (Flórez and Soto 2006). Despite a recent drop in the proportion of adolescent mothers, as will be described in this chapter, births to adolescents in Colombia continue to be a concern for the government, schools, researchers, service providers, and certainly for families. Although data on teen pregnancy's prevalence and variation according to several indicators are updated every five years through Demographic and Health Surveys (ENDS in Spanish), the sexual and reproductive information, these surveys' gather comes only from females. This methodological limitation exists as well in many other Latin American countries (Milosavljevic 2007). Even though fatherhood among male adolescents is much lower than among female adolescents in the Latin American region (Villa and Rodríguez 2001), males' reproductive experiences and choices obviously impact adolescent fertility. Consequently, their inclusion could fill many gaps in the current knowledge of adolescent pregnancy and birth.

To partially fill this void in Colombia, a few studies conducted in the largest cities have included male adolescents and used both quantitative and qualitative methodologies (Sandoval et al. 2008; Zuleta 2008; Florez 2005; Florez et al. 2004). Although these studies are not representative of the country and are urban-based, 75 % of the Colombian population lives in urban centers and 44% is under 25 years of age (Central Intelligence Agency [CIA], 2013). Those studies, as well as the latest ENDS, also reflect the pervasive effects of socioeconomic and

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political factors on adolescents' reproductive behavior (see Profamilia 2011; Sánchez 2006).

According to DANE, the public office in charge of most population statistics, Colombia is the third most populous country in Latin America after Brazil and Mexico with 45,508,205 inhabitants in 2010; it is expected to reach 50 million by 2015. Most Colombians live in the north and western *departamentos* (states) while only 3 % of the population occupies 54 % of the territory distributed in the low lands of the eastern and southeastern states (US Department of State 2011). However, as much as ten percent of the population has been forcibly displaced by the internal armed conflict (CODHES 2010) and 1 in 10 Colombians lives abroad (Migration Policy Institute 2011). Forced and voluntary migration is the result of sociopolitical and economic problems, as well as the consequence of insecurity. For example, as of 2010, 27 % of all victims of landmines had not reached their 18th birthday (Díaz 2010). All these elements combined have prompted a humanitarian crisis in which millions of young people find little to no opportunities to better their lives.

Historical Context

Colombia's quandary has been labeled as a humanitarian emergency (see Väyrynen 2000) in which thousands of people have died and millions have suffered from war and displacement. This has been caused mainly by the internal armed conflict between guerrillas, paramilitaries, and the Colombian military, as well as by drug trafficking, kidnapping, massacres, attacks on civilians and infrastructure, and acute poverty (US Department of State 2002). During the last few years, some improvements have been made in terms of security to civilians, lower unemployment, and increased foreign investment. Despite this, Colombia still exhibits one of the highest levels of income inequality in the world (US Department of State 2011).

Much of Colombia's social and political instability has its roots in a period of internal conflict and civil unrest known as 'La Violencia' (The Violence), which began in 1948 after the assassination of the leader of the Liberal Party, Jorge Eliécer Gaitán, who was expected to become president following the 1950 election. The traditional political parties, the Liberals and Conservatives, fought a five-year armed conflict for power and landownership until 1953, when General Rojas Pinilla took control. Subsequently, in 1958, they formed a coalition government known as the National Front (Casa Editorial de El Tiempo 1999). This coalition excluded other political views, however, and consequently, several rural guerrilla groups formed during the 1960s.

After decades of deepening poverty and inequality, rising political corruption, and insufficient government services, drug trafficking evolved in the 1970s as a new economic alternative. By the 1980s, it had also become an additional source of violence. Extortion and violence by guerrillas who had survived from the 1960s were on the increase, and resentment was mounting among peasants and landowners due to a lack of state protection. Some large landowners and drug traffickers sponsored self-defense entities (Meertens 2001), which constituted the core of right-wing paramilitary groups (Amnesty International 2004). Most of these fell under the umbrella of the United Self-Defense Forces of Colombia (AUC). By the end of 2006, the AUC ceased to exist as a formal organization, after more than 31,000 former paramilitaries demobilized. During the paramilitary demobilization process, "…emerging criminal groups arose, whose members include some former paramilitaries" (CIA Fact Book 2011). Therefore, the legitimacy of this demobilization has been seriously questioned.

Currently, the two main guerrilla groups are the Revolutionary Armed Forces of Colombia (FARC) and the less powerful National Liberation Army (ELN). Both have used kidnapping and extortion to generate income. The former AUC and FARC derive finances for their operations through drug trafficking, an endeavor that has led to fights for strategic territories to cultivate and process illicit drugs. Some of these areas are also crucial for weapons smuggling

into the country. As the Global IDP Project argues, internal displacement is not just a consequence of war, but also a deliberate strategy (2004). Although illegal armed groups have weakened since the early 2000s, all have rural and urban cells that seek to control entire sections of towns and cities, causing intra-urban displacement, an overlooked aspect of the crisis that the internally displaced population (IDP) lives. Because most adolescents live in urban areas, or settle in urban areas after displacement, they have been uniquely affected by the armed conflict. Likewise, those who stay in their rural homes may be caught in the cross fire or simply continue to live with the traditionally limited educational, cultural, and health services that have characterized rural Colombia.

Next sections analyze the situation of Colombian female adolescents, paying particular attention to the effects of gender and economic inequality, ethnic/racial discrimination, and political conflict. Medical and legal issues are also analyzed with a focus on vulnerable adolescents. Although 90 % of Colombians are Catholic, no studies linking religion and sexual behavior, fertility, or contraceptive use among adolescents were found.

Colombia's Adolescent Birth and Fertility Rate

The adolescent birth rate in Colombia has fluctuated since 1990 when it was estimated at 70 per 1,000 15–19-year-old females. It experienced an upward trend and reached 89/1,000 in 1995; then it decreased to 85/1,000 in 2000 and went up again to 90/1,000 in 2005. Currently, the national birth rate among Colombian adolescents is at 84/1,000 (Profamilia 2011). Consequently, not only has there been no significant reduction in the national teen fertility rate in the last 10 years, but it is much higher than it was 20 years ago. As a comparison, the adolescent birth rate in the USA is 42.5/1,000; in the United Kingdom is 27/1,000; and in Switzerland it is 4.3, the lowest adolescent birth rate in the world (The National Campaign 2007). Fertility rates among adolescents in different Latin American countries are usually not released at the same time, which limits comparisons. In the Andean Region between the years 2000 and 2005, live births to 15–19-year-old adolescents were: 12.6 % in Bolivia, 10.1 % in Chile, 16.8 % in Colombia, 14.8 % in Ecuador, 11.7 % in Perú, and 20.6 % in Venezuela (Lora et al. 2009). In the year 2000, 20.2 and 25 % of births in Costa Rica and Nicaragua, respectively, were to 15–19-year-old girls (Milosavljevic 2007).

Adolescent Mothers by Region in Colombia

One in five Colombian adolescents has been pregnant at least once, and as of 2010, 15.8 % were already mothers; this represents a small overall national reduction from 16.2 % in 2005 (Profamilia 2011). Notwithstanding, the proportion of adolescents who are mothers varies depending on the state where adolescents live, including the capital of the country, Bogotá. The range goes from 12.2 to 26.9 % in the state of Putumayo (ENDS 2010) which has been for decades at the center of the guerrilla, paramilitary, and drug-trafficking violence. According to the latest ENDS (Profamilia 2011), the proportion of adolescents who are mothers increased in some regions of the country from 2005 to 2010, particularly in Orinoquía-Amazonía, one of the most rural, underserved, and underpopulated areas of Colombia with the highest concentration of indigenous groups. The Orinoquía region has also been heavily affected by drug trafficking and guerrilla activity. It comes as a surprise that in the state of Chocó, where 26 % of adolescents are mothers (the second highest after Putumayo), the percentage of pregnant adolescents decreased since 2005. Chocó is a state with one of the worst socioeconomic and health indicators in the country and with high internal conflict between guerilla, paramilitary, and the Colombian armed forces. It is also a state with a high concentration of Afro-Colombians. Paradoxically, the proportion of adolescents who were pregnant with their first child increased in Bogotá, where access to

health care and education is among the best in the country. It could be argued that these two unexpected findings of the 2010 ENDS may be due to the exodus of many of Chocó inhabitants and to the influx of internally displaced people into Bogotá as a result of the armed conflict.

Factors Associated with Adolescent Pregnancy

In Colombia, as in the rest of Latin America, several factors are associated with higher prevalence of pregnancy and birth among adolescents, such as area of residence (rural vs. urban), ethnicity (indigenous/African descent), socioeconomic status, and level of education (Guzmán et al. 2001). As expected, there are more adolescent mothers in rural Colombia (22.2 %) than in urban centers (13.8 %). However, total fertility rate (among all women 15–45 years old), as well as adolescent fertility rate, decreased in both rural and urban areas compared with 2005 levels (Profamilia 2011). Similar to the effect that it has on other demographic indicators, poverty increases the likelihood of motherhood among adolescents. Twenty-three percent of the poorest Colombian adolescents are mothers compared with only 5.5 % of the richest adolescents (Profamilia 2011). This effect of economic disparity in adolescent fertility rates is consistent with other Latin American countries and has originated the expression “the demographic dynamic of poverty” (Villa y Rodríguez 2001).

Several demographic surveys in Latin America have shown that adolescent women of different socioeconomic levels initiate sexual relations at a similar age; however, marriage or consensual unions and reproduction occur at younger ages among adolescent women of the lowest socioeconomic levels (Guzmán et al. 2001). While poverty is a risk factor associated with higher rates of adolescent fertility, the most influential aspect seems to be the level of education of a teenager at the moment of her pregnancy. Data from Latin America show that by the time of their first pregnancy, most girls have already abandoned school (Guzmán et al. 2001). Although the same pattern is observed in Colombia, one-third of very poor teenagers drop-out of school when they get pregnant (Flórez and Soto 2006). Therefore, pregnancy does impact the educational path of the most economically disadvantaged Colombian teenagers. Furthermore, as of 2002, 10 % of women younger than 20 years of age in Latin America interrupted their studies due to adolescent pregnancies (Gaviria cited in Profamilia 2011).

Among Colombian female adolescents with no education, 53.6 % have at least one child. This is the case for 41.5 % of those with only primary education. Among adolescents with secondary and tertiary education, the percentage of mothers is 14.2 and 7.7, respectively. Therefore, the more education a woman has, the lower her fertility. For example, women with no education have almost three more children, on average, than college-educated women (Profamilia 2011). Low levels of education and poverty appear to follow a dynamic that traps teenagers into a hopeless vicious cycle. Therefore, the lack of education, an essential right for claiming and enjoying reproductive rights, limits women’s empowerment and that of their families and communities.

The Vulnerability of Very Young Adolescent Girls

Nowhere is lack of empowerment more evident than among very young teens (under 15 years of age) who get pregnant, most of the time by men who are 10 years older than them; the younger the teen, the older the father of her children. As Guzmán et al. (2001) argue, this is an indication of the unequal power structure of gender relations in Latin America. Table 1 illustrates the current situation among young Colombian adolescents, and Table 2 compares changes since 1990.

Among 15–19-year-old Colombian adolescents who had a live birth, 1.8 % had their first

Table 1 Pregnancy and fertility experiences of adolescents by their 15th birthday

Year	Already mothers (%)	Pregnant with 1st child (%)	Ever pregnant (%)
2010	3.1	2.1	5.2

(Profamilia 2011)

Table 2 Proportion (%) of adolescent mothers before their 15th birthday

Place of residence	1995	2000	2005
Urban	1.0	1.1	1.4
Rural	2.1	1.5	2.9
Total	1.3	1.2	1.7

(Flórez and Soto 2006)

child before their 15th birthday. Among urban adolescents, 1.5 % had this experience compared with 2.5 % of teens in rural areas (Profamilia 2011). This shows the higher vulnerability of and less availability of resources for rural adolescent girls.

The experiences of teenagers before their 15th birthday are described in Table 2 and classified by place of residence.

It is apparent that motherhood among very young adolescents has had a steady increase since 1995, and even more worrisome is its greater prevalence and escalation among rural adolescents from 2000 to 2005. This was the period when the controversial Plan Colombia, the United States billion-dollar package to Colombia, began to be implemented to combat narcotics and insurgency (Global IDP Project 2004). This led to an escalation of violence, as predicted by analysts (Nagle 2001). It is possible that more young adolescents in rural areas were victims of sexual violence by armed actors (guerrilla, paramilitaries, or the Colombian army) who took over their towns. They may also have fallen prey of relatives/acquaintances after the disappearance, assassination, or displacement of their parents. Unfortunately, the report of violence against women of any age is very low, and those least likely to report are young, single, from rural areas, with low or no education, and poor (Profamilia 2011).

According to statistics from the unit of sexual crimes of the Colombian *Instituto de Medicina Legal* (Institute of Legal Medicine), most sexual crime victims are girls between 5 and 14 years of age, but the official report of these crimes, and their prosecution, are rare. Most people do not believe in the judicial system, girls and families are ashamed of publicly admitting sexual victimization, and there is an under-registration of the prevalence of sexual crimes. This is more so when sexual crimes are related to the armed conflict; that is, when the perpetrator is a member of the Colombian military, paramilitary groups, or guerrilla (Sánchez 2006). The sexual victimization of very young teens may explain why, as of 2004, four thousand minors under the age of 15 were living with HIV. According to the Colombian Penal Code, if the minor is over 14 years old and found having sex with an adult, she/he could testify that the act was consensual and the adult is not prosecuted. This stipulation fragrantly ignores the power that adult men (especially armed men) exercise over minor's wishes and decisions and places minors in conflict affected areas in a deeply vulnerable state.

Prenatal, Partum and Postpartum Care

The latest ENDS (Profamilia 2011) revealed that only 3 % of pregnant women since January 2005 did not receive any medical help during delivery. Ninety-two percent were assisted by a doctor and 5 % by a nurse. Most women who received partum care by a medical doctor tended to be older than 20 years of age and live in an urban center. Ninety-eight percent of women with the highest educational levels and 97 % of women from the

highest socioeconomic strata received prenatal care. Women who did not have prenatal care tended to be younger than 20 years of age or older than 34, from rural areas, had more than three children, and were from the lowest socioeconomic strata. Except for slightly lower levels of depression and involuntary loss of urine, a greater proportion of women younger than 20 years of age experienced more postpartum complications ranging from vaginal bleeding, fainting, to breast infections than older women.

Despite the almost universal coverage of prenatal, partum, and postpartum care, 57 % of female adolescents who already have a child and 34 % of those who are pregnant lack health insurance (Barrera and Higuera cited in Carrillo 2007). Although partum care would be provided for free if the adolescent reaches a public health care facility, the fact that a teen lacks coverage suggests that her prenatal and postpartum care is not optimum.

Abortion

Access to adequate reproductive health services is one of the means by which women can enable themselves to decide whether to have children, and if so, how many, and when. According to Pallito and O'Campo (2004), many Colombian women have not been able to make such choices. For example, 55 percent of ever-married (or in unions) Colombian women aged 15–49 between 1995 and 2000 have endured at least one unintended pregnancy.

Information on abortion rates is generally very reliable in the industrialized world, but not so in the developing world, particularly where it is completely illegal or highly restricted. This is the reason why in most developing countries, adolescent pregnancy is usually measured by prevalence of adolescent mothers or adolescent fertility rate, instead of adolescent pregnancy rate. Due to the lack of reliable abortion statistics in Latin America and the Spanish Caribbean, it is not possible to determine how many pregnancies among adolescents end in abortion. Only in Cuba and Guyana, where abortion is not criminalized, accurate adolescent pregnancy and abortion rates may be established (Guzmán et al. 2001). Despite the fact that abortion in Colombia was illegal under any circumstances until May 2006, it has been widely documented as being available through clandestine channels (Guttmacher Institute 1996). Larger cities have clinics that perform safe procedures for a fee (Shepard 2000), and it has been known for years that in medium-sized cities, abortions take place in the privacy of a doctor's office at a high cost (Morgan and Alzate 1992).

After a Constitutional Court decision (C-355) on May 10, 2006, abortion in Colombia was decriminalized under specific circumstances: when the life or health of the woman is threatened, as certified by a medical doctor; in case of rape, incest, or involuntary artificial insemination, which requires the woman to present evidence of the report of the crime; and when the fetus has malformations that are incompatible with life outside the womb, as certified by a medical doctor (Corte Constitucional Colombiana 2006). In these situations, the universal health care system of the country is supposed to cover the cost of the abortion procedure. Health-insurance-paid abortions, then, would constitute the most accurate measure of the incidence of legal abortion. Unfortunately, five years after the historic Constitutional Court decision, most abortion procedures are still illegal (Redesex 2011). This is due to several factors: many women are not aware of all the circumstances in which abortion is legal (Profamilia 2011); many health care and legal professionals are either not informed of the specificities of the new law, or misinformed, or simply do not follow the law (Redesex 2011). Therefore, abortions that are not health-insurance covered, or performed at private doctor's offices, or by nonqualified personnel, whether they adhere to the law or not, are unaccounted for in official statistics of the incidence of abortion in the country.

The Court's decision, however, was instrumental to set a precedent as a result of the case of a 13-year-old girl who was raped and denied a legal abortion in Colombia. This young teen endured not only the denial of her constitutional

right, but also a complicated cesarean section as a result of a sexually transmitted disease contracted during the rape. She was also mistreated by health care professionals, and harassed due to her filing charges against her aggressor, and by giving up the newborn to adoption. All of these experiences led her to attempt suicide three times. The nongovernmental organization Women's Link Worldwide, based in Bogotá, took the case to the Inter-American Court of Human Rights, which, for the first time involving a legal abortion case, asked the Colombian government to protect the physical and mental health of this young teen and to issue all necessary protective measures (Women's Link Worldwide 2011). Due to the obstacles, many women found when requesting a legal abortion, the Constitutional Court issued a subsequent ruling in 2009, limiting the right of medical professionals to conscientious objection to abortion (Center for Reproductive Rights 2011).

The 2006 Court decision applies as well in the case of minors who are as young as 14 years of age; for those younger than 14, the Court allowed legislators to establish provisions of representation, protection or tutelage, but without impairing the minor's consent (Corte Constitucional Colombiana 2006). As the 13-year-old girl's case illustrates, there is a gap between the intention of the Constitutional Court judges and the reality that takes place in women's everyday lives and their navigation of the health and judicial systems. Notwithstanding, the decriminalization of abortion in such circumstances is a significant advancement in the promotion of women's health and rights.

Maternal Mortality

As long as the implementation of the new abortion legislation is uneven, poor, very young, and vulnerable women will continue to be affected by unsafe, illegal abortion, which still is the third cause of maternal mortality in the country (Castellanos 2008). Colombia's maternal mortality rate (MMR) up to the year 2002 (104 per 100,000 live births) increased among 15–19-year-olds between 1992 and 2002 (Boada and Cotes 2003). Currently, there is a discrepancy in terms of the latest official maternal mortality rate in the country. This is due to the lack of agreement between the statistics released by the Ministry of Social Protection—in charge of all health policies—and the office of Vital Statistics—in charge of the officially registered new births (Carrillo 2007). Therefore, different publications have different values for Colombia's MMR. According to a UNICEF (2011) report, Colombia's adjusted MMR for 2008 was 85 per 100,000 live births, the same value as for the entire Latin American and Caribbean region. In contrast, the MMR for all developed countries was 14. Therefore, for Latin American standards, Colombia has an average MMR, but compared with industrialized nations, it has a long road ahead. Sadly, most of these maternal deaths are related to the lack of quality reproductive health services and to women's precarious living conditions (Carrillo 2007).

Similar to the rates of teen fertility in the country, maternal mortality also varies according to several demographic indicators, such as percentage of population with unsatisfied basic needs, number of children per woman, number of women's years of education, and women's contraceptive use. Although these broken down statistics are from 1992 to 1996 estimates, it is interesting to note that the highest MMR among those variables was for women with 5 years of education or less: 150/100,000 live births (Carrillo 2007). Again, low education is a constant among the most vulnerable women. The high coverage before, during, and after pregnancy described previously is obviously not correlated with the high rates of Maternal Mortality. As Carrillo (2007) argues, it may be that many women in reproductive age are not affiliated to any health system (through their work or as a dependent), or the services they receive are very limited due to the poor conditions of many public facilities that may also be understaffed.

Among Afro-Colombian and indigenous women concentrated in some regions of the country, such as the states of Chocó and Amazonas, MMR has traditionally been more

pervasive (three times higher) than within the general population (WCRWC 2003; Guevara Corral 1997). Additionally, indigenous and Afro-Colombians are less likely to have health coverage (Carrillo 2007). Therefore, it is safe to affirm that Afro-Colombian and indigenous female adolescents may be the most affected by this largely preventable cause of death. MMR, then, embodies one of the negative consequences of inequality in Colombia and reflects what Rebecca Cook has labeled as "…a larger social injustice…" (1998, p. 357).

Contraceptive Use

Thanks to effective but discrete contraceptive campaigns and despite the opposition of the Catholic Church and other cultural forces, the Planned Parenthood Federation Affiliate—Profamilia—is largely responsible for the decline of Colombia's total fertility rate (TFR) from 1964 to 1990. During these years, the TFR decreased from 7.0 to 2.8 children per woman (Ramírez 1990). In addition to Profamilia, other nongovernmental organizations, especially women's health centers founded since the mid 80s, have contributed to the further decline of fertility among Colombian women. Currently, the TFR is 2.1 (Profamilia 2011). Furthermore, government policies and legislation have helped this decline through media campaigns and coverage of contraception through health-insurance plans, including male sterilization.

The latest ENDS (Profamilia 2011) found that 99.9 % of all Colombian women know at least one modern method of contraception and 68 % know about emergency contraception (70 % of urban women and 48 % rural women). Overall, there is no significant difference in the knowledge of modern contraceptive methods based on socioeconomic status, level of education, or rural or urban residence. Differences by ethnicity in terms of contraceptive knowledge were not included in the survey. Among all women, the most commonly used methods, at least once, were the condom and the pill; however, condom use is more prevalent among younger women and the pill among older women. In terms of current use of contraception, the preferred method among married women or in unions is female sterilization (48 %). Ninety-eight percent of sexually active adolescents (15–19 years old) have used a modern method at least once, 30 % have used emergency contraception, and almost 40 % currently use condoms. Nevertheless, 20.8 % of sexually active teens do not use any method.

Since lack of knowledge does not appear to be the reason for not using modern methods, it would be necessary to explore what factors keep them from doing so. As stated earlier, more than half of adolescent mothers and one-third of pregnant ones lack health coverage; thus, the inability to access services may help explain this situation. Even adolescents who have health insurance, through their families or guardians (up to 18 years of age), may find geographical, cultural, or economic barriers to obtain needed services (Sánchez 2006). Additionally, other obstacles related to access or sociocultural barriers are probably important considerations. For example, their partners may refuse to use condoms or may only use them sporadically, as studies with adolescents in one large city of the country have shown (Zuleta 2008). Furthermore, their parents' expectations and values may keep them from actively seeking contraception (Villa and Rodríguez 2001).

Socioeconomic Conditions and Education

Poverty and economic inequality are some of the most critical problems Colombia faces. As of 2004, 66 % of the total population and 78 % of women and children under 18 lived below the poverty line. This situation characterizes the country as one of the most unequal in Latin America (Sánchez 2006). The sources of this inequality have varied over time. During the nineteenth century and until the middle of the twentieth century, inequality was the result of transformations in the economy and long-time educational gaps. As a result of educational

advances in the 1960s, economic inequality diminished and increased again since the 1990s. This time, the causes of inequality were due to accelerated technological changes and the expansion of global commerce (Profamilia 2011). Additionally, for centuries, productive land has been concentrated in the hands of a minority who, in turn, have had the resources to increase their wealth through inheritance and entrepreneurship (US Department of State 2011).

Nevertheless, positive changes have occurred in economic terms. The poverty rate, which measures the percentage of households with one unsatisfied basic need, changed from 70 in 1973 to 20 in 2005. Likewise, the misery rate (two or more unsatisfied basic needs) decreased from 45 to 6 percent. These positive outcomes were reached despite mediocre results in terms of economic growth during the last decades (Profamilia 2011). Given the economic dependence of children and adolescents, these improvements have benefitted their quality of life in terms of satisfaction of basic needs.

In the education realm, the landscape is mixed. There has been a significant improvement in the number of youth enrolled at school and in the number of years of education per adult. Additionally, while in 1951 only 1 % of the population had a college degree, 12 % did so in 2005. At the same time, serious concerns exist about the quality of education. According to international standardized tests, Colombian students' scores are among the worst in the developing world (Profamilia 2011). The armed conflict has also left its mark on education. Children and adolescents in conflict affected areas face a different problem that truncates their educational path. The United Nations Special Rapporteur on Education found in 2003 that teachers of displaced children have been victims of violent threats (US Office on Colombia 2005), only six out of every ten internally displaced children enroll in schools, and of these, two finish elementary school and one finishes high school (CODHES, cited in El Tiempo 2003). The above-mentioned situations have a profound impact on the economic prospects of the young population as well as on the advancement of the society as a whole.

Legislation on Sex Education

In 1993, as a result of a decision of the Colombian Constitutional Court, the Ministry of Education required sex education at schools, public, and private. A law enacted in 1994 backed the National Project on Sex Education (NPSE) which established sex education as a pedagogical tool and as integral component of children's and youth's general education (Sánchez 2006). The NPSE involved the entire school system, from pre to the last grade of high school, and it was to be developed around four themes and twelve areas of emphasis. The themes were: person, couple, family, and society. The emphasis ranged from identity and dialog, to love sex, responsibility, and critical thinking. Both themes and emphasis were intertwined with processes of autonomy, coexistence, self-esteem, and health. The NPSE was successfully implemented until 1997 with the help of the Ministry of Health and nongovernmental organizations (Sánchez 2006).

Due to lack of resources and political will, the implementation of the NPSE has been significantly reduced. After a call for action from the mass media and the civil society in 2004, the Ministry of Education revised and ratified the NPSE. Along with the Ministry of Health, the Red Cross, and UNAIDS, the project "Escuchamos Propuestas" [We Listen to Proposals] was developed. It consisted upon the education of school youth leaders as peer educators in sexual health, and it was implemented in 60 cities and towns of 21 states (Sánchez 2006). According to Sánchez (2006), three categories of problems have been identified to continue the implementation of NPSE: (a) the Government's involvement; (b) the educational system; and (c) social representations of sexuality. Ideological pressure by some sectors of the government, a lack of resources assigned to the NPSE, and poor technical assistance to implement the project at the regional and local levels are among the first

category. The emphasis of coverage as opposed to quality in education, as well as a focus on cognitive functions in detriment of affective ones, is the main concerns in regard to the educational system. The third category has to do with cultural reproductions of sexuality as taboo, lack of dialog among generations, and inequality between women and men.

In the last few years, NPSE has limited its scope to promotion of information and services to help youth reach the necessary level of maturity to make responsible decisions, understand their sexuality, and learn how to protect themselves from undesired outcomes. Despite the intentions of the Ministry of Education, the implementation of the NPSE depends on the willingness of each educational institution, and as a result, Sánchez (2006) argues, sex education has almost disappeared from the school curriculum. This is a tragic outcome for a country where, as stated earlier, almost half of the population is below 25 years of age and adolescent fertility among the most socioeconomically deprived girls has increased.

National Policy of Sexual and Reproductive Health

As a result of poor indicators in several aspects of sexual and reproductive health, the Ministry of Social Protection issued the National Policy of Sexual and Reproductive Health (NPSRH) for the Presidential Period of 2002–2006. The main purposes of the NPSRH was to promote sexual and reproductive rights, reduce vulnerability factors and risky behaviors, stimulate protective factors, and pay particular attention to groups with special needs. The Ministry selected several priority themes in sexual and reproductive health that impact the development of the country. Such themes and their specific objectives were: safe motherhood (reduction in maternal mortality), family planning (coverage of unsatisfied demand of this service), adolescent sexual and reproductive health (reduction in adolescent pregnancy), cervical cancer (early detection and treatment), sexually transmitted infections—including HIV/AIDS—(prevention and provision of services), and sexual and domestic violence (provision of services to victims). Each theme incorporated a research component in order to collect necessary information to design and guide future policies and services. The Ministry based this policy on the agreements reached through the different United Nations Conferences, such as the Conference on Population and Development and the Fourth Conference on Women, as well as decisions of the Colombian Constitutional Court (Ministry of Social Protection 2003).

As has been described in previous sections, one may conclude that the NPSRH of the previous Presidential administration fell short in its attempts to accomplish most of its specific objectives.

The Case of Medellín

The second largest city of Colombia, once known as the "murder capital of the world" during the times of infamous drug trafficker Pablo Escobar, is the only place in the country whose local government has actively launched a program to reduce pregnancy and prevent HIV transmission among youth 10 to 19 years of age. This segment of the population (total youth 353,000) represents 17 % of the total inhabitants of the city. The program, entitled *Sol y Luna* [Sun and Moon], was funded by the Inter-American Development Bank (68 %) and the local administration of the city of Medellín with a total cost of $ 1,106, 000 (one million one hundred and six thousand dollars) to be implemented in two years. The proposal was supported by the Mayor and First Lady of the city and the result of the work of 45 individuals from several organizations, public and private, academia, the media, as well as individual experts that created the *Red Para la Prevención del Embarazo Adolescente en Medellín* [Network to Prevent Adolescent Pregnancy in Medellín] (Alcaldía de Medellín 2004), the only such functioning network in the country. The Network was coordinated by the Office of the First Lady of the city.

In 2002, there were 7,021 pregnancies among 10–19-year-olds and 4 % of them occurred among 10–14-year-old girls. In that year, 21.6 % of all deliveries were among adolescents and the fertility rate among 15–19-year-olds in the city was 74.72/1,000. This was double the total fertility rate of the country in 2002 (Alcaldía de Medellín 2004). The highest rates were observed in the poorest neighborhoods of the city, while the richest neighborhood presented a rate similar to that of Switzerland. The specific goal of the project *Sol y Luna* was the reduction in adolescent pregnancy by 25 %. Project *Sol y Luna's* philosophical foundation was based on relevant United Nations Conventions that emphasize sexual and reproductive rights, as well as the United Nations Millennium Development Goals. In 2005, it was found that 1 in 100 pregnancies among 10–19-year-olds occurred among 10–14-year-olds. By 2006, there was an increment of births to adolescents: 25 % of all births were among 10–19-year-old adolescents.

After data gathering, the Network determined the causes of adolescent pregnancy and the reasons why previous prevention programs had not worked. The causes were classified as:

Structural: family violence, armed conflict, displacement, marginalization from services, social exclusion at school, and sexual exploitation.

Individual: myths/misinformation about sexuality, identity search, need of approval by men and peers, overvaluation of motherhood, and men's lack of involvement and responsibility in sexual and reproductive health.

Institutional barriers: crisis in the family, lack of positive role models, domestic violence, sexual violence, single mothers, lack of supervision, early adoption of adult responsibilities, lack of knowledge of sexual and reproductive rights.

The main reasons for the failure of programs were the lack of coordination of services among providers and unfriendly environments. Then, a pilot project with a control group in Medellín and in Cali (third largest city in the country) determined the effectiveness of the intervention. The project included the sustainability component through services to be administered by the different organizations of the network and impact evaluations to be carried out by researchers that belonged to the network. In 2007, *Sol y Luna* began to be implemented in ten government-run sites in the most marginalized areas of the city and continued even after a new Mayor was elected. This is an accomplishment by itself considering how volatile social policies may be when they are the result of temporary administrations and are not mandated by the law. Today, *Sol y Luna* is implemented in 33 sites throughout the city, and it involves mainly nurses, but also medical doctors, social workers, psychologists, and other health care professionals (Bermúdez 2011).

The new administration continued the efforts and implemented *Servicios Amigables Para Jóvenes* [Friendly Services for Youth], an initiative of the *Plan Andino Para la Prevención del Embarazo Adolescente* [Andean Plan for the Prevention of Adolescent Pregnancy]. Plan Andino is an agreement among the Ministries of Health of Bolivia, Chile, Colombia, Ecuador, Perú, and Venezuela, and it is considered an international public law treaty. Through *Servicios Amigables Para Jóvenes*, other local projects such as hands-on workshops, as well as guaranteed access to health services for adolescents, the birth rate among 10–19-year-old girls in Medellín dropped to 42.9/1,000 girls in 2007 and to 39/1,000 in 2011. Therefore, the city has become an example for Colombia and the Andean region.

A Focus on Internally Displaced Adolescents

More than half of all internally displaced persons in Colombia are women and children, one-third are Afro-Colombians—although they represent 25 % of the Colombian population— and 11 % are indigenous, who are just 2 % of the total population of the country (Gónzalez Vélez and de la Espriella 2002). Despite the lack of accurate statistics according to ethnicity, it may be concluded that ethnic minority adolescents

are overrepresented among internally displaced persons.

As stated throughout this chapter, adolescents affected by the armed conflict are particularly vulnerable to pregnancy, diseases, violence, and exploitation. According to Pacheco Sánchez and Enríquez (2004), 81 percent of young, sexually active displaced individuals, male and female, do not use contraception. As a result, by 2005, thirty percent of displaced adolescents (13–19 years old) were mothers or pregnant (Profamilia 2005), and there is no current statistical information on abortion or maternal mortality rates among IDA.

Of particular, concern is the sexual exploitation of IDA, both male and female. Based on research conducted by this author (see Alzate 2008), IDA often falls prey to adult male displaced leaders who demand sexual "favors" as a precondition for helping their families. Furthermore, to support their families in their new urban location, male and female minors have turned to prostitution (El Tiempo 2003). For IDA girls and young women in tourist sites, the best way to make ends meet is through prostitution; while for IDA boys and young men gangs provide a source of income (Arcieri 2004). Thus, a gendered behavior is revealed. Young displaced men prefer to engage in violence or illegal activities, such as drug trafficking, while young displaced women become involved in prostitution. It is obvious that both women and men exposed themselves to danger, trauma, disease, and even death, but how they exposed themselves reflects the unequal power relations based on cultural gender norms. Sexual exploitation, then, exposes the exacerbated deprivations of this at risk group.

Sexual violence is also common among IDA, particularly rape by relatives, neighbors or acquaintances. In a study with internally displaced women, Vergel (2003) found that the parents of adolescents do not respect adolescents' wishes about what action to take if pregnancy occurs in such cases (see Vergel 2003).

The Future of Adolescent Pregnancy in Colombia

Currently, this is the general panorama regarding sexual and reproductive health among adolescents that impact efforts on pregnancy prevention:

Except for recent success stories, such as that of the city of Medellín, many adolescents are not aware of the few public sexual and reproductive health care services available.

Most existing services target mainly adults and married or cohabiting couples, leaving adolescents and unmarried/non-cohabiting women with few or no alternatives, depending on where they live.

Many governmental health care providers, unfamiliar with sexual and reproductive rights guaranteed by Colombian legislation, censor information on emergency contraception or the provision of information to young, unmarried people.

To overcome these obstacles, the following concrete actions to prevent pregnancies among adolescents and improve their overall sexual and reproductive health may be implemented.

Inclusive coalitions of organizations or networks, similar to the network in Medellín, should be among those planning and implementing programs.

Public and private organizations must offer specific sexual and reproductive rights and health outreach programs to rural, marginalized, displaced, and ethnic and sexual minority adolescents.

Materials must be made available to promote sexual and reproductive rights and health, gender equity, and pregnancy prevention. These must be appropriate with regard to the gender, age, ethnicity, and sexual orientation of the adolescent receiving services, as well as to his/her literacy level.

Personnel who work with internally displaced adolescents must be trained to recognize their particular plight and to be sensitive to their needs.

Health care and human services workers must be trained in sexual and reproductive health and rights, cultural competency, and internal displacement legislation.

Special attention and consideration should be given to very young adolescents (under 15 years of age) and assessment of sexual violence should be made. Additionally, the age of consent (currently at 14) should be increased.

Special attention and services should be provided to adolescent victims of domestic or sexual violence.

Confidential information on the diversity of adolescents seeking services should be recorded. This includes gender, age, socioeconomic level, urban/rural origin, ethnicity, and level of education, among others.

Colombia has made great advancements in its legislation regarding rights to adolescents, including sexual and reproductive rights; the general intention of public policies is to empower adolescents and improve their sexual and reproductive health. Unfortunately, despite progressive rhetoric, intentions have been greater than actions at the national level and more political will and pressure from the civil society are necessary in order to reverse the current fertility trend among adolescents and help design the future that they deserve. Furthermore, gender and economic inequality, which significantly impact human development and the peaceful progress of the Colombian society, must be greatly reduced in order to offer adolescents true opportunities for social mobility and self-realization.

At the family level, it is necessary to create and promote interventions to prevent domestic violence, educate family members about women's and men's rights and responsibilities within the family, the rights of children (Colombia has ratified the Convention on the Rights of the Child), and gender equality. By doing this, household and care-taking responsibilities may not only fall on female adolescents, but their brothers as well. Likewise, less female adolescents may be inclined to establish relationships with older adolescents and men, and thus, maintain more equal personal interactions.

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Adolescent Pregnancy in Costa Rica

Susy Villegas

Keywords
Costa Rica: adolescent national policies • Adolescent pregnancy • Abortion • Condom use • Poverty • Sexuality and reproductive health • Sexual education • Sexual initiation • Sexually transmitted infections • Teenage fertility

Introduction

Costa Rica is a small country in Central America known as a peaceful, democratic, and prosperous nation with high achievements in the health care and education of its people. The country, however, is facing questions regarding adolescent pregnancy and the education of children and youth in areas of sexual and reproductive health. Coming from a long Catholic tradition and patriarchal views concerning gender and family, Costa Rica is making important decisions that could have a transformative impact on not only adolescents' pregnancy, health, and education, but also on the areas of human rights, gender equity, and economic prosperity that are at the heart of its democratic identity.

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A Contextual Background

Costa Rica is one of the oldest democracies in the region. After the arrival of the Spaniards in the 1500s, Costa Rica declared itself a sovereign nation in 1838, and general elections began in 1889. The 1949 ruling constitution of Costa Rica abolished the army permanently and guaranteed free elections and peaceful succession of power (Aguilar Bulgarelli and Fallas Monge 1977), and for the last 60 years, the electoral process and succession of power in the government have been peaceful despite Costa Rica's geographical proximity to conflict-affected countries such as Nicaragua, Salvador, and Guatemala. The government of Costa Rica is a democratic republic with national presidential elections every 4 years and a cabinet of 57 Legislative Assembly deputies. In 2010, Costa Rica elected its first female president.

Population

Since the 1970s, Costa Rica has experienced a steady national population increase. The

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population in 2009 exceeded 4.5 million individuals with 49.3 % of those being women (INEC 2009). This sharply compares to the 1.8 million inhabitants of Costa Rica in 1973 (Aguilar Bulgarelli and Fallas Monge 1977). Reflecting a heavy European influence, Costa Rica's population is primarily made up of mestizos or people of mixed European and indigenous descent (94 %) (U.S. Department of State 2011). Indian people comprise 1.7 % of the national population, and Blacks comprise 3 % of the population (Political Risk Services 2010; U.S. Department of State 2011). Other important groups include Nicaraguan documented and undocumented immigrants and refugees who account for no less than 10 % of the population. Nicaraguans, primarily young people 20–39 years of age, 50.9 % of whom were women, began to immigrate to Costa Rica in significant numbers at the end of the twentieth century seeking peace and options for prosperity. They make up the most relevant immigrant group in Costa Rica (Fondo de Población 2009; INAMU 2008).

Religion and Contemporaneous Influences

Conquered by the Spaniards, Costa Rica has a Catholic religious tradition, which is stated in the national constitution. Article 75 of the constitution indicates that the Roman Catholic Apostolic Church is the religion of the state (as amended with regard to its number by Article 1, Law No. 5703, June 6, 1975). Today, 76 % of the population in Costa Rica is Roman Catholic. However, Evangelical Protestant religious groups have been emerging and growing in the country, with 13 % of the current population as followers (Pearson 2010; U.S. Department of State 2011). The remaining 10 % of the population reports practicing other religions (6 %) or not practicing any religion (3 %). As the primary religion practiced in the country, Catholicism is influential in matters of the state. Its position regarding issues of human sexuality, reproductive health, and birth control is central to the topic of adolescent pregnancy and has contributed to the current national debate on women's and children's rights, gender equity, sexuality, and reproductive health education.

Congruent with a tradition of the Roman Catholic Apostolic Church, the views of the church follow traditional hierarchical and patriarchal definitions of the family, gender relations and roles, and sexuality. For example, regarding single motherhood, Budowski (as cited in Chant 2002) reported that, according to the Catholic Church in Costa Rica, single motherhood is the result of sinful behavior and as such is a threat to the moral and social order of the country. Chastity, celibacy, and virginity are considered cardinal values for the Catholic Church, so sexual abstinence until marriage is favored. Sexuality or physical intimacy is to occur between a married man and woman, and it is within this union that children are to be born. Marriage, sexuality, and procreation are inseparable in Catholic teachings (Pontifical Council 1995; Trujillo 2003). The Catholic Church also is clear on its position regarding human sexuality education for children and adolescents, which is considered to be the parent's right and first duty. Sexuality education in other institutions is perceived as discouraging parents from performing their duties and roles.

Regarding birth control and barriers to sexually transmitted infections (STIs), the Catholic Church has been critical of programs endorsing condom use as a safe alternative for preventing HIV\AIDS and other sexually transmitted illnesses. Aside from the moral reasons, the Church is concerned that young people may be misled to assume that condoms provide total protection against STIs. Instead, promotion of abstinence before marriage and fidelity to one's spouse are the Catholic Church's alternatives for 100 % prevention of STIs (Pontifical Council 1995; Trujillo 2003).

The Catholic Church recognizes the value of human life from conception and consequently opposes abortion (Barrantes Freer et al. 2003). Perceived as offending the religious code, a

woman who has an abortion can be excommunicated from the Catholic Church.

Besides the traditional religious influences, Costa Rica has not escaped the impact of globalization, market-driven economy, scientific advances in birth control, the pandemic of HIV\AIDS, the absorption of women into the work force, the feminist movement, and the ascent of women to important leadership positions (Chant 2002) that paved the way to increased recognition of women's and adolescents' rights, and have fueled the changes in the structure and composition of Costa Rica's families since the 1970s.

The provision of birth control by the Caja Costarricense del Seguro Social (CCSS) (Costarican Social Security) in the decade of the mid-1960s to mid-1970s was a salient factor in the decline in Costa Rica's fertility rate because it made birth control available to all women across the national territory (Carranza 2009; Rosero-Bixby 1984). Concurrently, the impact of feminist thinkers since the 1970s led to important achievements in the advancement of women's rights and gender equity legislation, and the creation of key institutions such as the Instituto Nacional de las Mujeres (INAMU) (National Institute of Women) (Chant 2002). Chant (2002) points to the rise of and advocacy for women, not only in political and leadership positions but also in professional fields traditionally occupied by men, which resulted in significant legislation and programs on behalf of women, such as the Law for Social Equality for Women (No. 7142), and the Law for the Protection of Adolescent Mothers (Law no. 7739).

In addition, since the early 1980s, global economic pressures have pushed women to enter the work force and be subjected to global and national economic trends (Martinez Franzoni et al. 2009; Milosavjevic 2007; Rosero-Bixby et al. 2009). All of these issues came together to significantly influence the composition and structure of Costa Rica's families, evidenced by a decline in marriages, an increase in divorces, cohabitating couples, and a drastic increment in mono-parental families headed by women (Barquero Barquero and Trejos Solórzano 2004; Chant 2002; Milosavjevic 2007). For example, Costa Rica has experienced an increase in the number of children born out of wedlock, with 23 % in 1960 compared to 49 % in 1998 (Budowski and Rosero-Bixby 2003). Also, the marriage rate for every 1,000 people in Costa Rica declined from 7.71 in 1989 to 5.30 in 2009 (INEC 2009). Families headed by women make up a large proportion of Costa Rica's households and families living in poverty (Chant 2008). In addition, the HIV\AIDS epidemic has presented society with diversity in sexual expression and the need for prevention of STIs. These variations and needs are dissonant with the patriarchal heterosexual concept of a nuclear family, and they challenge traditional religious views of the family, which has ignited the involvement of the Catholic Church in the debate about sexuality and reproductive health education for children and adolescents.

It is among these forces—traditional patriarchal and religious family views, global and economic trends, scientific advances in birth control, poverty, diverse family configurations, awareness of diverse sexual expressions, women's achievements, and the advancement of a feminist ideology for increased women's rights and gender equity—that the debate regarding adolescent sexuality and pregnancy is situated today in Costa Rica's society.

Children and Adolescents in Costa Rica

The age of adulthood in Costa Rica is 18 years. In 2005, the number of children younger than 18 in Costa Rica was approximately 1.5 million or a little more than a one-third of the total population. However, it is important to observe that the number of children in Costa Rica has been in decline for several decades due to a reduced national fertility rate. In 2005, there were 8,500 fewer children born in Costa Rica than in the year 2000 (UNICEF 2005). In 1988, children 15 or younger represented 37 % of the national population. For 2009, the same age group represented 25 % of the total population, marking a 12 % decline (INEC 2005, 2009, 2011). National 2009

estimates indicate that teens age 13–17 represent 9.4 % of the population. Including youth 13–19, estimates for 2010 show a total of 591,222 individuals (INEC 2008, 2011).

Adolescent Sexuality and Pregnancy

Sex initiation and practices: The onset of intercourse and sexual experience for people in Costa Rica has been changing, with a trend toward early intercourse initiation. However, gender differences in sexual practices continue to prevail, with men initiating sexual intercourse at a younger age than females do. For example, adult men 61–80 years old reported having their first intercourse experience at age 17.8; the women in the same age group reported their first experience with intercourse at age 20. In addition, 80 % of men 65–69 years old reported having at least one masturbation experience in their lives compared to 7.65 % of women. Among those reporting experiences with masturbation, the first masturbation was reported to have occurred around 13.5 years of age for males and 22 years for females (Ministerio de Salud 2011b).

In terms of premarital intercourse experiences, Morris (1988) documented that 18 % of Costa Rican women aged 15–19 said they had premarital sexual intercourse; the mean age for the first premarital intercourse experience was reported to be 17. Interestingly, the women participating in this study reported that their first sexual partner was 6 years older than they. In 1991, Rosero-Bixby noted that 23 % of Costa Rica's women reported engaging in premarital sex before age 18; by age 19, the rate increased to 30.6 %. Ten years later, in 2001, the Programa de Atención Integral a la Adolescencia (Program of Integral Care for adolescents), sponsored by the CCSS (2002), reported that 20 % of adolescent women and 31 % of adolescent men aged 13–17 had been sexually active. Sexual intercourse was initiated between 14 and 15 years of age, with the highest number at age 15.

Regarding abstinence, in a study conducted by Gutiérrez Fernández et al. (2010), 82 % of teens aged 10–19 reported abstaining from sex. Again, important variations across gender were noted, with 72 % of the men relative to 92 % of the women reporting sexual abstinence.

Recently, the latest national report on sexual and reproductive health by the Ministerio de Salud (2010) (Health Ministry) corroborated an early onset of sexual intercourse for adolescents in Costa Rica. Sexual intercourse was reported to begin between ages 15 and 16, with adolescent men initiating sexual intercourse a year earlier than adolescent women. First sexual intercourse was reported by 68 % of men and 51.4 % of women to have occurred before age 18 overall (Ministerio de Salud 2011b). The first sexual partners for teens were again reported to be older than the adolescent; 5 years older than the adolescent girls and 2 years older than the teen boys (Ministerio de Salud 2010, 2011b). Among 15- to 44-year-olds, 22 % of males and 11.2 % of females reported having their first sexual intercourse before age 15. Regarding masturbation, 86.7 % of men reported having masturbated at least once in their lives, while only 23.4 % of women in that age group reported the same (Ministerio de Salud 2010). For immigrant groups, 59.5 % of youths 14–17 from Nicaragua reported intercourse initiation, which is higher than the 52.3 % of Costa Rican youths in the same age group (Fondo de Población 2009).

On the number of sexual partners, 60.7 % of women 15–17 reported having only one partner compared to 38.3 % of adolescent men. The adolescent men reported female sexual partners in the same age group as themselves or younger, but adolescent women reported male sexual partners older than themselves. For 1.6 % of adolescent women 15–17 and 3.8 % of young women 18–24, male partners were 40 years old or older (Fondo de Población 2009). According to Costa Rica's penal code, some of these relations may be unlawful, but besides the legality of the relationship is the issue of the impact of these relationships on adolescent women's identity and autonomy development.

A number of factors influenced teens in their decisions about whether or not to engage in sexual intercourse. However, for all young people 15–35, love for their partner was identified as the primary reason to engage in sexual intercourse (Fondo de Población 2009).

Fertility rate: Now, in contrast with the steady national population increase, the national fertility rate in Costa Rica has been in decline for the last 40 years. In the last decade, the fertility rate declined from 2.39 children per woman in 2000 to 1.82 in 2010, which is one of the lowest fertility rates in Latin America (Carranza 2009; INEC 2010). However, it is important to clarify that the fertility rate for teens 19 and younger has shown smaller rates of decrease (INEC 2010; Ministerio de Salud 2011c).

The highest fertility and birth rates for Costa Rica are reported for women aged 20–29. This age group of women contributed more than 55 % of the national births for the year 2009. The median age in 2009 for Costa Rica's first-time mothers was reported to be 25.2 years (INEC 2009). In the same year, teen mothers 15–19 contributed close to 19 % of the national births (INEC 2009; Ministerio de Salud 2011b). For 2008, the fertility rate for women 15–19 was 20.18 % (INEC 2008). There were also in 2008 a total of 15,217 births for mothers 11–19 years of age (Ministerio de Salud 2011c) and a total of 1,633 births for mothers younger than 15, representing 2.2 % of the national births for 2008 (Ministerio de Salud 2011b). In 2004, mothers younger than 19 gave birth to a total of 27,877 children in Costa Rica, equivalent to 19.9 % of the national births; also, a total of 455 mothers were younger than 15 years of age (Naciones Unidas et al. 2010; UNICEF 2005). For teens 18 and younger, the percentage of births was 14.09 % in 2005 (INEC 2005).

In contrast to the overall fertility rate for Costa Rican women, the number of births for immigrant women in Costa Rica has increased. In 2005, 18 % of the national births were to immigrant women, which compares to 15.5 % in 2000 (INEC 2010; UNICEF 2005). For Nicaraguan women, Camacho and Rosero-Bixby (2001) reported that in 1998, the overall fertility rate for Nicaraguan immigrant women was 40 % higher than the fertility rate for Costa Rica's women.

Within the national territory, the rate of adolescent fertility and births for indigenous groups is 40 %. This is alarming as many indigenous adolescent mothers are as young as 11 and 12 years of age, and the infant mortality rate was reported to be double for areas with indigenous populations, such as Talamanca (18.4 %), Coto Brus (16.9 %), Corredores (15.2 %), and Buenos Aires (13.9 %) (República de Costa Rica 2008a).

Among adolescents and young women, many pregnancies are unintended. Morris (1988) reported that 28 % of women 15–24 conceived or became pregnant before entry into a union or marriage. More than half of the births in 1986 that occurred during the first 7 months of union or marriage were the result of premarital or preunion conceptions. Among single mothers (not married or in a union) aged 15–24, 53 % reported that their first pregnancy was unintended, and 59 % reported that their most recent pregnancy was also unintended.

Health

In areas of health, Costa Rica has a socialized health care system. The main public health institution in Costa Rica is El Ministerio de Salud Pública (Ministry of Public Heath), which guides the nation on health policies, epidemiological controls, and health programming. The CCSS is the primary organization in charge of implementing and providing health programs and direct health services to the population. Public expenditures on health approach 7 % of the national GDP (Political Risk Services 2010). Children covered in 2005 by the national health care system were proportionally 90 % of infants (children less than a year old), 80 % of children 7–12, 50 % of children 1–6, and 30 % of adolescents aged twelve and older. Regarding child immunizations, in 2004–2005, 90 % of all children were covered. However, it is important to note that this is less than the 97 % immunization

coverage achieved in 1997 (UNICEF 2005). Costa Rica's infant mortality has continued to decline from 10.21 infant deaths for every 1,000 births in the year 2000 to 8.84 in 2010 (INEC 2010). The average life expectancy for Costa Ricans is 77 years of age.

Adolescent Pregnancy Health Concerns

Health risks for pregnant teens and mothers increase as the age of the adolescent decreases and relates to the level of poverty and deprivation in their living conditions (Barrantes Freer et al. 2003). In Costa Rica, health and medical concerns related to teen sexuality, pregnancy, and delivery include lack of routine gynecological exams, lack of early detection of STIs, unplanned pregnancies, pregnancy complications, anemia, spontaneous abortions, late prenatal care, malnutrition, low birth weight and premature births, and increased risk for maternal and infant deaths (Barrantes Freer et al. 2003; Núñez Rivas and Rojas Chavarria 1998). Based on these concerns, health care services are available to all pregnant teen women independently of health insurance (República de Costa Rica 2008a, b).

For 2008, the total of maternal deaths in Costa Rica was 25; six of those were adolescents mothers, including one death of a mother younger than 15 (Ministerio de Salud 2011c). In general, maternal deaths in Costa Rica decreased from 3.58 deaths for every 10,000 births to 2.11 from 2000 to 2010. In 2010, there were a total of 15 maternal deaths, which included women's deaths during pregnancy or delivery, or due to postnatal complications. Two additional deaths were reported due to abortion complications during the same year (INEC 2010). In 2004, only 30.44 % of adolescents 12 years or older were covered by the national health care system (República de Costa Rica 2008a). This statistic is important since in 2003, the CCSS reported that a total of 5,646 adolescents 17 or younger were treated and released from national hospitals due to complications during or after the births of their babies. Including the number of teens that were treated due to pregnancies ending in abortions, the number increased to 6,410 teens. Overall, 6.71 % of all births in the country were reported to present with low birth weights in 2004. However, the low birth weight prevalence for teen mothers aged 15–19 was 7.84 %, and for those aged 10–14, the number reached 10.14 %. These numbers are significant, as low birth weight is associated with increased risk for later health complications and even death for both the teen and the baby. For 2004, the number of deaths for neonatal babies (less than a month old) and postnatal infants (1–11 months old) reached 508 (UNICEF 2005).

Regarding prenatal education, 39.9 % of teens 15–17 and 49.4 % of young women 18–24 reported receiving prenatal education during pregnancy (Fondo de Población 2009). In 1998, 97 % of births to pregnant teens were reported to occur in hospitals (Núñez Rivas and Rojas Chavarria 1998). For all women in 2002, 99.4 % of deliveries were reported to occur in hospitals (Organización Panamericana 2007).

There is also a concern for the mental health of pregnant teens and mothers due to the impact of sexual violence and trauma in some cases, but also because of the growing awareness of the impact of early intercourse initiation and pregnancy on young women's identity, self-definition, sense of power, and autonomy. This is a major concern as many adolescent women have male sexual partners much older than themselves, which may challenge their ability to navigate these relationships (Fondo de Población 2009; Ministerio de Salud 2010, 2011b). In regard to this, Law no. 7739, Code on Childhood and Adolescence, Article 44, point G, determines that services provided to pregnant teens and mothers need to involve a team of professionals with expertise in adolescent pregnancy and early motherhood, including a physician, a social worker, and a psychologist.

Pregnancy Prevention and Condom Use

In 2007, the Fondo de Población de las Naciones Unidas (2009) reported on the use of methods of birth control and infection prevention barriers: 54 % of women 15–24 reported using condoms, 33 % reported using birth control pills, 3 % turned to surgical interventions, 1 % trusted natural methods, and 14 % reported using some other method. For the men, 48 % reported using condoms, 39 % relied on the use of pills by their partners, 1.8 % turned to surgical interventions, 0.7 % trusted natural methods, and 13.5 % used other methods. A recent national report on the use of contraceptive methods indicates that the prevalence of birth control in Costa Rica is 82 %. The methods more frequently used include female sterilization (30 %), oral birth control (21 %), injections (9.3 %), male condoms (8.9), male sterilization (5.8 %), and IUDs (3.3 %) (Fondo de Población 2011).

It is interesting to observe the low proportion of vasectomies, the high number of women using surgical sterilizations for birth control, and the decline in condom use from 16 % in 1992 to 9 % in 2010, which poses increased risk for STIs, including HIV. On women's surgical sterilization, Carranza (2007) points out that even though therapeutic sterilization is a procedure legally restricted by the penal code to be used only when the mother's health and/or life is at risk, it has been generalized as a contraceptive method. Even though frequently used as birth control, sterilization is not an alternative for women seeking only temporary prevention of conception, such as those women in their adolescent years.

On the use of condoms among individuals aged 15–49, women reported fewer incidents of condom usage during their last sexual intercourse experience relative to the men. The same pattern was observed with teens 15–19, with only 44 % of women compared to 66 % of men reporting the use of condoms during the last intercourse experience (Ministerio de Salud 2011b).

Concerns about effective family planning and contraceptive options for Costa Rica's women have been raised. In Re: Supplementary Information on Costa Rica, which is a letter responding to reports submitted by Costa Rica, the Joint NGO Commission (2011) denounces the CCSS for not making available newer and safer contraceptives appropriate for women and teens (e.g., vaginal rings, hormonal IUDs like Mirena, and progestin-only based pills).

Specific to teens, the value placed on female virginity and avoidance of intercourse until marriage, versus the acceptance and value of men's sexual experimentation, was reported to have an impact on the use of birth control by teens (Núñez Rivas and Rojas Chavarria 1998). Fear of being discovered often discourages adolescent girls from accessing birth control and barriers for disease prevention, while adolescent males are not often encouraged to take a proactive role in and responsibility for pregnancy and disease prevention. Soper and Tristan (2004) observed that teens are misinformed about STIs and birth control, and Molina Chavez and Leiva Diaz (2010) also noted that even when teens know about birth control, many fail to act on their knowledge, as the low usage of condoms shows. Consistent use of condoms is more likely by older teens but not younger adolescents (Gutierrez Fernandez et al. 2010). The INAMU report based on a national survey of perceptions of women's rights specified that almost 69 % of the responders support the use of contraceptives by adolescents, while 21.3 % do not. The large majority of responders in favor of birth control for adolescents, however, contrast with public policies that do not support the distribution of birth control to teens (INAMU 2008). This is puzzling as intercourse initiation has been documented to occur several years before age 18 (age of adulthood in Costa Rica), and teens as young as 15 can get married with parental consent. On this issue, Carranza (2009) notes that the lack of clear policies by the CCSS regarding the provision of contraceptive services to teens impacts the standardization of services

adolescents receive across the national territory, often leaving the decision on which services to provide to the attending professionals. Also, (a) short consultation time available for women and physicians to truly discuss contraception methods and recommendations, (b) changes in attending physicians, which limits the continuity of care and follow-up, and (c) a reduced variety of contraceptives available to women that use the CCSS are some of the concerns about birth control in Costa Rica (Carranza 2009; Chen Mok et al. 2001).

Regarding emergency contraception, decisions about the approval of use and distribution have been pending since 2007 (Joint NGO Commission 2011). Even though the Ministerio de Salud (Health Ministry), the Panamerican Health Organization, and the International Federation of Gynecology and Obstetrics have determined that emergency contraception pills are not abortive, legislators have not acted on the issue for years (Joint NGO Commission 2011; The Morning After Pill 2009; Fondo de Población 2005). While the use of emergency contraception is not criminalized in Costa Rica, the CCSS does not distribute the emergency contraception nor has the medication in its pharmacies or hospitals. This limits the ability of women, including those victims of sexual violence, to secure the medication. The lack of emergency contraception for Costa Rican women has been denounced as a violation of women's rights (Joint NGO Commission 2011).

Sexually Transmitted Infections

In Costa Rica, 87.4 % of teens 15–17 and 83.1 % of young adults 18–24 reported receiving information on STIs. Across all age groups, the proportion of women (84.4 %) that received information on STIs was higher than the proportion (82.5 %) of men (Fondo de Población 2009). There were 125 cases of STIs in children up to 17 years of age treated in the hospitals of the CCSS in 2003. The majority of those (99) were cases of congenital syphilis, emphasizing the importance of preventive and opportune maternal health education and care (UNICEF 2005).

A total of three cases of teens 13–17 were reported to have been treated and released from the hospital due to HIV in 2003. The total number of HIV cases for all youths younger than 18 was 36. The majority of those cases (33) were children nine or younger and were probably due to maternal infection. It is important to note that in 2002, the total number of children treated and released from the hospital due to HIV infections was 16, and three of those were teens aged 17 (UNICEF 2005).

In 2004, HIV\AIDS was reported to have affected a total of 314 women, which is 12.8 % of all reported cases. The highest risk for HIV infection for Costa Rican women is for those 20–49 years of age. Women aged 30–39 are at the highest risk for presenting with AIDS symptoms (Fondo de Población 2009). In the year 2008, there were 263 reported cases of HIV. Men were primarily affected; so, for each 4.5 cases of infected men, there is one infected woman in Costa Rica. No cases of HIV were reported for children 0–14. After age 15, the number of cases increased to reach a peak in those aged 20–34. There were no documented cases of AIDS for youths younger than 19 in 2008. However, the total number of cases increased in people aged 20–49, with the highest number of cases in the group of 40- to 44-year-olds. A total of 81.82 % of registered AIDS cases affected men (Fondo de Población 2009).

Abortion

Costa Rica's penal code establishes that abortion is illegal except when the life or health of the mother is at risk (articles 118–121). As such, abortion in Costa Rica has legal implications for those who perform them and those who have them. This has an impact on the accuracy of the reporting of abortions.

In cases in which the pregnancy poses a risk to the mother's life or health or is the result of

rape or incest, or when there are serious physical and mental deficiencies or malformations affecting the product of the pregnancy, therapeutic abortions have been allowed under the nation's laws since 1971. Therapeutic abortions require the woman's consent; teens younger than 18 cannot consent (Barrantes Freer et al. 2003; Joint NGO Commission 2011).

Chen Mok et al. (2001) reported that 55 % of women ages 15–49 opposed abortion, and only 37 % approved of the procedure for cases presenting health risks for the mother or in cases of incest. Therapeutic abortions, however, are rarely performed in Costa Rica, which is surprising due to the health risks and complications associated with pregnancy during teen years. In its Re: Supplementary Information on Costa Rica (2011), the Joint NGO Commission points to the lack of equipment, professional expertise, and clear abortion guidelines for health care professionals to deliver services in optimum conditions and without fear of legal repercussions. Professional medical guidelines for conducting legal abortions have been pending approval by the government since 2009. The lack of action places women's lives and well-being at risk, especially those with high-risk pregnancies like young adolescents or those pregnant as a result of sexual violence. Lack of abortion services may encourage women to seek abortion services outside the public health system. Carranza (2007) reported that only seven therapeutic abortions were documented or performed by the CCSS between 1984 and 2003. Nevertheless, the CCSS reported a total of 764 pregnancies that ended in abortions for teens 17 or younger, including 215 from girls 13–15 years old in 2003 (UNICEF 2005). The number increases to 8,038 for all women treated and released from hospitals run by the CCSS due to abortions in the same year. However, it was not clear whether any of these were induced or elective abortions (Fondo de Población 2005). In the case of elective abortions, it is very likely that they are underreported because the illegality of the practice in Costa Rica limits and obscures its study. However, 6,500–8,500 therapeutic abortions were calculated to have occurred among women 15–49 from 1988 to 1991 (Brenes Varela as cited in Carranza 2007). The Joint NGO Commission (2011) points to a yearly average of five legal abortions performed by the CCSS, contrasting with at least 10,000 abortions outside the public health care system. The number 10,000 represents women seeking postabortion health care services in public health organizations, signaling a larger number of abortions occurring every year outside the public health system in clandestine facilities.

Adolescent Pregnancy Social and Economic Concerns

The links between adolescent pregnancy, education, and poverty are some of the main social concerns regarding teen pregnancy. Early pregnancy and motherhood have an impact on teens' ability to continue their education and, consequently, on the opportunities to get out of poverty, which often affects the well-being of both mother and child.

Poverty Structural Factors

Adolescent pregnancy is not a homogenous phenomenon. The fertility of Costa Rican teens is linked to socioeconomic conditions and determinants that do not favor women. Poverty, few opportunities for comprehensive health care, lower educational options and attainment, lower wages and work options, lack of consistent and integrated sexual and reproductive health education, and reduced opportunities for single-women families and women heads of households are some of the related factors in adolescent pregnancy in Costa Rica (Barquero Barquero and Trejos Solórzano 2004; Collado Chaves 2003; Fondo de Población 2005; Gutierrez Fernandez et al. 2010; Mainiero 2010; Núñez Rivas and Rojas Chavarria 1998; Soper and Tristan 2004).

From the 1960s to the 1990s, Costa Rica achieved important reductions in the nation's poverty rate. The poverty rate decreased from 51 % of households in poverty in 1961 to a low

of 20 % in 1994. However, since the 1990s, significant reductions in the poverty rate have not been observed, especially for families headed by women (Barquero Barquero and Trejos Solórzano 2004; Chant 2008). In 2005, poverty was estimated to affect 20 % of the people in Costa Rica, which marks an increase in the poverty rate reported for 2000 of 17 % for urban areas and 25.4 % for rural areas. Unemployment increased from 5.25 % in 2000 to 6.6 % in 2005. It is relevant to observe that unemployment among men was 5 %, while unemployment for women was almost double that at 9.6 %. In 2002, one-third (32.1 %) of the nation's poor families were composed of one-parent households with a women as the head of the family. This number is significant as families headed by women almost tripled between 1990 and 2005 (Chant 2008).

Aggravating the situation is that households headed by women comprise a large proportion of Costa Rica's families in extreme poverty. In 2005, extreme poverty affected 5.6 % of all Costa Rica's families. Across gender, 4.3 % of families headed by men were affected by extreme poverty, while more than double that number, 8.9 %, of families headed by woman were living in extreme poverty in 2005, signaling a persistent gender differential in the nation's poor (Chant 2008). Teen pregnancy has increased across the national territory, but it is overrepresented in the coastal provinces, regions with indigenous populations, or in urban areas with high levels of poverty and limitations to education, and in families with a women as the head of the household (Barquero Barquero and Trejos Solórzano 2004; Collado Chaves 2003; Fondo de Población 2005; Organization Panamericana de la Salud 2008; Slon Montero and Zúñiga Rojas 2005). Following this, the women-headed household's family structure is an important risk factor for poverty and extreme poverty (Chant 2008; Organización Panamericana 2007) and consequently for adolescent pregnancy. For girls younger than 18, the probability of adolescent pregnancy was reported to be four times higher among the poorest third of the population relative to the wealthiest third (Rodrigues Vignoli 2004). Areas affected by social disadvantage also present high adolescent fertility rates; Collado Chaves (2003) documented a link between metropolitan poor areas and areas with the highest teen fertility.

Another concern regarding adolescent single mothers is that many of their children do not have legally identified fathers on the national registers. In 2000, two-thirds of births to teens under 19 had unidentified fathers, and 33 % of the children born to adolescent mothers 15–17 also had unidentified fathers (INAMU 2001; INEC 2001). Reforms to the Family Code in 2001 include the current Law for Responsible Paternity (Law No. 8101[2001]), intended to increase the number of identified fathers of children born out of wedlock or unions and their responsibility in the parenting and care of their children.

Teen pregnancy is salient among Nicaraguan immigrant women. The main discrepancies in the fertility rates between immigrant Nicaraguan and Costa Rican women were observed in the younger age groups, with a 55 % increase in the fertility rate for Nicaraguan immigrant teens 15–19 relative to Costa Rica teens and 25 % higher than Nicaraguan teens in their home country. This compares to the fertility rate of Nicaraguan immigrant women aged 40–44, which is very similar to that of Costa Rican women in that age group. High teen fertility rates and motherhood also occur in impoverished metro areas of San Jose, where a higher concentration (42 %) of immigrant Nicaraguan women reside, compared to the 27 % concentration of Costa Rican women. Overall, it was estimated that the fertility rate for single 25-year-old Nicaraguan immigrant women is 40 % higher than for Costa Rican women, but for those unmarried Nicaraguan immigrants living in San Jose, the fertility rate is 121 % higher than for Costa Rican women with the same characteristics (Camacho and Rosero-Bixby 2001). This is significant as prenatal care was also reported to be lower for Nicaraguan immigrant women, especially for those in the metro

area of San Jose (León Solís and Rosero-Bixby 2001).

A high rate of adolescent pregnancy is also reported in indigenous populations, which are also affected by isolation, high rates of poverty and unemployment, poor health care access, and low levels of education. Cultural factors are believed to relate to the early intercourse and high fertility rates among young Indian girls (Fondo de Población 2005; República de Costa Rica 2008a). However, the strength of association between cultural factors and early intercourse and motherhood for 10- to 12-year-old girls is puzzling, particularly when considering the salient unfavorable socioeconomic factors that affect them. This high rate of pregnancy is striking, as infant mortality doubles for regions such as Talamanca, with 18.4 % infant mortality; Coto Brus, with 16.9 %; Corredores, with 15.2 %; and Buenos Aires, with 13.9 % (República de Costa Rica 2008a). Compounding the situation, some regions with high indigenous concentrations, such as Cabecar de Chirripo, are reported to have a high proportion of deliveries not occurring in hospitals or medical facilities, increasing the health risk for mother and child (República de Costa Rica 2008a).

Education

Education in Costa Rica began since the 1880's (Quesada Camacho 2005), and the Ministerio de Education (MEP) (Education Ministry) is the organization in charge of the nation's education. Education in Costa Rica is free and compulsory until age 15, requiring 6 years of primary and 3 years of secondary schooling. Costa Rica annually allocates 6 % of its GDP to education, and the overall literacy rate is 95.2 % (Political Risk Services 2010; República de Costa Rica 2008a). Overall, 75.5 % of youths 15–17 were attending school in 2009 (Fondo de Población 2009). However, since 1990, a small decline in school enrollment by boys has been observed, and in 2004, the dropout rate at any school level was higher for boys than girls (INAMU 2009a). For youths 15–17, 20 % were reported not attending school in urban areas and 30 % in rural areas (Fondo de Población 2009). At the university level, 60 % of graduates were women (INAMU 2009a).

Increased education is associated with increased economic opportunities and a reduction in poverty, so adolescent sexuality, pregnancy, and motherhood relate to education (Fondo de Población 2005; Slon Montero and Zúñiga Rojas 2005). Early pregnancies are related to the discontinuation of education, while educational achievements are associated with a delay in sexual initiation and first pregnancy (Rosero-Bixby et al. 2009). The link between education and sexuality in Costa Rica has been documented for several decades. Rosero-Bixby (1991), in a national study, observed a negative association between education and premarital sex activity. The proportion of college-educated women who reported premarital sexual experiences was half the proportion reported by women with an elementary-school education (17–34 %). Of the women with secondary-school levels of education, 25 % reported having premarital sex. Again, this is important for Nicaraguan immigrant women, as 44 % have not completed a primary-school education, a figure that is much higher than the 13 % of Costa Rican women living in the same conditions (León Solís and Rosero-Bixby 2001).

The relationship of school absenteeism to high fertility was documented by Collado Chaves (2003), who reported that 47 % of the conglomerates with high fertility in the metro area of Costa Rica have youth populations between 13 to 17 years old who are not attending school, suggesting a link between school nonattendance and teen fertility. Pregnancy was identified as a reason for dropping out of school for 11.3 % of adolescent women aged 15–17. However, differences were observed between teens in the same age group residing in rural and urban areas. For adolescent women 15–17 in urban areas, pregnancy was reported as a reason for dropping out of school for 9.5 %, but the percentage was 12.7 % for those in rural areas. It

is also important to note that many teens experience pregnancy after they have abandoned or dropped out of school, and school desertion is a risk factor for teen pregnancy (Molina Chaves and Leiva Díaz 2010). Living with a partner as a couple was a reason for dropping out of school for 24.8 % of teens in urban settings and for 7.5 % of teens in rural areas. Having to work was a reason for 20.7 % of teens in urban areas (Fondo de Población 2009).

In Costa Rica, the number of pregnant teens attending school is rising. The Ministerio de Educación reported that in 2009, a total of 1,434 pregnant teens younger than 18 were attending school; this number marks an increase in 578 pregnant teens from 2004. In 2004, there were 2.2/1,000 pregnant students attending school; for the year 2009, the number increased to 3.6/1,000. Of the pregnant teens attending school in 2004, 86 were in primary school. Of these teens, 72.9 % were 13–15 years old, and 43 of them were attending the sixth grade; there were 11 pregnant children ages 11–12 in third, fourth, and sixth grade. Eight pregnant teens 17 or older were also attending primary school. In addition, there were 2,099 teens attending secondary school (seventh to twelfth grade). A total of 167 were 14 or younger, and 1,286 were 15–17. There were 746 teens aged 18 and older attending secondary school, with 50 % in the tenth and eleventh grades (Ministerio de Educación 2011).

Adolescent Labor

Early pregnancy and motherhood increase social exclusion for adolescents during their pregnancies and after the births of their children, which has an impact on their work opportunities and economic conditions (Arroyo 1997). The relationship between unemployment, underemployment, and teen fertility was noted by Collado Chaves (2003). In the metropolitan areas of Costa Rica, 54 % of the zones with high unemployment also present high poverty and teen fertility. Fondo de Población de las Naciones Unidas (2009) reported that in 2007, 18 % of teens 15–17 and 47.8 % of those aged 18–24 were working. Women 15–35 reported not working because they were taking care of the family (47.4 %) or going to school (24.8 %). For men in the same age group, reasons for not working were going to school (60 %) and difficulties having access to work (12.1 %).

Costa Rica's labor laws prohibit work for children younger than 15 and regulate the work activities of those teens under age 18. However, a total of 11.4 % of children and teens as young as 5–17 were reported to be economically active in 2003. Work activities for children and adolescents vary by gender, with construction predominantly absorbing adolescent men, and childcare and domestic work absorbing adolescent women or girls. The proportion reported of boys working, 16 %, was more than double the proportion of girls, which was 6.7 % (INAMU 2009a). Domestic work has been plagued with low salaries and low enforcement of labor laws regarding working hours and worker rights (Martinez Franzoni et al. 2009). This situation is relevant for unskilled pregnant teens and young adolescent mothers, who often seek domestic work to support themselves and their children, which again restricts their ability to pursue opportunities for social advancement and break the cycle of poverty. It is important to note that according to the recent 2009 reforms to the Labor Laws [Article 108], no adolescent younger than 15 can be contracted as a domestic worker in Costa Rica. Those 15–17 who are hired as domestic workers are under special provisions and protections, according to the Código de los Derechos de la Niñez y la Adolescencia (Code of Children and Adolescent Rights) and the laws for the protection of young people (No. 8261). It is important to add that 40 % of women working as domestics are heads of their households in mono-parental families, and 87 % have children under their care. Their salaries are 78 % of what men employed in domestic work receives (Martinez Franzoni et al. 2009).

Legal Issues

The legal age for marriage in Costa Rica is 18 (Law 8517, Family Code article 14), but with parental authorization youths can marry as early as age 15 [Sistema Costarricense de Información Jurídica (SCIJ), Código Penal n.d.]. Carranza (2009) observes that this poses interesting dilemmas for health care providers working with young adolescents because under the same Costa Rican Penal Law, providing contraceptive services is restricted to teens 15 and younger.

Costa Rica Penal Code (Sección 1 Articulo 156, 157, 159, 161) (SCIJ, Codigo Penal Título III n.d.) clarifies that any sexual activity with a youth under the age of 13 is a crime. For all youths under 18, any sexual activity that takes advantage of the youth's age is also a crime even when the youth consents. Higher penalties apply to those who engage in sexual relationships that take advantage of teens 13–15 (Ministerio de Salud 2009; SCIJ n.d.; UNICEF 2005).

However, national reports and studies consistently document sexual partners for teens, especially for young women, much older than themselves (Fondo de Población 2009, 2011; Morris 1988). The reported number of pregnancies and births in adolescent girls 14 or younger can signal illicit sexual violence and exploitation that needs to be investigated (Carranza 2009; Ministerio de Salud 2009, 2010). This is particularly troublesome in light of the number of young girls delivering babies. In 2008, there were 15 children 11 years or younger who had babies, and in 2009, there were eight. Girls 12–14 years of age delivered 669 babies in 2008 and 697 in 2009. Minors 15–17 had 7,242 babies in 2008 and 7,084 in 2009 (Naciones Unidas et al. 2011). It is very likely that the number of young girls and children having intercourse in Costa Rica is larger, as the reported numbers do not include abortions or miscarriages, which can be assumed to occur among such young girls.

On other types of maltreatment, youths 15–17 residing in urban regions reported being the victims of insults, screams, and threats from their families (12.5 % for adolescent girls and 12.9 % for adolescent boys). Physical violence was reported by 5.4 % of adolescent girls and 4.5 % of adolescent boys in the same age group (Fondo de Población 2009). The Patronato Nacional de la Infancia (PANI) is the leading child protection agency in Costa Rica. In 1999, PANI attended 115 cases of child sexual exploitation (UNICEF 2005). The National Children's Hospital in Costa Rica reported 331 children seen at the hospital in 2002; more than half (53.5 %) were victims of sexual abuse and more than one quarter (25.5 %) of physical abuse. In 2005, PANI provided services to 7,621 children (younger than 18); half (49.5 %) were physically abused, 34 % were victims of sexual abuse, and 16.7 % were emotionally abused (Organización Panamericana 2007). In March of 2008, PANI had under its protection, a total of 3,755 children and adolescents (Naciones Unidas et al. 2010). Bolaños Salvatierra (1989) documented a total of 113 adolescent admissions during a 6 month period (1986–1987) to the National Psychiatric Hospital in San Jose, Costa Rica. Of those admissions, 17.7 % reported experiences of incest, pointing to some of the detrimental consequences of child abuse and maltreatment. Claramunt (2002) reported that sexual exploitation primarily affects teens 12–18 years of age. In 2009, Fondo de Población de las Naciones Unidas (2009) indicated a total of 0.8 % of all adolescents 15–17 reported experiences of sexual abuse, and of those, 1.7 % were adolescent women.

In areas of intervention and treatment, the Ministerio de Salud published the 2009 Manual for the Attention of Children and Adolescent Victims of Commercial Sexual Exploitation. The manual provides specific guidelines for the detection, treatment, and reporting of child and adolescent victims of sexual exploitation to attending health care professionals. The guidelines are intended to facilitate the delivery and standardization of quality health care services to child and adolescent victims of sexual exploitation across the national territory and to ensure the fulfillment of legal responsibilities to report

such crimes according to the stipulations of the Penal Code.

Adolescent Pregnancy Public Policy

Costa Rica has assumed significant responsibilities in accordance with international agreements for the advancement of human rights, social justice, and gender equity, with particular relevance to the phenomenon of adolescent pregnancy in the country. Among those, the U.N. Convention on Children Rights was ratified in 1990 (Law no. 7184) and the Optional Protocol to the U.N. Convention on the Elimination of All Forms of Discrimination Against Women was approved in 2001 (Law no. 8089) (República de Costa Rica 2008a).

To fulfill these commitments, the country has embarked on vigorous revision and creation of legislation to establish and signal to national entities the allocation of resources, the enactment of guiding policies, and the creation of responsive programming for the advancement of and adherence to these agreements. The work has been massive, including significant revisions and planning at all levels of the public sector in accordance with the rights of children and adolescents and equity among genders. Costa Rica has submitted its fourth report for the 2002–2007 periods to the Convention on Children and Adolescent Rights and has received further recommendations (Naciones Unidas et al. 2010, 2011; República de Costa Rica 2008a). PANI, as the main child protection entity, is designated on the reports as the leading institution to oversee the efforts toward the protection and enforcement of child and adolescent rights. This includes matters related to pregnant adolescents. PANI is undergoing significant restructuring to be able to serve in such a role. Also, almost all public institutions have specialized teams on children and adolescents, called to coordinate and integrate programs and services for this population (República de Costa Rica 2008a).

Regarding national legislation, Costa Rica has been able to advance significantly in the creation of important national legislation on the rights of women, children, and adolescents; safety and protection relevant to the issue of adolescent pregnancy and motherhood. Some examples include:

Law no. 7142, Promoting Social Equity of Women, approved in 1990;

Law no. 7769, Act on Women Living in Poverty, approved in 1998;

Law no. 8261, Young Persons, approved in 2002;

Law no. 8539 on penal consequences of violence toward women;

Law no. 8590, against the Sexual Exploitation of Children and Adolescents.

Specific to adolescent pregnancy and early motherhood, two laws are salient: Law no. 7739, Code on Childhood and Adolescence, approved in 1998 and Law no. 8312, general act on the Protection of Adolescent Mothers Reform, approved in 2002.

Law no. 7739, Code on Childhood and Adolescence: This law, approved in 1998, appoints the Ministerio de Salud under its Article 44, Point C, to guarantee the development of preventive programs and services to all children and youth, including sexual education and reproductive health.

Specific to pregnant adolescents, Point G establishes the creation by the Ministerio de Salud of comprehensive integrated health programs and services for teens, including social and psychological programs and services, during all stages of pregnancy. Focusing on integrative and holistic services, Article 50 adds that all public health centers must give pregnant children and adolescent maternal-infant information and services. Besides medical care, supplemental food during the pregnancy and breast-feeding period is to be provided if needed.

For pregnant teens or mothers living in poverty, Article 51 emphasizes the right of teens to receive comprehensive services, including economic assistance, while attending training

programs aimed to support their continued personal and social development, according to the Instituto Nacional de Ayuda Mixta (IMAS) guidelines; the IMAS is the main national welfare organization.

Article 52 mandates all employers to provide adequate conditions for breast feeding for teen mothers. Article 70 prohibits all public and private institutions from imposing corrective or disciplinary measures or penalties on students due to pregnancy; it also adds that the MEP must develop a system that supports the continuity of education for pregnant children and adolescents.

Law no. 7735 and Law no. 8312: Law no. 7735, for the Protection of Adolescent Mothers, was approved in 1997 and later revised in 2002 to become the current Law no. 8312, general act on the Protection of Adolescent Mothers Reform. Under this law, the Inter-Institutional Council for the Attention of Adolescent Mothers was established. Adjoined to the Ministerio de Salud, representatives from the main public organizations form the Council. The responsibility of the Inter-Institutional Council is to coordinate integrative prevention, education, and intervention programming on behalf of pregnant teens and adolescent mothers. It designs an annual strategic plan to guide, coordinate, and support the programs and actions of both public and private organizations for pregnant teens and mothers. Following this, the responsibilities of the different public institutions concerning the provision and coordination of services are delineated by the law and overseen by the Inter-Institutional Council. For example, the health centers and clinics of the CCSS are charged with the provision of free prenatal and postnatal services; the MEP is to provide prevention, education, and training programs regarding the implications of pregnancy during adolescence for secondary students and their families; the IMAS is to secure resources for adolescent mothers to allow them to raise and educate their children adequately.

National Policies

Among the most relevant national policies concerning adolescent sexuality and pregnancy are the National Health Polices on Sexuality and Reproductive Health 2010–2021, the Children and Adolescent National Policies 2009–2021 (PNNA), and the Policy for the Young Person 2010–2013.

National Health Policies on Sexuality and Reproductive Health

The Ministerio de Salud of Costa Rica recently published the national sexuality policies for 2010–2021 (2011a, b). The document includes nine main areas for policy development and corresponding strategies. Departing from a definition of sexuality as a human right that includes the right to a safe, informed, coresponsible, and satisfying sexual life for both genders, the first section (e.g., Policy 1.1) focuses on communication, capacity building, awareness, and promotion. Section Population is about strengthening the notion of sexuality as both an individual and social right, so it proposes strategies for setting norms, rules, and protocols according to judicial mandates. It also sets strategies for the involvement of people and organizations in monitoring for compliance in order to safeguard the sexual rights of all people.

Most relevant to this chapter is section Adolescent Pregnancy Health Concerns on service integration. It guarantees to everyone in the national territory access to sexuality and reproductive health education that is scientifically based and current, inclusive, diverse, and congruent with the stages of human development across the life span. The section recognizes that education and services on human sexuality and reproductive health must be embedded in both formal education and health systems and aims to integrate sexuality education and reproductive

health across all service areas. The following section, Policy 4.1, focuses on guaranteeing equitable access to quality services. The policies also address strategies for prevention and intervention regarding sexual violence (e.g., Policy 5.1). On the same line, section Amor Joven (Young Love) and Construyendo Oportunidades (Building Opportunities) is about increasing knowledge and research about the scientific-technological as well as the psychosocial aspects of human sexuality that can feed intervention programs. The last section of the national sexuality polices (e.g., Policy 9.1) is about the coordination and integration of services across different national institutions and international organizations.

Even though the policies are comprehensive, detailed information about specific provisions on adolescent sexuality, adolescent gender relations, adolescent reproductive health, and adolescent pregnancy is not clearly defined or articulated.

Child and adolescent national policies: According to the convention of children's rights, La Política Nacional Para la Niñez y la Adolescencia Costa Rica 2009–2021 (PANI-UNICEF 2009) delineates the national laws concerning children and adolescents until 2021. The document includes important legislation on a variety of topics concerning the rights of children and adolescents.

Pertinent to adolescent pregnancy and motherhood, the document recognizes that sexuality constitutes an integral part of human development. As such, children and adolescents have the right to be educated and receive scientific information on human sexuality and reproductive health that is appropriate to their stage of development and conducive to thoughtful decision making.

Following this, it identifies the Ministerio de Educación (MEP) as the responsible entity for delivering sexuality and reproductive health education programs to children and adolescents in the national education system and across the school curriculum. Specific learning opportunities and activities are to be designed and made accessible to all children and youth, including those with special needs and those outside the formal school system. The document also clarifies that the state must guarantee the preparation and training of teachers in human sexuality and reproductive health to implement the curriculum. Law No. 7739 adds that a monitoring office is to be created within the MEP to safeguard the rights of children and adolescents.

Public Policy for the Young Person 2010–2013: This Public Policy for the Young Person was created after the ratification of the Ibero-american Convention for the Rights of Young Persons in 2007 and was approved to be enacted from 2010 to 2013 (Consejo Nacional de la Política Pública de la Persona Joven 2010). The main goal of the policy is to secure within a context of human rights that the rights young people, which includes those ages 12–35, are represented and respected. The policy addresses (a) the civil and political and (b) the socioeconomic and cultural rights of young people. Relevant to this paper, the policy clearly establishes (a) the right of young people to have sexual education that is responsible and based on human sexual and reproductive rights, and (b) the formulation and application of sexuality education across all school levels that is developmentally congruent and oriented toward the full development of individuals, including acceptance of one's identity; responsibility in the expression of one's sexuality and reproductive rights; respect for sexual diversity; responsibility in the prevention of violence, sexual abuse, and STIs, including HIV/AIDS; and unplanned pregnancies. And, (c) the policy includes the development of inter-institutional assertive actions geared to orient and inform families on human sexual development and reproductive health. The effort aims to equip families with adequate knowledge and tools on human sexuality and reproductive health, so they can fulfill their responsibility in the sexual education of their children (Consejo Nacional 2010).

Programs

Amor Joven (Young Love) and Construyendo Oportunidades (Building Opportunities)

Among the programs that have been developed in Costa Rica, according to the legislative mandates and policies for prevention and intervention regarding at-risk, pregnant adolescents, or teen mothers, two are salient: Amor Joven (Young Love) and Construyendo Oportunidades (Building Opportunities).

From 1998 to 2002, a joint effort was undertaken by the Inter-institutional Council for the Attention of Adolescent Mothers, INAMU, and the MEP, to address adolescent sexuality, reproductive health, and pregnancy. Endorsed by the first lady, these efforts were guided by a holistic view of human rights, gender equity, and social justice in relation to the needs of children and adolescents. The programs aim to provide integrated and comprehensive services to at-risk, pregnant, or adolescent mothers and their families across the different public institutions, and to facilitate the delivery of services. This is how Amor Joven and Construyendo Oportunidades emerged.

Araya Umaña writes that Amor Joven was a teen pregnancy prevention program that promoted education and thoughtful decision making in youths regarding sexuality and reproductive health, not only as a sexuality-based education program but within the context of women's rights and gender equity. Amor Joven was designed to integrate sexuality and reproductive health education by the MEP in the school system and across the entire school curriculum. It included the training of teachers specializing in the teaching of human sexuality and reproductive health to deliver the formal curriculum. The program was also to disseminate information in communities and reach youth out of the school system. The program design was completed in 1999, but during initial stages of implementation, the ecclesiastical authorities and the OPUS DEI reacted against the program (Araya Umaña 2003). A joint commission of church and government representatives was convened to no avail (Faerrón as cited in Araya Umaña 2003). In 2002, the church withdrew its members from the joint commission and undertook a media campaign to disseminate the rationale of its decision and concerns against Amor Joven. The Catholic Church then published its own sexuality education guides and presented its unanimous decision to break any collaboration with the government in the implementation of Amor Joven (Araya Umaña 2003). The program disappeared in 2002 during the transition to a new presidential administration (República de Costa Rica 2008a).

Construyendo Oportunidades was also established in 1998 and supported by Laws No. 7739 and No. 7735. It was designed as an intervention program to guarantee comprehensive services to at-risk, pregnant, and adolescent mothers in support of their personal and social growth toward independence by providing family planning, health, educational, vocational, economic, and employment assistance. The program facilitates adolescent reintegration into school and vocational centers, intending to increase economic options and disrupt the cycle of poverty for the well-being of both mother and child (INAMU 2004; República de Costa Rica 2008a). However, the program was not funded as initially planned. Currently, the program continues to exist on paper, but there is no planned implementation. Instead, PANI is operating a free national telephone hotline attended by professional psychologists and lawyers. The hotline program began in 2007 and focuses on assisting adolescent mothers with issues of sexuality, substance abuse, maltreatment, and the legal procedures often related to establishing paternity for their children. There is an emphasis on supporting adolescent mothers in continuing their education in order to break the cycle of poverty. Consequently, the program offers scholarship funds to adolescent mothers, including monthly monetary resources while they attend school. To date, there are a total of 500 adolescent mothers who have benefited from the program (República de Costa Rica 2008a).

Avancemos (Advancing)

Another relevant program is Avancemos, or Advancing, created in 2006. This program targets adolescents, establishing monthly funds for teens living in poverty to help them stay in school; however, this is not a program exclusive to pregnant adolescents in poverty. Also, the Program for Integrative Attention to Adolescents (PAIA) from the Ministry of Health and the CCSS has been able to create a network of adolescent groups across the national territory. The focus of the program is to train adolescents in communities to provide and coordinate health preventive activities, including sexuality and reproductive health education.

Education Programs on Human Sexuality and Reproductive Health

The trajectory of the implementation of educational programs in human sexuality and reproductive health in the school system in Costa Rica has been arduous. Since the 1960s, efforts have been undertaken by the MEP and other organizations toward the implementation of sexuality and reproductive health education in accordance with national policies, but to no avail.

Prior to the attempts with Amor Joven from 1998 to 2002, several efforts were made that were partially achieved, archived after completion, or simply discontinued. Some examples include La Asesoría y Supervisión General de Planificación Familiar y Educación (the Advisory and Supervisory Board for Family Planning and Education), formed in 1969 to create policies and implementation plans for the education of human sexuality for children and youth. The department included the Programa de Adiestramiento en Educación Sexual, which was a program aimed to train the trainers on human sexuality (Araya Umaña 2003). However, the program was only partially completed or implemented (Faerron as cited in Araya Umaña 2003).

In 1985, the MEP charged the Proyectos Especiales del Centro Nacional de Didáctica (Special Projects Unit) to develop specific actions to promote education on human sexuality. Educational materials, supporting activities for students, and training for teachers were created (Arias Guzmán 2006). However, there is no clarity concerning the whereabouts of these efforts.

Later, from 1990 to 1994, a joint effort between the MEP and the Conferencia Episcopal (Episcopal Conference) produced a series of curricular guides for education on human sexuality to high-school students or those in diversified alternative schools, but they were not used (Araya Umaña 2003).

During 2000–2001, the MEP establishes El Departamento de Educación Integral de Sexualidad Humana (Department for the Integrative Education of Human Sexuality), in charge of implementing the integration of human sexuality and reproductive health education across all education levels. Concurrently, the Plan de Capacitación en la Educación de la Sexualidad del Programa Amor Joven (Plan for the Training and Education of Sexuality in the Program Young Love) was undertaken, resulting in 2001 in public disapproval by the Conferencia Episcopal and the Catholic Church, as noted earlier (Araya Umaña 2003; Arias Guzmán 2006).

The latest report to the Children and Adolescent Rights convention (República de Costa Rica 2008a) indicates that as part of the restructuring of the MEP during the transition to a new presidential administration, the Departamento de Educación Integral de la Sexualidad Humana (Department for Integrative Education of Human Sexuality) became a new department, this time called the Departamento de Promoción del Desarrollo Humano y Educación para la Salud (Department for the Promotion of Human Development and Health Education). With this new department, which focuses on all areas of health, the specific delivery of the controversial sexuality and reproductive health education curriculum becomes less salient and perhaps diluted.

Among the specific actions regarding sexuality and reproductive health education achieved since 2004 by the MEP, the República de Costa Rica (2008a) report to the Convention on Children and Adolescent Rights for the period 2004–2007 notes that a budget was established for the selection of teachers, and educational support was provided to organizations dealing with substance abuse.

Lately, INAMU (2009b) reports that to date, there is no permanent program on human sexuality and reproductive health across the nation's education system. It adds that the MEP and the National University (UNA) are jointly in the initial planning stages of working on the diagnostic tools, methodology, and materials for a sexuality and reproductive health education program. The latest report by Costa Rica to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) indicates that the MEP is having difficulties regarding the provision of human sexuality and reproductive health education. It adds that the policy in place lacks clarity, so consequently each education center has to make its own decisions on how to approach the topic of human sexuality and reproductive health education (República de Costa Rica 2008b). It is important to add that the Joint Nongovernment Organizations (NGO) Report (2011) denounces the lack of follow-up from Costa Rica regarding sexuality and reproductive health education as a violation of its commitments to CEDAW.

Recently, el Ministerio de Salud, in the National Sexuality Policies for 2010–2021 (2011a), reiterated the right of children and adolescents to received sexuality and reproductive health education. However, specifications about implementation were not identified. The role of the MEP is still not clear regarding the implementation of a comprehensive and holistic scientifically based and developmentally appropriate human sexuality and reproductive health curriculum for all children and youth. Compounding the situation, it appears that programs such as Construyendo Oportunidades are not funded, rendering them ineffective. Instead of responding to the state's or country's clear needs, programs appear to change based on the priorities of whatever government administration is in power, which challenges the evaluation of their impact.

Conclusions

Costa Rica is a small country with a long history of peace that takes pride in its democratic system. One of the challenges it faces is that adolescent pregnancy has been on the rise even though the national fertility rate has been in decline for several decades. Teen pregnancy and motherhood is multicausal and relates to poverty, low education, isolation, and lack of preventive consistent sexuality and reproductive health education. Facing international commitments regarding human rights, Costa Rica has embarked during the last decades on legislative revisions, policy changes, and program restructuring, hoping to improve the living conditions of its people. All the compromises that Costa Rica has undertaken with international entities have spurred the country to research and document the status of those on the margins of its society. The association between a woman's identity, sexuality, and maternity has been overemphasized in the patriarchal culture of Costa Rica, confining both males and females to rigid stances on gender roles and values that mask the oppression of women. These rigid stances are woven together with religiosity and political postures that cloud the advancement toward an inclusive, progressive society.

Costa Rica has a rich legislative, organizational, public policy, and programmatic base for advancement in the areas of prevention and effective intervention regarding adolescent pregnancy and maternity. This progress is huge and clearly identifies the resolve of its people not only to address issues of adolescent sexuality and pregnancy, but of the complexity of the cultural, social, economic, and human rights matters these issues encompass. On one hand, Costa Rican laws, public policies, and programs on teen pregnancy are the result of a process of social transformation that permeates every layer

of the culture. On the other hand, it is now that the challenging phase of implementation, application, and change must go forward with relentless resolve.

The phenomenon of adolescent pregnancy provides Costa Ricans with a platform to move beyond religious and political discourses to actions and true reforms congruent with human rights and an authentic democracy as stipulated in many national documents. Costa Rica is a country that takes pride in its trajectory of democratic and peaceful history, and the decisions regarding adolescent sexuality and pregnancy are providing the nation with an opportunity to live up to democratic standards. As such, the need for clear boundaries between state and church is obvious, and the needs of people prior to any party/political agenda must be valued. Clear boundaries between state and church ensure inclusivity and freedom for the expression of every perspective, which is the hallmark of a democratic society. However, those outcomes are hard to achieve if there is no firm planning and continuity regarding the nation's priorities across government cycles.

As the nation moves forward in this transformative experience, it is important to continue to gather more information on adolescent fatherhood and on the socialization of the genders. Congruent with human rights and systemic thinking, the voices of young men need to be included, so their needs can be addressed.

Costa Rica is a country with much strength, including institutions of higher learning that provide a research infrastructure and places where intellectuals can engage in critical thinking, civil debate, and thoughtful decision making. This important work will need continued support as the country faces changes in the priorities of governments and in international pressures and influences.

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Adolescent Pregnancy in Eastern Europe

Douglas Rugh

Keywords
Bulgaria · Czech Republic · Eastern Europe: adolescent pregnancy · Abortion · Birth control · Fertility · Health disparities · Healthcare policy · Prevention · Sexual behavior · Sexual health education · Roma

Introduction

Eastern Europe's recent history includes fighting two World Wars and subjugation, first for a short while, by Germany, and then for 40 years, by the communist state of the Union of Soviet Socialist Republics. The dissolution of the USSR in 1991 disrupted cultural institutions and effected millions of lives, launching a process of nation-building including participation in Europe's data collection and social measurement systems. Twenty years later, we can now investigate the divergence of key health indicators such as adolescent pregnancy rates. A competitive analysis of the different countries within this region will lead to distinguishable explanations for a better appreciation of the role opportunity and aspiration have in decisions to start families.

Since from at least 1997, the region's mean adolescent fertility rate has steadily dropped. In 2007, some 28 per 1,000 Eastern European adolescent females delivered a baby: 65 % less than delivered by American adolescents and 50 % less than delivered by the rest of the world's adolescents. The regional mean like all measures of central tendency disguises inequalities in the distribution of adolescent pregnancy rates. The Czech Republic's rate is surprisingly low at 13 births per 1,000 (60 % of the average for all developed countries), and Bulgaria's rate is surprisingly high at 46 births per 1,000 (5 % higher than the United States). The Czech Republic has an adolescent birthrate as low as the developed countries, and Bulgaria has an adolescent birthrate that rivals the developing countries of the world. Separated by less than a 1,000 miles, these two countries will help readers understand causes for the discrepancies in adolescent birthrate. Managing vulnerable populations such as young children and marginalized communities require political leadership with an understanding of the importance of equality, justice, opportunity, and control over one's life. These two countries represent the extremes of management, and this chapter examines the Czech Republic and Bulgaria for delineating the cultural, medical, political, and historical influences on adolescent pregnancy in a region of the world, which emerged from a shared system of economic and political regulation.

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To understand the influences on adolescent pregnancy in these countries, the author interviewed local residents who work in health care, toured cities, villages, and institutions, and analyzed publicly available data. This process involved interactions with government officials, public health doctors, and staff from nongovernment organizations—people passionately concerned about the countries they live in. The rapid pace of change during the last 20 years inclines them to blame social ills on encroaching Western lifestyles, harking back to more traditional approaches. These multiple conversations contribute local perspectives on complex multidimensional issues, and the analyses of population demographics enable the inclusion of social context and hierarchy. The next section begins with the historical context contributing to the sense of continuity inherent in contemporary observations.

Historical Context and Cultural Influences

People lucky enough to survive World War II in Eastern Europe witnessed a remarkable and profound series of changes. A person after the Versailles Treaty found an entirely new military on his streets with statues of unrecognizable people or people loathed by the population. New store clerks did not seem too friendly or overly eager for business. Money in the banks devalued to the point of near worthiness and coupons required for goods. Forgetting a particular coupon resulted in the inability to buy tomatoes or bananas until next week. Standing in line waiting patiently with resigned acceptance and being afraid to talk about what you see out of fear that someone will turn you into the authorities with little recourse to lawyers became the new normal. The feeling of the streets in your neighborhood renamed with a tendency toward easy to organize numbers—First Street, Second, Third, etc. The confusion one feels when the television does not agree with what is so easily observed day-to-day. Similar to the lack of variety was the question: What happened to the plenty? The feeling that it cannot possibly get worse than this, when in fact, it does. Life seemed drabber. The winters are colder and more difficult, and summers are warmer and more difficult than before the war.

Eastern Europe encompasses the post-communist countries, Belarus, Bulgaria, the Czech Republic, Hungary, Moldova, Poland, Romania, Russia, Slovakia, and Ukraine, which were once part of the Warsaw Treaty Organization of Friendship, Cooperation, and Mutual Assistance (1955–1991), commonly called the Warsaw Pact. Several crucial events occurred shortly after the Warsaw Pact dissolved and the Soviet Union disbanded: the opening of the borders, the establishment of democratic parliamentary political structures, the segregation of Czechoslovakia into the Czech Republic and Slovakia, and the marketization and privatization of the once-nationalized economy. Institutions and businesses orienting themselves to the European Union at the same time defines this region and creates a unique opportunity to compare separate approaches to adolescent pregnancy.

Market economies require an information network for determining demand and supply by price instead of by quotas from central planning institutions. Instead of fixed markets with regulated demand and set prices, the region entered an open market with multiple suppliers and competitive prices. For the first time in at least two generations, firms began to compete with price and quality. Many Eastern European firms failed as they lost market share to more established European firms. Two distinct periods of economic downturn occurred: 1990–1992 with the initial reorientation after the collapse of the Soviet Union and 1997–1998 with the privatization of large industries. The situation in the early 1990s was dire with poverty throughout the region intensified by high unemployment, unknown under the control of the Soviet Union. Yet, Bulgaria and the Czech Republic responses to these circumstances developed at various rates, producing different results. Countries that educated their workforce for this change responded to the requirements of the new economy quicker.

Like all countries in the region, Bulgaria and the Czech Republic's gross domestic products abruptly dropped in the early 1990s. During the Warsaw Pact years, prices and quantities were established by the Soviet Union at five-year intervals. This system failed to reflect changes in demand and costs resulted in inefficiencies, the most conspicuous being shortages made visible by queuing and hoarding, but it succeeded in providing consistent markets. Independence ended the inefficiencies introduced through centralized planning but also ended the guarantee of the Russian market. Without a guaranteed market to purchase products, production declined and prices rose. Products designed under the Soviet system conformed to a monopoly but were inferior in quality for markets outside the Soviet Union.

Both countries have aggregate fertility rates fewer than two births per female, below the replacement rate for a population, and both countries are losing population. The most rapid drop occurred after the collapse of the Soviet Union. The Czech Republic's crude birthrate is 8.7 births per 1,000 females. This is one of the lowest birthrates in Europe. The Czech Republic ranks 213 out of 221 Europe countries. Bulgaria's rate is 9.3 births per 1,000 females ranking it 203 out of 221, the lowest rate ever recorded for a European country in peacetime (CIA World Factbook 2011). If these trends continue, each new generation will be about half the size of the preceding one.

Discrepancies in Opportunity

The discrepancies in opportunity between the Czech Republic and Bulgaria became apparent immediately after 1991. Bulgaria lost more than two million citizens from 1990 to 1995 to emigration as people looked elsewhere for opportunity, while the Czech Republic realized a net gain in immigrants. The contrast between the quality of life between these two countries is large. One overt distinction between the two countries is the social welfare programs. The Czech Republic maintained extensive social welfare programs throughout the 1990s. In Bulgaria, however, the leadership withdrew price regulation and eliminated subsidies for food, housing, health care, transportation, and energy. They also withdrew universal medical care and education, instituting policies that ignored short-term welfare. Between 1991 and 1994 alone, the cost of food rose 240 % in Bulgaria. This was followed by widespread illnesses linked to unhealthy diets, nutritional deficiencies, and malnutrition (Cockerham 1999). Subsequently, many people emigrated from Bulgaria, and those who remained faced severe adversities.

The Czech Republic government met declining fertility with generous social welfare programs that supported family-related policies with the objective to provide incentives to encourage childbearing and help for mothers to remain in the labor force. The government introduced programs such as the extended maternity leave, the introduction of further childcare leaves with a job guarantee, a maternity allowance, loans for newlywed couples, and development of childcare facilities in 1970–1972 (Sobotka et al. 2008). Consequently, the social cost of the transition from communism for Bulgaria has been one of the worst in Eastern Europe, much worse than the Czech Republic. Five million Bulgarians or 75 % of the population lived at a bare subsistence level (Dimitrova 2004). The crime rate, especially the violent crimes, rose through the 1990s. In 1989, recorded crimes were 660 per 100,000, and by 1997, crime increased four times to 2,900 per 100,000 (UNDP 2004). The majority of the Czech Republic's social measures since the early 1990s have risen, but even though the two countries left the Warsaw Pact realizing different levels of success, they must contend with low birthrates which have been declining since 1960 for both countries. In summary, the Czech Republic and Bulgaria simultaneously experienced the same existential threat to their countries, and they both demonstrate individual historical responses, which can be further elucidated with their religious and traditional cultures.

Each country has different religious and cultural traditions that influenced their responses to the social welfare needs of the population

through the 1990s and today. The Czech Republic is not a religious society. According to the 2011 census, 59 % of the country is agnostic, atheist, or irreligious; 27 % is Roman Catholic; and 3 % is Protestant (Czech Statistical Office). Most of the Bulgarian population (67 %) identifies themselves as Orthodox Christian (2011 Census). Along with religion, another traditional influence on the countries' responses to social issues is neighboring countries and the physical environment.

The Czech Republic, situated in the geographic center of Europe, encompasses 79,000 km^2, contains a stable population since 1990 of 10 million people, and consists of three historic provinces: Bohemia (Czech, Cechy) in the west, Moravia (Czech, Morava) in the east, and two small portions of Silesia (Slezsko) in the northern part of the province of Moravia-Silesia. The southeast of the Czech Republic is less industrialized and more agricultural. Bulgaria comprises 111,000 km^2 and contains a population that has fallen from almost nine million in 1986 to approximately seven million in 2011. The Czech Republic has more resources and a more efficient transportation network than Bulgaria. Also, both countries have Roma (Gypsies) minority populations characterized by early and universal family formation, high fertility, and greater than two-child family norm. Their traditional community ties were fragmented during the socialist era, when many Roma experienced forced settlement and employment in the manufacturing and construction sectors. Hit particularly hard by the transformation of society after 1991, the Roma are now facing widespread poverty, mass unemployment, marginalization, and negative attitudes from the majority of the population.

The historical context and cultural influences on the Czech Republic and Bulgaria responses to the immediate aftermath of the Warsaw Pact provide two examples of social welfare approaches to economic stressors and low fertility rates. General social indicators have diverged, but adolescent pregnancy in particular will enable a more detailed examination of responses to family planning and health care for marginal groups.

Adolescent Pregnancy in the Czech Republic and Bulgaria

Loss of population and decreases in fertility rates correspond to decreases in adolescent pregnancy rates. Low fertility rates reduced the proportion of children below the age of fifteen (from 21 % in 1990 to 15 % in 2005). As one would expect, adolescent pregnancy rate dropped, but these expected drops were not uniform.

Adolescent pregnancy rate as a proportion of the aggregate fertility rate fell in the Czech Republic from 13 % at the beginning of the 1990s to 4 % in 2005, making adolescent motherhood in the Czech Republic increasingly marginal and confined to specific social groups, particularly among older adolescents (18–19 years of age), whose fertility rates dropped by 45 %. After 1991, attitudes about modern contraception for planning families after finishing university education and starting a career became more acceptable. Abortion rates among women below 20 years of age also fell 37 % in 2005 (Sobotka et al. 2008). The effect of these delays on pregnancy rates among women below 18 years of age was weaker. The prevailing social norms considered childbearing among the youngest adolescents accidental and unacceptable while childbearing among older adolescents (between the ages of 18 and 19) acceptable. In this younger age group, pregnancy was usually unplanned and linked to insufficient information about the responsibilities of motherhood except for Roma populations.

The loss of population is reducing Bulgaria's absolute adolescent pregnancy rate too, but still the adolescent birthrates average three times higher than in the Czech Republic, and there are substantial discrepancies between the mean ages at the start of reproduction according to ethnic group. Roma often enter motherhood as teenagers, while among Turks the mean age of motherhood is 20, and Bulgarians start childbearing at an average of 23 years of age. Roma populations throughout Eastern Europe have a high adolescent birthrate (Masseria et al. (2010; Colombini et al. 2011). Adolescent pregnancy

within this community is not only tolerated but also encouraged (Ramporov 2009). Giving birth at a young age for these women confers the advantage of gaining control within the home, and it provides a tending role for the family, while simultaneously it opens opportunities for the female to bond with her Roma community. Since Roma do not perceive an association between success, economic improvement, and education, Roma females after they are pregnant are likely to withdraw from school. Childbearing is near universal among Roma women; only 30 % of young women between 20 and 24 years of age are childless. Only 3 % of females 30 years old or older are childless. In contrast to the total population, a large majority of Roma women have at least three children, commonly achieved before reaching the age of 30. One half of Roma women born between 1977 and 1981 became mothers before reaching age 20 (for the aggregate population, only 9 % of women in 1979 became mothers by 30 years of age).

The Czech Republic concentrated efforts on increasing fertility rates after adolescences, while Bulgaria's efforts have not been able to substantially alter the country's adolescent pregnancy rates. The next sections further explore these differences in approaches between the two countries starting with health care.

Health care

The Czech Republic has superior health care compared to Bulgaria. The infant mortality rate, a sensitive indicator of basic health care and development, has trended down since 1990 in both countries; however, Bulgaria's rate 17 deaths per 1,000 live births is over four times the Czech Republic's rate of four and is about two times the European Union average.

In the Czech Republic, mortality started to improve immediately after 1990. This resulted in an increase in life expectancy, particularly among men to 74 years of age. This was a 6-year increase between 1990 and 2008, and a reduction in the life expectancy gap between men and women to 6 years in 2008 (down from 8 years in 1990). These increases in longevity resulted from national investments in health care, especially modern technologies and drugs that were unavailable during socialism, combined with lower smoking rates, exercise, and a generally healthier lifestyle. In Bulgaria, average life expectancy has declined by 2 years since the late 1980s and is now 73 years of age. Male life expectancy is only 70 years, and female life expectancy is 77 years. In turn, average healthy life expectancy at birth has declined by 6 years since 1990. With a life expectancy of 66 years, the Bulgarian people have the distinction of lowest life expectancy in Europe (WHO 2008). Falling longevity is the direct result of Bulgaria's social and economic problems, such as stagnant living standards, low real incomes, high poverty rates, unemployment, growing social inequality, environmental pollution, and a healthcare crisis that have resulted in untreated disease and early death, especially among the elderly and the poor. One example is the growing incidence of tuberculosis and anemia in Bulgaria; two diseases thought to be eradicated. Tuberculosis cases have more than doubled since 1990. The National Center of Hygiene found protein deficiency in 20 % of all school-age Bulgarian children. The health of the Bulgarian people has deteriorated, and successive birth cohorts of Bulgarians born after 1991 are less healthy than their parents.

Abortion in Bulgaria and Czech Republic is legally permitted during the first 12 weeks of pregnancy, 24 weeks for cases of medical problems with the fetus. Abortion in both countries is affordable, and public health insurance pays for abortions performed because of medical reasons. The rapid diffusion of modern contraception, particularly oral prophylactic drugs, has contributed to a steady fall in abortions.

Community Support and Structure

Interviewees from both countries remember near-universal marriage with most young people getting married in their early twenties. Today, younger people are more likely to delay marriage

and childbearing except in the Roma communities where families encourage childbearing at a young age. In both countries, older generations and conservative groups view Western popular culture as detrimental to stable traditional norms. Western influence is noticeable in the music listened to by the youth. Some people fear that young males are overexposed to models of male domination of females, leading to criminal and violent identities, and analogously, some fear that young females are overexposed to seduction without opportunities for modeling mature women with established careers.

Less traditional family structures, especially unmarried cohabitation, have become widespread, and marriages have been progressively delayed or even foregone by many younger men and women. Youths are now much less likely to marry than their parents and are more likely to divorce if married. The Czech Republic has a long history of high rates of divorce. Currently, with divorce occurring in one of three marriages, it has one of the highest incidences of divorce in Europe. Bulgaria, however, is a religious society with stricter divorce regulations. The proportion of extramarital births has increased rapidly, surpassing 33 % in the Czech Republic and 46 % in Bulgaria (Vassilev 2006). In the Czech Republic in 2005, only 13 % of births among adolescent mothers occurred within marriage as compared to 82 % in 1990. More tolerant attitudes and the increased acceptance of premarital cohabitation give pregnant adolescents the option of not marrying (Sobotka et al.2008).

The two countries instill different degrees of hope in perceived opportunity. The Czech Republic has achieved accelerated economic growth combined with a rapid rise in wages and living standards. The gross domestic product per capita reached about 80 % of the European Union level in 2006, surpassing Portugal and all countries of Central and Eastern Europe except Slovenia. Though deaths outnumbered live births from 1994 to 2005, the Czech Republic has seen a population increase since 2003. Migration is an important component of population growth, as well as another indicator of the population's perceived opportunity.

In Bulgaria, people feel pessimistic and hopeless. One can feel and see people expressing a lack of commitment to the future when traveling through the area. Efforts of reform over the past 20 years have generated unrealistic expectations derived from false promises by the county's leaders. Bulgarians generally do not believe that reform is possible. When people have little hope for a financially rewarding future such as in Bulgaria, emigration increases. When people have more hope such as in the Czech Republic, immigration increases. Real income losses among young families, the high unemployment rate, and pessimistic expectations of future prosperity have all contributed to one-child families becoming the norm in Bulgaria. Hence, the number of first-graders has dropped from more than 341,000 in 1990 to just 61,000 in 2005 (Stefanova 2005).

The Czech Republic has had a net migration gain of 50,000, while Bulgaria has a net migration loss of 50,000 per year since 2000. Before 2000, the discrepancy in migration rates was even greater. Immigration to the Czech Republic is mostly work-related. Ukrainians, Slovakians, and Vietnamese, who also form the largest immigrant communities, account for two-thirds of the net migration. A total of 900,000, mostly young people, emigrated from Bulgaria between 1990 and 2004. So along with high morbidity and mortality rates, Bulgaria is also losing population from emigration among its young and most talented people. As a result of having the largest negative population growth rate in Eastern Europe, Bulgaria has experienced a severe demographic crisis since its population began to fall in the late 1980s. Bulgaria is now undergoing one of the most severe peacetime population declines in history: 5.1 per 1,000. The country's sharp decline in population can be attributed to a low reproductive rate, a high mortality rate, and high emigration.

Bulgaria employs about three times more females in agriculture than the Czech Republic and about two times more males. Generally, while Bulgaria employs six times the agricultural employees as the Czech Republic, wages in the Czech Republic are 16 times higher than in

Bulgaria. The unemployment rate for educated Bulgarians who completed tertiary education is three times higher than it is for Czechs, and females have six times the unemployment rate at this level of education in comparison with the Czechs. There is almost twice the number of technicians working in research and development in the Czech Republic as there are in Bulgaria. Scientist in the Czech Republic publishes three and a half times more scientific and technical journal articles than Bulgarian scientist. Along with education, the composition of a country's legislative leadership also reflects opportunities that specific groups have within a society. The Czech Republic has roughly twice the female ministers and parliamentarians as Bulgaria, even though Bulgaria elected its first female parliamentarian in 1945, almost 50 years earlier than the Czech Republic.

Several interviewees stressed the pragmatic attitude of the Czech people, which enables a flexible adjustment to changing societal conditions. The opening up of society since 1990 brought a broader acceptance of phenomena previously perceived negatively, such as non-family living arrangements, voluntary childlessness, and homosexuality. Because of these liberal attitudes, Czech society has not debated social issues that other societies perceive as controversial. For instance, the majority of the population consistently supports access to abortion on request (possible since 1957), and political parties have not attempted to prohibit or seriously restrict access to abortion.

In summary, Bulgaria is an agricultural society with a high degree of polarization between the wealthy and not wealthy. Bulgaria is losing population to other countries. People come to the Czech Republic because of greater opportunities for advancement, whereas Bulgaria's closed religious hierarchy is a barrier to inclusiveness. For both countries, family life has undergone a considerable change. The most noticeable change is the postponement of family formation.

There is no doubt that babies born to adolescent females are more likely to have low birth weight, to be born prematurely, to be at higher risk of dying in infancy and, as they grow up, to be at greater risk of educational failure, juvenile crime, and becoming adolescent parents themselves. Adolescent motherhood perpetuates an intergenerational cycle of adversity and distress. Bulgaria's vital statistics reflect higher adolescent birthrate—a high mobility and mortality rate for infants, less educational attainment for mother and child, increased crime rates, and consequently a less productive the labor market.

Prevention: Educational Programs, Sex Education, and Birth Control

Education confers opportunity to members of society, and these opportunities manifest themselves differently in males and females. Educational opportunities with the career potentials that go along with them tend to keep the male population from emigrating to another country in search of better economic prospects. The same opportunities for females tend to confer a sense of control in augmenting status, and they will have fewer children and wait until after they complete their education to start a family. As females perceive a higher degree of future opportunity and a higher social status, adolescent fertility rate drops. Ethnic groups without encouragement for a university education have a high rate of adolescent birth, whereas those groups with encouragement for a university education have a low rate of adolescent birth. University education indicates future economic opportunity. As with a number of European countries, educational expansion constitutes the most important factor for the postponement of family. Formal education provides a range of opportunity for employment and status along with instruction in sexual health.

Both countries have nearly 100 % literacy rates, yet the two countries operate different higher education systems. The Czech Republic trains its students for a greater variety of career opportunities in comparison with Bulgaria. The Czech Republic is a more equitable society with an educational system that encourages advancement through merit with both males and

females. Traditional agricultural economies such as Bulgaria require more manual labor. Aggregate primary and secondary school enrollment has decreased because of Bulgaria's low birthrate in the post-Soviet period, resulting in reductions in teaching staff and facilities. Bulgaria does not have a developed university structure, whereas the Czech Republic does.

The Czech Republic has a more advanced, inclusive educational system. Students are mandated for two more years in the Czech Republic educational system as compared to Bulgaria. A Czech student will spend 10 years in mandatory education, while the Bulgarian student will spend 8 years. The Czech library system has over twice as many books and almost five times more library employees. In 2006, females graduating from tertiary education were greater than that of males in all countries. Women tertiary graduates are one and a half times greater than that of males in Bulgaria; however, the ratio of females to males completing secondary education is dropping, while in the Czech Republic, it is rising. Fewer females in Bulgaria graduated from secondary schools. However, females with this level of qualification are still higher than males. The high proportion of females is especially noteworthy in the Czech Republic, where three females to every two males have a general upper secondary level education.

Sexual Health Education in the Czech Republic

In addition to general and professional education, school prevention program directed toward youth is an important indicator of a country's approach to adolescent pregnancy. Sexual health education from the mid-1940s depended on local school leadership who chose whether to use one of the approved guest lecturers for presentations to students. The approach became more popular. The Ministry of Education in 1956 required one sexual health lecture for 14-year-olds, and in 1971, instructional classes in sexual health at all school levels were required (David 1999). It began in the second year of primary school at 7 years of age. As reported by the Czech News Agency, most believe sexual health education is consistent and adequate. Those that do not agree with sexual education live in religious regions of the country such as Moravia. Efforts to improve teacher training and publishing textbooks in sexual health have been hampered by the Catholic Church (David 1999). The curriculum appears comprehensive for preparing adolescents for responsible sexual activity and emphasizes using contraceptives and creating relationships from partnerships. Lessons warn students about sexual abuse of children, define other sex crimes, and promote tolerance to homosexuals.

Hospitals, health clinics, and nongovernmental organizations such as IPPF Member Association, Spolecnost pro planovani rodiny a sexualni vychovu, or Czech Family Planning Association provide counseling, educational, and information services related to sexual health. There have been regular public health and prevention campaigns and various educational and information programs organized mostly by nongovernmental organizations, which have focused particularly on preventing teenage pregnancies and sexually transmitted illnesses.

Sexual Health Education in Bulgaria

Sexual health education in Bulgaria is not mandatory with no minimum standards. Efforts to introduce sexual health education in Bulgaria happened later than in the Czech Republic. Single lectures by invitation started in the 1970s and in the 1980s with an optional curriculum for students over 15 years of age. The curriculum consisted of a 2-h lecture on biological discrepancies between the sexes without psychological or social aspects of sexuality.

Starting in the 1990s, nongovernmental organizations supplement the education in the schools. The Bulgarian Family Planning and

Sexual Health Association (BFPA), the International Planned Parenthood Federation (IPPF) Member Association in Bulgaria, and the Ministry of Education use peer education and informational campaigns and programs funded by IPPF, the United Nations Population Fund (UNFPA), the World Health Organization, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Population Services International, and the Poland and Hungary: Assistance for Restructuring their Economies (PHARE) program (an instrument financed by the European Union to assist accession countries in their preparation to join the European Union).

There is some conjecture that, where sexuality education does exist in Bulgaria, it is adequate and modern, but the coverage is insufficient. Classes are not regularly held, and teachers are not adequately trained. Sexual health education does not happen in rural areas, while in urban areas, provision depends on school authorities and local communities.

Currently, in the Czech Republic, most men and women use effective contraceptive methods at the start of their sexual life and the first pregnancy therefore mostly involves a carefully deliberated discontinuation of contraceptive use. The proportion of women aged 15–49 prescribed oral contraception increased by a factor of 12, from 4 % in 1990 to 47 % in 2006. Less educated women with a partner, however, are less likely to use any form of contraception (Sobotka et al. 2008).

The Future of Adolescent Pregnancy in the Czech Republic and Bulgaria

Research

Human development happens within a social context which structures life chances so that advantages and disadvantages tend to cluster cross-sectionally and accumulates longitudinally. Cross-sectional data provide information on advantages or disadvantages in a sphere of life which can be theoretically linked to analogous advantages or disadvantages in other spheres. A life course perspective recognizes that advantages or disadvantages in one phase are likely to have been preceded by, and to be succeeded by, analogous advantage or disadvantage in the other phases of life. Contextual influences help us recognize that the current situation did not arise from a vacuum. Effective research, policy, and programming solutions rely on as complete an understanding as possible. Essential discrepancies persist in the cultural and political structures of these countries, as well as in the stages of their economic development, especially regarding the role of the public sector and the quality of life. Bulgaria belongs to the group of these countries where the societal transition proceeded more slowly, faced more difficulties, and was more painful. The following section begins to review adolescent pregnancy in the present.

Adolescent pregnancy research begins with studying the early spheres of life. What happens when people do not have the opportunity to develop? What will people do—how will they aspire to increase their opportunity? The family home environment, peers, education, and media influence adolescents. Does adolescent birth influence immigration rates or vice versa? High adolescent birthrates may lead to a country where people view the economic future with negativity, or an economically dismal future precedes a high adolescent birthrate. With resources expended on the question, high adolescent age birthrates drag the economy and therefore create an environment where people want to leave when they are able, further dragging the economy down.

Males and females respond differently to perceived opportunity. The stress response to lack of opportunity might correspond with a fight or flight. Males and to lesser extent females that can leave for better economic opportunity do leave, whereas those males who cannot leave (along with females who cannot leave for better opportunity) may well respond with a higher

birthrate during adolescents. Answers to these basic questions will inform policy.

Policy

Adolescent motherhood is a healthcare policy issue because adolescents risk low birth weight babies, greater birth complications, continued poverty, loss of family support, and augmented medical complications for the mother and child(ren). Often, adolescent births occur within unstable family environments that exist because of lack of information, social support, and options.

Adolescent birthrates indicate female inclusion and opportunity, and the discrepancy in adolescent birthrates between these two countries demonstrates the positive effect of inclusive educational and employment policies for females. People everywhere value living well and satisfactorily, which means having opportunity for control over their lives. As long as these two countries continue to encourage various groups to participate in educational and economically productive activities, adolescent pregnancy will continue to drop.

Exclusion is manifested through drops in status from intolerance, repression, discrimination, and poverty. Status is relative. After the planned economy promoted by the Soviet Union, inequality of the haves and have-nots became more noticeable and the common. New goods became available, but they were too expensive effectively shutting out many people from basic necessities and the rewards for hard work. People quickly realized that the gains after the Soviet Union benefited the elite with little opportunity for the majority to realize analogous gains. This decreased people's status and opportunity to purchase basic needs.

Both Bulgaria and the Czech Republic need to increase their educated population for a contemporary knowledge-based society. Better health care with increased life expectancy, lower infant mortality, and decreased adolescent pregnancy is an important aspect of the countries' long-term strategy.

Programming

Certain groups of people have access to quality health care; some have almost immediate access, while the majority relies on infrequent contact. Access depends on contact. A person with a health dilemma needs information and guidance. Patients are seeking answers. If people receive information from valid scientifically sound sources, then people act accordingly, but if not, then people become confused when they attempt to understand conflicting messages.

Health disparities are unnecessary discrepancies in the distribution of a problem across population groups, sustained over time and beyond the control of individuals. A program that educates individual patients, for instance, without reducing systemic barriers will mostly educate socially connected and less vulnerable patients. The result will be an exacerbation of disparities with the socially excluded communities slipping further behind.

The implications of adolescent pregnancy include the possibility of ameliorating contraceptive use among sexually active adolescents by providing suitable access to contraception and encouraging consistent use of more effective contraceptives. In addition, healthcare providers, parents, and educators could encourage delaying the onset of sexual activity and abstinence, provide facts about the conditions under which pregnancy can occur, increase adolescents' motivation to avoid pregnancy, and strengthen negotiation skills for pregnancy prevention.

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Adolescent Pregnancy in France

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Keywords
French: abortion · Adolescent pregnancy · Contraception · Double standard of sexuality · First intercourse · Women's liberation movement · Maternal and child health · Sex education · Sexually transmitted infection · Unintended pregnancies

Introduction

Teenage Pregnancy: A Major Public Health Issue?

In France, "teenage pregnancy" refers to pregnancy that occurs before the age of 20. In general, the public perception is that these pregnancies are problematic, regardless of the emotional or social situation of the adolescent girl or boy (Le Den 2012; Le Van 1998). Many French researchers and public health providers use the World Health Organization's (WHO) definition of "adolescence" a person between 10 and 19 years of age. This is a period when adolescents are maturing both physically, emotionally, and socially. There is widespread agreement in France that adolescence is not a good time to become a parent which it is more an adult responsibility (i.e., individuals who have acquired their residential, economic and emotional independence from their family (Galland 1996). Motherhood at a young age is thus seen as a hindrance to the personal development of adolescent girls. Jeannette Bougrab, Secretary of State for Youth, stated in 2012 "Pregnant at 13 or 14 years, this is not normal.[1]" Pregnancy in adolescence is therefore seen as a deviant behavior. This implies that the pregnant or parenting adolescent has not conformed to the standards of French society, thus directly contributing to the stigmatization of pregnant adolescents (Le Den 2012). While teen pregnancy was considered to be a "medical risk" in the 1970s–1980s, adolescent pregnancy today is considered "a psycho-social risk" (Le Van 1998).

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[1] Interview with Jeannette Bougrab: Ados enceintes, Jeannette Bougrab sonne l'alarme, published in lepoint.fr the February, 16th, 2010.

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The media and public officials regularly seize upon this issue and present it as a "major public health issue." To support this position, they qualify as "alarming" the statistics on number of abortion among minors and warn that the number of adolescent abortion is increasing. Roselyne Bachelot-Narquin, Minister of Health, Youth, and Sports in 2010 stated that, "Faced with the worrying resurgence of unwanted adolescent pregnancies, we cannot remain inactive.[2]"

Yet, the demographic indicators show a marked decrease in pregnancies since the 1970s among French adolescents. Births to adolescents 18 years of age and younger decreased by 60 % between 1980 and 1997, and represented about 0.6 % of all live births in 1997 compared with 1.3 % in 1980 (Brouard and Kafé 2000). In 2011, the births to adolescents 18 years of age or younger accounted for only 0.3 % of total live births in France. The prevalence of pregnancies among adolescent girls is in the order of 30 per 1,000, holding steady since the mid-1990s.[3]

At the same time, the number of abortions among girls 15–19 years of age remained relatively stable, somewhere between 15 and 17 abortions per 1,000 adolescents between 1976 and 2009. Adolescent abortions in France were the lowest at the end of the 1980s and early 1990s, averaging 12 abortions per 1,000.

Mariette Le Den notes, ''Teenage pregnancies upset and are a concern among actors in the public sphere even though the numbers are relatively small and have been decreasing for 30 years." The United Nations Children's Fund notes that globally, "Although the number of teenage pregnancies has decreased, the public perception of teenage pregnancy as a social problem has increased" (Adamson et al. 2001).

What precisely is the history of teenage pregnancy in France? Has it always been regarded as a major public health issue? And, what social meaning can be attributed to these adolescent pregnancies? It is these questions that we try to answer in this chapter using demographics, epidemiological, and public health data.

Adolescent pregnancy in France is often characterized as "girls" who become pregnant before the age of 20. This is the definition that we will use throughout this chapter. However, in our analysis, we will make a distinction between minor females (girls who are younger than 18) and those between 18 and 20 years old.

After reviewing the history of fertility among young French women starting in the eighteenth century, we will describe legal developments regarding access to contraception, abortion, and the sexual education provided to adolescents in France. We will also examine the risks linked to unplanned adolescent pregnancies such as sexually transmitted infections STIs and HIV/AIDS transmission. Then, we will discuss developments in contraception use among adolescents and their sexual practices. Finally, we will present the historical trends in rate of adolescent pregnancies, as well as factors that govern the decision to abort or to continue the pregnancy.

Historical Context

In his studies, Louis Henry (1978) explores the demographic behavior of the people of France in the "Ancient Régime" (before the French Revolution of 1789) until the beginning of the twentieth century. His sources of information were the parish registers for the prerevolutionary period, and then, he uses the civil registers after the 1790s. These data, however, are inadequate to provide an estimate of the population at each age (now estimated by the population census), which makes the extent of fertility by age impossible. According to demographers, "out of wedlock births" were more or less common across regions and time, but these births often referred to as "illegitimate" births did not occur in large numbers because of social pressures and religious standards, which allowed having children only in the context of marriage (Blayo 1975). In these

[2] Discourse of Roselyne Bachelot-Narquin, Minister of Health, Youth and Sports for the Women International Day, Mesures en faveur de la prévention et de la prise en charge des grossesses non désirées, Paris, March, 8th, 2010.

[3] Source: Insee, Bilan démographique 2011.

conditions, the average age at first marriage may give an idea of the age at which females have their first child, since the union of the two spouses also meant the entry into sexual and reproductive life.

The average age at first marriage for French women over the last few hundred years has varied by only by a couple of years. It was 24.5 years for the period 1680–1689 and reached the record value of 26.5 years in 1780–1789. The age declined to 23.9 years in the period 1880–1889 and observed a slow progression to reach 24.1 years in 1900–1909.

The average age at first marriage for men followed the same trend with a gap of 2 years, except for the period 1840–1909 where it stabilized at around 28 years of age. The difference in age between the bride and groom on average was fairly stable at 3 years (Houdaille and Henry 1979). The decrease in the average age at marriage for men just after the Revolution (1789) seems to have been due to individual efforts among young men to avoid conscription. The average age for men again became stable in the second half of the nineteenth century, while the average age for women continued to decrease. The increase in the age at the wedding for males appeared to be a gender imbalance caused by the loss of males during the wars (Houdaille and Henry 1979).

Because of the Catholic doctrine stating that a sexual union has to be procreative, birth control practices, essentially coitus interrupts and abortion, were not or seldom used by couples. This is important because age at first marriage and a relatively high rate of permanent celibacy could reduce fertility and thus the growth of the population (Hajnal 1965).

The fertility rate among married women younger than 20 years of age was very high from 1670 to 1819, varying between 200 and 350 births per 1,000 (Henry 1978; Houdaille and Henry 1973). However, the actual number of married adolescents was actually small. Thus, the number of pregnancies and births among adolescent girls was relatively insignificant when compared to all women, regardless of their marital status. Pregnancy at a young age was therefore not a common occurrence in traditional French culture. Moreover, young mothers were not even considered to be deviant individuals.

With the introduction of general and periodic population census starting in 1801, the age structure of the French population was better known. The study of fertility rates in France began in the early twentieth century. Census data show a high rate of stability in terms of fertility over the years. The exception was during the war years. Fertility rates retuned to previous levels and then increased. The "baby boom" period (1945 to the late 1970s) is characterized by an increase in fertility at all ages. From the late 1970s onwards, however, the rate of births in France began a dizzying fall, especially for the 20–24-year-old age-group for which the fertility dropped over 70 % (see Fig. 1a). Among girls 17–19 years of age, their fertility rates dropped almost 80 % during the same period (Fig. 1b).

The decrease in fertility rates of younger women, primarily the 20–24 age-group, and to a lesser extent the 15–19-year-old girls has led to an increase in the average age of childbearing since the 1970s in France.

Apart from the periods of world wars (1914–1918 and 1939–1945), the average age of first motherhood declined between the beginning of the twentieth century to the 1970s—end of "baby-boom"—to reach its lowest point, 23.8 years of age. After this period, the average age of first childbirth increased in France and reached an average age of 28.0 years in 2008 (see Fig. 2). The average age of motherhood (for all births) follows the same trend: its lowest level of 26.5 years in 1977; it reached 30.2 years of age in 2011.

The decrease in age at motherhood between the end of the Second World War and the beginning of the 1970s can be explained, in part, by the decrease in the age at marriage. Some explain that it was a way for a woman to escape her family, but she becomes dependent both financially and legally to her husband.[4] Another

[4] The Code Napoleon (1804) considers women as minors under the guardianship of their father, then their husband. In 1965 they won the right to manage their property, open a bank account, to practice a profession without the permission of their husband (or father).

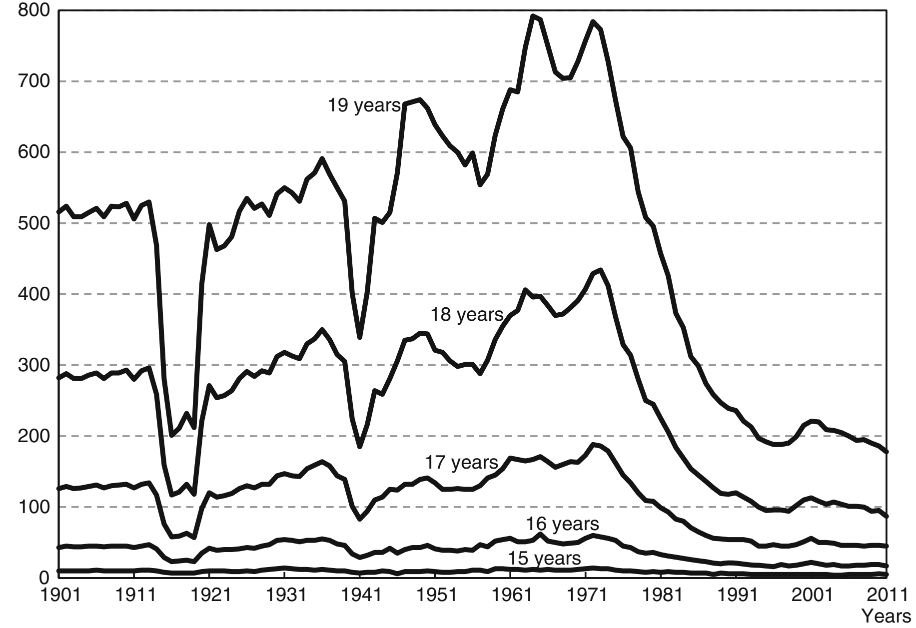


Fig. 1 **a** Trend in fertility rates of 15–19 and 20–24 in France since 1900. *Source INSEE*. **b** Trends in fertility rates of 15–19 in France since 1900. *Sources* Pison (2012), INSEE

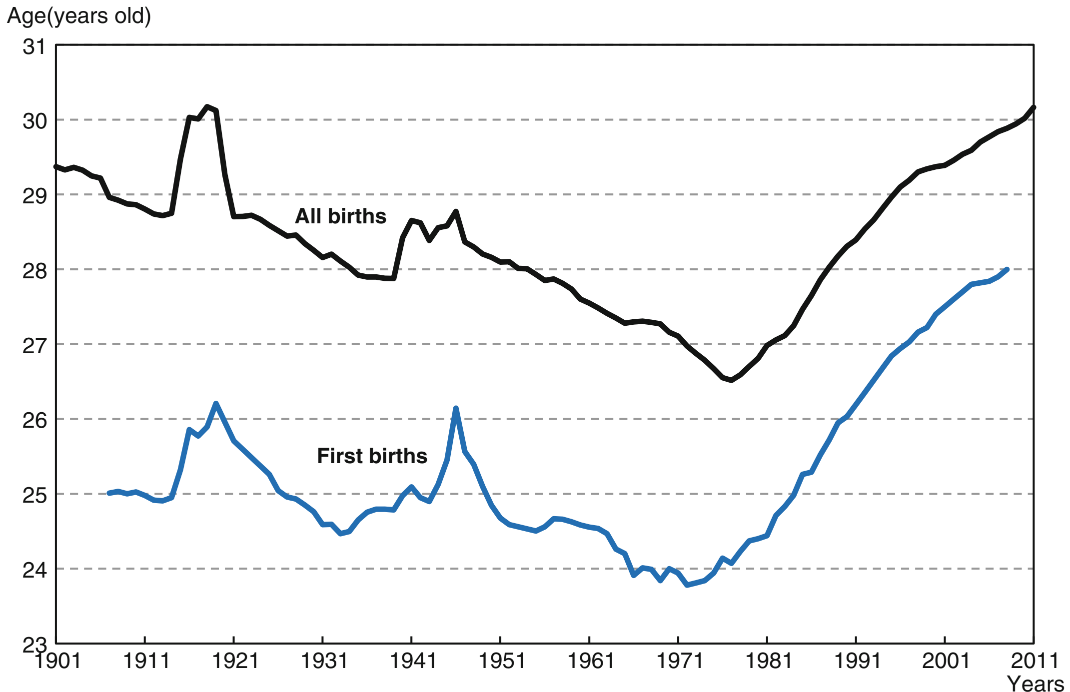


Fig. 2 Trend of average age at childbearing in France since 1900. *Sources* Mazuy et al. (2011), Pison (2010)

explanation was the need to legitimize a birth conceived outside of marriage (Pison 2010). Indeed, during this time, contraceptive practices were essentially limited to coitus interruptus, and if pregnancy did occur, abortion was prohibited and considered to be a crime.

The 1970s is the period when the decline in adolescent motherhood began. It is, therefore, a critical phase that needs careful study to better understand reproductive behavior in France. What are the political and cultural changes that took place to cause or promote changes in reproductive behavior (average age of motherhood in 1977 was 26.5 years and 30.2 years in 2011).

Legal Context and Public Policy

Changes in the Legal Context: Access to Contraception and Abortion

The sudden drop in the fertility rate of young people since the 1970s in France seems to be explained by a combination of several factors: the democratization of higher education and the presence of women in the workforce. Employment provides young women the opportunity to acquire a new social status. France is evolving through a phase of high social mobility, a phase that started with the "May 1968" social movement and the formation of the *Mouvement de libération des femmes* (Women's Liberation Movement, MLF). The approval of laws legalizing contraception and abortion was victory of this movement, which enabled women to plan their maternity and families.

Passage of the Neuwirth Law in 1967, legalizing contraception, affirmed the emergence of sexuality as a subject of public debate and marked the beginning of official government involvement in this area. A section of the act specified that underage girls should have parental consent to use a contraceptive (Bajos and Durand 2001).

In 1974, a softening of the 1967 law on contraception gave minors access to contraception without parental consent, but only if they obtained services at government-sponsored

Family Planning and Education Centers (Centres de Planification et d'Education Familiale, or CPEF). Supported by leftist progressive forces, the strong mobilization of the feminist movement promoted passage of the Veil in 1975, legalizing abortion. This law allows all women to have an abortion at a medical center upon request. Like all other legislations, the Chirurgical Act requires that underage girls need to have parental agreement to access to abortion (Bajos and Durand 2001).

The last important modification in 1967's and 1975's laws was made in 2001. The fact that underage girls needed parental consent to obtain an abortion could reduce access for pregnant adolescents, due to the difficulty in confessing to having sexual intercourse to their parents (Bajos and Ferrand 2001). Instead of parental consent, underage girl can now obtain an abortion if they have the consent of any adult of their choosing. On top of that, legal term limit to have an abortion in France was extended from 12 to 14 weeks of amenorrhea.

All legislative changes about contraceptive and abortion contributed to a changing public awareness that sexual behavior has a social dimension. Since then, the sexuality of young people has become the subject of increasingly detailed opinion surveys and is often a common topic of public debate: "The issue has now entered the discourse at meetings and forums where decision makers make choices for society as a whole" (Mossuz-Lavau 1991). This trend was reinforced the advent of the Aids'epidemic. Starting with a national campaign launched in 1987, the government and other public authorities intensified HIV prevention activities (Bajos and Durand 2001).

Sexuality Education in France

In the 1950s, the sexuality of young people had not yet become a topic for discussion in France (Mossuz-Lavau 1991). Moreover, there was almost no public discussion about sexuality among young people until 1974 when the legal age for consensual sex was lowered from age 21 to 18. In that same year, the High Council on Sexual Information, Birth Control and Family Education (Conseil Supérieur de l'Information Sexuelle, de la Régulation des Naissances et de l'Education Familiale, or CSIS) was created as an advisory body. Sex education and information then became part of the school curriculum (Bajos and Durand 2001).

The first Ministry of Education memo about sex education and information was dated July 23, 1973 (Memorandum No. 73-299). It explained the need to replace an outdated form of protective sexual education with a new formula, based on the mastery of information and on instilling responsibility. The memorandum specified that sex education should be provided in biology courses and in additional (elective) classes. These classes could be taught by teachers or outside experts. This was prior to the onset of HIV/AIDS. Finally, in 1995, the Ministry of Education office instituted a new training program for teachers designed to help them follow the new 1996 and 1998 curriculum policies that require two mandatory hours of sex education. The Ministry's efforts were to mobilize the entire educational community around this issue. Until the late 1990s, sex education in French schools was often not sufficiently broad and even though updated to include content on HIV/AIDS, and during that period, these sexual education curriculums were rarely implemented in the schools (Bajos and Durand 2001). In 2011, it was recognized that sex education should adopt a more comprehensive vision of preventing high-risk health behavior and should address the broader education of all citizens.

Since 1995, the Ministry of Education has organized a national training program, conducted by local school districts using funds specifically earmarked to provide sexual education by the Public Health Administration (Direction Générale de la Santé, or DGS). Its purpose was to train physicians, school nurses, social workers and management or supervisory personnel, teachers, and guidance counselors to become more involved in sex education. The program also instructed educators on how to evaluate needs in this area, how to meet those

needs, and how to encourage sex education initiatives in every school district. The work of this program provided the basis for the Ministry's revised sex education policies of April 1996 and November 1998. These were aimed at reducing risky sexual behavior in France, especially among young people. The initiatives represented a turning point in the Ministry's attitudes toward sex and the prevention of sexual risk behaviors. They affirmed the importance of the Ministry's role in the transmission of knowledge and in the development of responsible attitudes toward sexuality (Bajos and Durand 2001).

The CSIS is an advisory body whose analyses contribute to policy at the national level. The commission has reported to the Women's Rights Department (Service des Droits des Femmes) since January 1, 1995. A June 12, 1996 decree redefines the commission's general institutional context, which is under the joint aegis of the ministries in charge of women's rights, the family, and health. Four working commissions have been set up: (1) sex education and information for young people; (2) prevention of sexual violence; (3) child-rearing support for parents; and (4) family planning and prevention of sterility (Bajos and Durand 2001).

In a memo dated November 19, 1998, the Ministry of Education defined new policies for sex education in schools. These policies apply to all public and private institutions under contract to provide elementary and secondary education, but they place the greatest emphasis on the role of the middle (junior high) school in sex and health education. All 12–14-year-olds attend junior high school, and since 1995, these schools have become involved in sex education programs. The topic of sexuality is approached in middle schools through the teaching of reproduction in biology classes and through two hours of *mandatory* sex education. This requirement was implemented in 1996 (Memorandum dated 15 April 1996) and was reinforced in a 1998 memo (Memorandum dated 19 November 1998), which included sex education as part of the health education curricula. Sex education is also provided in health education workshops, which all students in the first 4 years of secondary education must attend for 30–40 h, over 4 years. These workshops also stress the prevention and reduction of violence and sexual abuse. The content of sex education programs is defined in policies issued by the Ministry of Education. In high schools, sex information classes may be held, but they are *optional*. The programs that have been developed, the approaches taken, and the policies issued by the National Education Office are applicable throughout the country. They apply to public schools and certified private institutions. The subject of abstinence is not discussed in France, either in messages targeting the public at large or in prevention messages disseminated at school. Conservative groups might broach the topic of abstinence; however, the concept is used more as an injunction to postpone young people's entry into sexuality (which these participants believe occurs too early) than as one among several prevention strategies adopted in a risk-reduction program. The topic of contraception is discussed in biology courses as well as in sex education and information sessions. In these classes, students are informed about where they can go for services near their school, particularly the Center for Family Planning (Bajos and Durand 2001).

The Act of July 4, 2001 reinforced the role of the school, at all levels, in terms of youth sexuality education. Information and education in sexuality from primary school and throughout the secondary school are required. With curriculum based on the age-group, children and adolescents are to be provided at least three annual sessions of the sexual education a year. These sessions are only taught by teachers of biology but can involve staff contributing to the mission of school health and educational staff as well as external stakeholders such as physicians of the CEPF. This last act confirmed the fundamental role of the school in the sexual education of the youth and its orientation toward structures dedicated to listening to this population about methods of contraception and prevention of risks related to sexuality.

The occurrence of the epidemic of AIDS in the 1980s placed sexuality in a new light. The fear of contamination by HIV pushed the French

State into informing the public of the HIV/AIDS risks associated with sexuality and to provide information as well as preventive measures, to reduce the spread of the epidemic.

The Campaigns of Prevention of Risks: HIV/STIs and Unplanned Pregnancies

Rarely used as a contraceptive method in France, and perceived as more related to prostitution (Paicheler 2002), the condom did not have a very good image in France. This attitude, however, had to change when the nation faced with the AIDS epidemic in the 1980s. Even then it took time, advertising condoms was forbidden until 1987, year of the first public HIV prevention campaign. The focus was that the condom become commonplace. Although the campaign did not focus on the ‘‘most at risk” groups; it was addressed to women, judged more responsible and capable to propose the condom. The French Minister of Health, Claudse Evin, propoted besides ”the relevant role of the women“ to limit the epidemic (Peicheler 2002).

The French AIDS Prevention Agency (Agence Française de Lutte contre le Sida, or AFLS) was created in 1989. The AIDS division of the Public Health Administration and an interministerial committee were both established in 1994. The Ministry of Education office has entered into several partnership agreements with HIV coordinators at the Ministry of Health to work toward prevention strategies among young people. Since 1996, the Ministry of Education has expressed interest in playing a major role to prevent sexual risk behaviors by implementing two mandatory hours of sex education in schools. Policy directives on the prevention of health and sexual risk behaviors focus specifically on sexual abuse and violence. However, there has been certain reluctance by school principals to install condom dispensers in high schools (Bajos and Durand 2001).

In 1997, following the arrival of triple-drug therapy for the treatment for HIV/AIDS (1996), the focus was on the early support and treatment of the disease; therefore, regular screening was encouraged. This included initiatives focused on youth, such as awareness campaigns against HIV at sports events, music festivals, all cultural gatherings where there are young people that can be reached with advertising. The 2003 campaign again tried to trivialize the use of condoms designating them a consumer product and allowing them to be sold. The “National Plan for combating HIV/AIDS and the IST 2010–2014” provided by the Ministry of Health and Sports in 2010 focused particularly on young people, women, and persons with disabilities (Ministry of Health and Sports 2010).

Advertising to publicize this government HIV screening program intensified. It was targeting young people as well as the doctors and social workers who were likely to be serving this age-group. However, government advertising on the prevention of unwanted pregnancies and the use of contraception is quite sporadic and relatively underdeveloped (Bajos and Durand 2001).

The first Government contraception campaign began in France in 1982. Supported by Yvette Roudy, then Minister of Women’s Rights, it was aimed at the female audience and was intended to reaffirm the right to contraception, still frowned upon by public opinion. A special section was also presented in colleges and high schools. In 1992, a second campaign, particularly addressing adolescents, was developed by a team from the Secretary of State for the rights of the women of the time, Véronique Neiertz. The issue was to talk about sexuality without shocking the parents. A first version of the TV spot had to be abandoned; the Prime Minister at the time sought a “less direct” version of the campaign deemed too suggestive. In 2000, a new campaign encouraged talking about sexuality and to choose its contraception. Emphasis was placed on the morning-after pill. In 2009, the campaign focused on women and men between 18 and 30 years of age. The message encouraged them to talk about contraception and promoted the diversity of contraceptive that are available.

The last campaign promoting contraception in 2012–2013 used media (TV, Internet, press, radio, etc.) and was titled, “the best contraception

is that one chooses," and it aimed at the entire population and focused on the different contraceptive methods available to women. The theme was to encourage women to choose contraception that best fits into their sexual and emotional life. This program was based on the results of the research, which showed that contraceptive failures were more frequent among women who were using a method of contraception that did not meet their emotional, sexual, and social needs (Bajos et al. 2003). One component of this campaign is particularly aimed at young people. Entitled "If boys could get pregnant would we be more interested in contraception?" And, it depicted young men who are "pregnant" and are therefore faced with the management of an unplanned pregnancy.

All these posts seem to reach their target as 99.7 % of youth 15–19 years of age in 2010 reported having had information about contraception (FECOND-Inserm/Ined 2010 survey). However, their sources of information appear to vary somewhat by sex. Some 91 % said that they learned about contraception in school. For young women, their mother was their second source of information (60.4 % compared to 34.0 % for their male counterparts, in fourth position). Young men turn more to the media (i.e., television, radio, newspapers). These sources of information were cited by 1 out of every 2 adolescents (54.8 % for boys and 53.4 % for girls). National Education therefore plays the role of providing the first information on sexual education of the population. The campaigns of information, cited by 1 out of every 2 adolescents (54.1 %), also have an important role in providing access to sexual information.

Sexual and Contraceptive Practices

Adolescent Sexuality

Over the past few decades, age at first intercourse has fallen among both French men and French women. The decline has been moderate for men and more pronounced for women (Bozon 1993). The difference in the pace of decline by gender is essentially due to the fact that average age at first intercourse was much higher to begin with among women born in 1936–1940 than among men in that same cohort (a mean of 20.6 years for women versus that of 18.8 years for men). The most marked decrease was seen among young men and women whose sexual lives started during the 1960s. This was a period of dramatically changing social values in France. During this period, the women's movement was fighting for legal contraception and abortion. The student movement culminated in massive protest and demonstrations in May 1968. However, in the 1970s and 1980s, age at first intercourse stabilized somewhat for men and women, at just over 17 for young men and 18 for young women (Bozon 2008). The results of the 2010 FECOND survey show that young people of both sexes have had their first sexual intercourse at practically the same age (median age of 17 years and 1 month for boys and that of 17 years and 6 months for girls) (see Fig. 4).

Although the age at sexual debut may have converged, female and male experiences of this event remain very different. For example, more women than men still have their first sexual experience with a partner who has already had sexual intercourse and who is at least 5 years older. However, it is noteworthy that with successive generations, women are increasingly likely to experience their sexual debut as something expected and planned for (Bozon 2008).

A Double Standard of Sexuality

Today in France, sexual behavior still remains socially determined by a context that attributes differential roles and statuses to each gender. While having multiple partners remains associated to men's sexuality, sexual stability and monogamy are seen as desirable aspects of women's sexuality. Thus, attitudes and behaviors that are valued in males may still be stigmatized when adopted by women (Bajos and Durand 2001).

The fact that the behaviour of young people is no longer so strongly controlled by their families does not mean that the differences between

women and men in socialization of sexuality have disappeared or decreased Bozon (2008). Through initiation to masturbation during pre-adolescence, one can say that men continue to serve an early apprenticeship in individual desire, backed by cultural representations, rather than in relationships. By contrast, young women are still educated, for the most part, to consider sexual debut as an experience which has to do with feelings and relationships. It may be that this representation of sexual initiation for women is linked to the responsibility which is still socially attributed to them, than that of trying to engage men in a monogamous relationship, even if this is only an end result (Bozon 2008).

While 1 out of 2 women (54.1 %) aged 15–19 in 2010 reported that their relationship with their first partner lasted 6 months or more, only 1/3 of men (29.9 %) reported the same. On the contrary, 8.5 % of men said their first sexual experience was a "one night stand." Only 1.3 % of women reported that their first sexual experience was a "one night stand" (Enquête FECOND-Inserm/Ined 2010). Thus, the obligation to remain a virgin until marriage has been less important for women since the 1960s. The expectation of women today is that sex is appropriate in a loving relationship (Bozon 2008).

So while some differences by sex and social group are tending to decrease over the generations, this stage of life is still very different for the two sexes. Sexual development during adolescence is a period of apprenticeship in conjugal sexuality for women, while it is more of a personal experience for men (Bozon 2008).

Another striking feature of changing sexual debut is that sexual initiation signifies less and less the beginning of an official conjugal history, a change that is particularly notable for women. Fifty years ago, two-thirds of women and a third of men had their first experience of sex with their future conjugal partner. Today, this is true for only one individual in ten (for both women and men). At the same time, age at first union, and even more at the birth of the first child, has risen markedly (Prioux 2003). So in France, as in many countries of the North and South (Wellings et al. 2006), the first sex now ushers in a non-reproductive sexuality between adolescence and parenthood for both sexes but one which is still lived out differently depending on whether one is a woman or a man (Bozon 2008).

So for women, the phase of their active sexual life before the first union has doubled in time in the space of a few decades, from 2 years for women of the cohorts of 1936 to 1945, to 4 years for those born between 1971 and 1980. This change has been much less significant for men over the same period: from 5.5 to 6 years, respectively (Toulemon 2008).

Differences between women and men in age at sexual debut and in number of partners during this young initiation period are becoming blurred. A pre-conjugal model for women is characterized by more long-lasting relationships. A non conjugal model for males is a succession of partners and where periods without sexual activity are more frequent (Bozon 2008).

In the Simon Survey (1970), young people's sexual attitudes were found to be radically different from those of previous generations. This was no longer the case in 2006; attitudes were fairly stable and no longer evolving. This phenomenon also was observable in other domains, for example in politics and in values in general (Galland 2004). Young people were no longer rebelling against unrealistic sexual sanctions because they were adolescents. Marriage was no longer the main passageway into adulthood. The right to a sexual life before first union or marriage is rarely contested even for teenagers. More generally, the attitudes of young people are the same as "adults" for the most part. In the CSF survey (2006), for example, a majority of young people believed that, "by nature men have more sexual needs than women." There were issues, however, where adolescents were more open-minded about sex than their elders; for example, they were more acceptant of homosexuality. Surprisingly, there also was a significant proportion of young men (a fifth of those between 18 and 24) who showed no interest in either sexuality or living together in a long-term relationship (Bozon and Le Van 2008). Moreover, since the age at first childbirth,

after first coitus, rose for females from 5.5 years 25 years ago (Bajos et al. 2004) to 9.5 years in 2009, the period of non-reproductive sexual activity has almost doubled during the last decades.

Changes in Contraceptive Practices

By the mid-1970s, over half (51 %) of girls between 15 and 19 years of age used some form of contraception during their first sexual intercourse. By 2009, over 90 % of girls in the same age-group used some form of contraception during their first sexual intercourse (see Fig. 3a). Among boys between 15 and 19 years of age, slightly over 50 % used contraception during the first sexual intercourse. By 2009, over 95 % of boys used some form of contraception during their first sexual intercourse (Fig. 3b). Among French adolescents today, initiation of sexual intercourse is associated with a powerful obligation to protect you and your partner (Bozon 2009b). To avoid HIV infection, adolescents use mostly condoms (92.3 %) and 15.9 % used both a condom and the contraceptive pill (see Table 1) (FECOND-Inserm/Ined 2010 survey). The "success" of condom use among young people in the 1990s is attributable to the condom being used to protect from sexually transmitted infections. By adopting a "responsible" behavior, as a viable part in the ritual of the first reported sexual intercourse, condom use may also be a way for partners to adapt to the uncertainty of these initial phases of sexual life and relationships (Bozon 2009b).

Young women, however, continue to be more concerned than men by unplanned pregnancies, although they reported that they used a condom as many as men. Support for sexual and reproductive health issues is thus primarily the responsibility the adolescent girl during the phase of sexual initiation. Young women have internalized the need to be responsible for themselves and their partner (Bozon 2009b).

The spread of contraceptive in France since its liberalization in 1967 was fast. Pill is the most widely used contraceptive, and the IUD (intra-uterine device) is the second most used one (Bajos et al. 2012).

However today, contraceptive standards may vary according to the age and the type of sexual relationship. With the outbreak of the AIDS epidemic, condom promotion campaigns strongly contributed to the dissemination of the current model. All sexual relationships start with a condom, which is succeeded by the pill as soon as the relationship stabilizes and the sexual life is assumed to be stable. Finally, when the desired number of children is reached, most women move to the IUD (Bajos and Ferrand 2001).

Today in France, approximately 70 % of 15-19 adolescent girls who were having sex and did not want to be pregnant use a medical method of contraception (pill, implant, patch, vaginal ring) and 26 % used a condom (FECOND-Inserm/Ined 2010 survey). The pill was the most widely used contraceptive (69 %) in this age-group, and 20 % of the girls used two forms of contraception, one being a condom. Young women aged 15–17 use more condoms as their main method of contraception than their older counterparts (respectively, 44.7 % and 16.5 %). This raises the question of reimbursement of this method in contexts where social acceptance of youth sexuality is limited. Financial barriers may also restrict access to other contraceptive methods requiring medical care.

What best describes sex among adolescents is its episodic nature. Typically, there are long periods without a sexual partner (Bozon 2008). Under these conditions, adolescent females often report that it is difficult to use contraception (such as the pill) that must be taken daily.

Contraception Failures

Among the 70 % of teenage girls who reported a reason for not using contraception at the time of conception, 31 % thought that they were not at risk of becoming pregnant and 23 % had not planned on having sex (FECOND 2010 Inserm/Ined survey). Other reasons included problems with contraceptive methods in the past (20 %), not thinking about contraception (14 %), partner

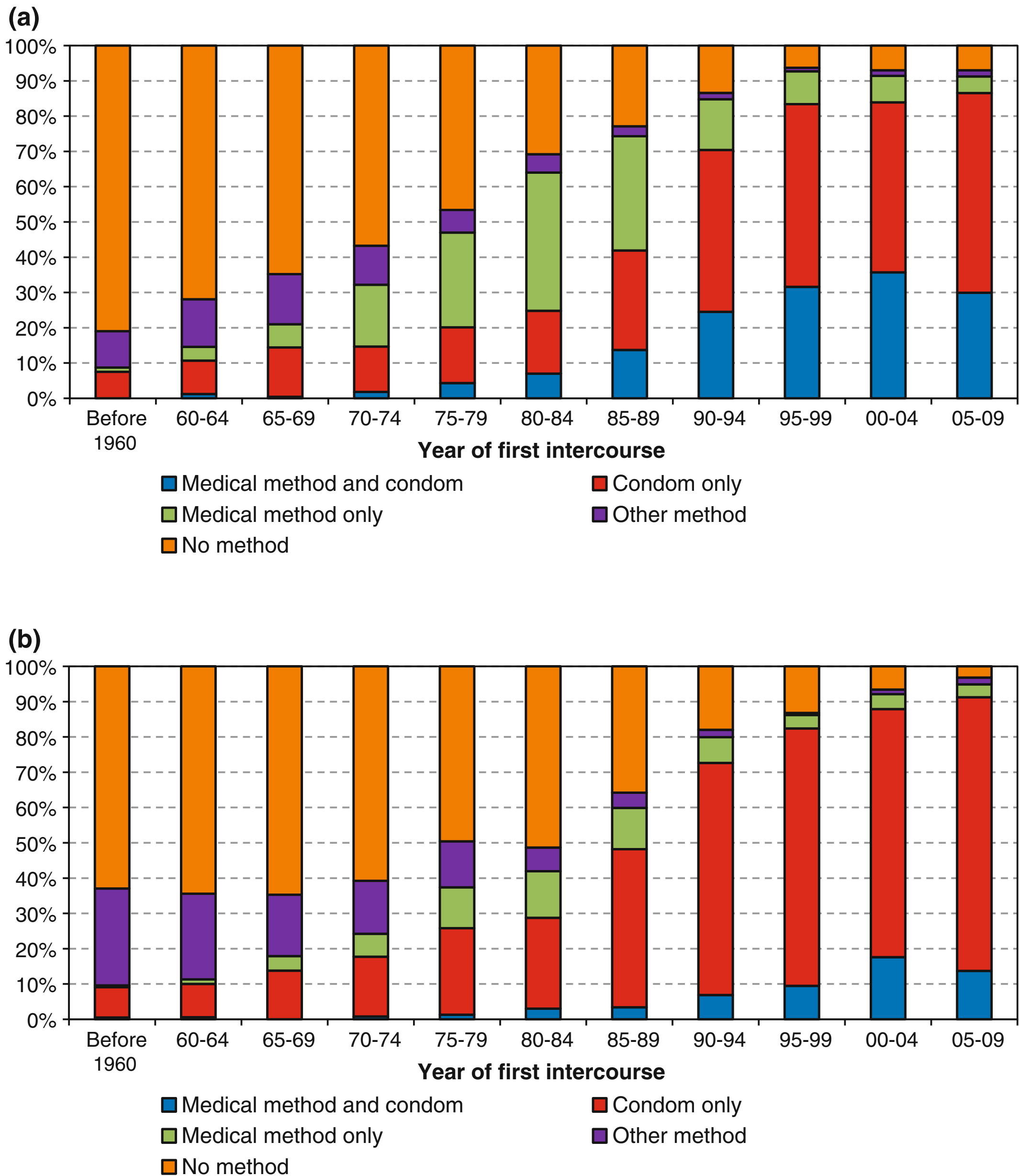


Fig. 3 **a** Contraceptive use at first intercourse for women. **b** Contraceptive use at first intercourse for men. *Sources* Beltzer and Bajos (2008), Fecond Survey (2010)

unwilling to use contraception or wanting a pregnancy (7 %), cost (5 %), and not wanting parents to know about their contraceptive practices (5 %) (Moreau et al. 2010a).

For the 20.6 % of women that used the pill, 93 % said that the conception is due to an inconsistent or incorrect use of it. For the 31.3 % of those who used a condom, 84 % reported that the condom slipped or broke (Moreau et al. 2010a).

After an abortion, 68 % of teenagers were given a prescription for a more effective method of birth control than the one they were using before the abortion. However, more than half the

Table 1 Principal contraceptive use in 2010 for 15–19-year-old girls

Percentage	Age at 1 January 2011		
	15–17 years	18–19 years	15–19 years
Pill	16.4	47.3	32.1
IUD	0.0	0.0	0.0
Others hormonal methods	0.1	0.6	0.3
Condom	14.1	10.0	12.0
Others[a]	0.7	1.3	1.0
Sterilization[b]	0.0	0.0	0.0
Sterile[c]	0.0	0.0	0.0
Pregnant	0.0	1.5	0.8
Without partner	68.3	36.3	52.0
Want to be pregnant	0.0	1.6	0.8
No contraception	0.3	1.3	0.8
Total	100	100	100
Observations	310	292	602

Hierarchic classification if the respondent uses more than one contraceptive at the same time (sterilization, implant, pill, IUD, injections, patch, vaginal ring, condom, and others)

[a] Other methods are local female methods, withdrawal, periodic abstinence, day after pill, no answer

[b] Contraceptive sterilization only

[c] Medical sterilization and sterile

Sources Inserm-Ined, Fecond 2010

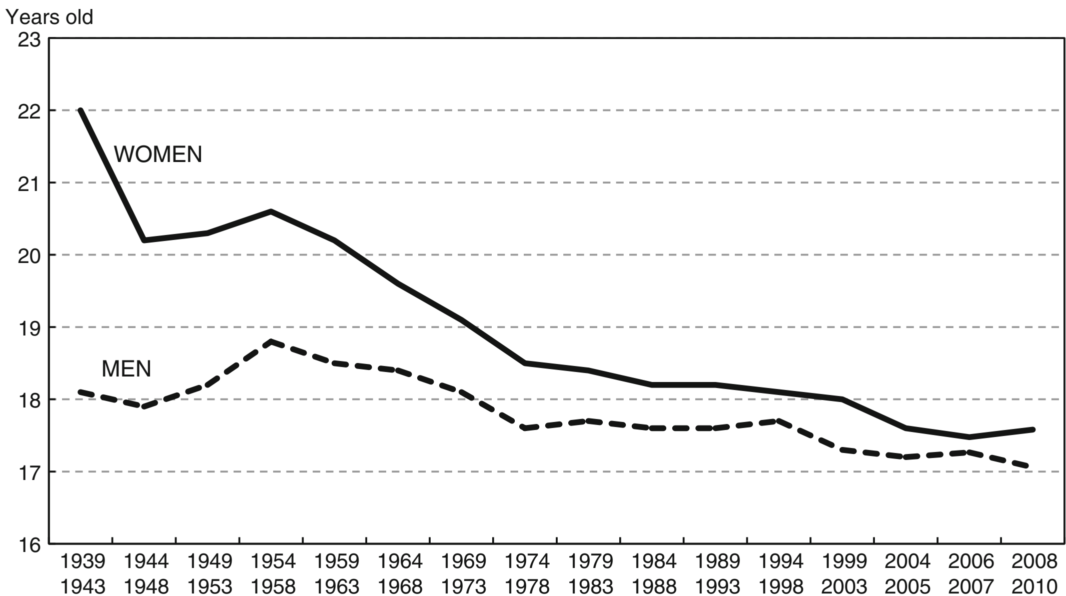


Fig. 4 Median age at first sexual intercourse, by gender and generation (during 18 years old). *Sources* Bozon (2008), Baromètre Santé Survey (2010)

women who described a pill failure (53 %) were prescribed the pill after the abortion. Conversely, 5 % of women who were using hormonal methods received no prescription for a method of contraception after the abortion (Moreau et al. 2010a).

Evolution of the Conceptions, Births and Abortions Since the 1970s

From 1976 to 2009, the rate of conception among adolescent girls in France dropped over 50 % (see Box 1 with the methodology used to calculate rate of conception). This strong decrease in the rate of conception is in part a reflection of the massive dissemination of modern methods of contraception among French girls and women.

Box 1: Methodology

We dispose of data about abortions in France since 1976. If we add fertility rates at 15-19 years old and abortion rates at the same age, we obtain conception rates. We assume that the proportion of unwanted pregnancy is the same for miscarriages than for other pregnancies.

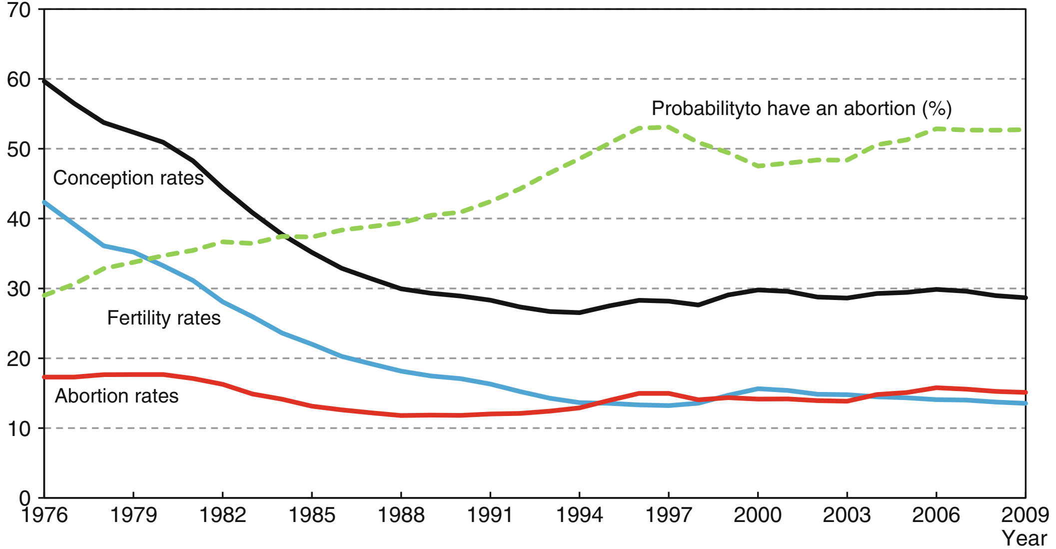
The average length of a pregnancy, when the outcome is an abortion, is 8.6 week after amenorrhea, while pregnancy that results in a birth lasts on average 40.3 weeks after amenorrhea. Thus, two women can be the same age at the time of conception, but one who chooses abortion and the other who chooses to give birth will not have the same age in the statistical databases. This flaw for example makes it look as if younger girls tend to opt for abortion more than older girls. To correct this bias, we transformed the fertility rate into a conception rate by reducing the age of adolescents who gave birth by 0.61 years.

In France, fertility rates follow the same trend as that of conception rates. What these rates show is that since 1976, fewer girls became mothers before the age of 20. Additionally, there was an increase in the average age at first pregnancy when the pregnancy ended in childbirth (see Fig. 2). This is explained by the additional years added to secondary school and to some extent by the precarious economic prospects. Young people in France have difficulties finding stable employment and thus difficulties accessing individual housing. Under these circumstances, the age of first union is increased (Prioux 2003), which delays the age of maternity.

At the same time, the abortion rate remained relatively stable between 1976 and 2009 (approximately 15 abortions per 1,000 women aged 15–19) and in fact reflects an increase in the probability of abortion from 29 abortions for 100 conceptions in 1976 to 53 today (Fig. 5a) for girls found pregnant between the ages of 15 and 19. For girls aged 15–17, the likelihood of resorting to an abortion if pregnant has increased by more than 80 % over the last 30 years. Among adolescent girls between 18 and 19 years of age, the probability to have an abortion if pregnant by 70 %. The younger the girl, the more likely she is to choose abortion than girls 18–19 years of age (respectively, 64 and 47 abortions for 100 conceptions in 2009—see Fig. 5b) although they become pregnant less often than older teens (16 conceptions per 1,000 girls aged 15–17 against 47 for 18–19-year-olds in 2009).

The Decision to Continue or to Terminate her Pregnancy

As already noted, two major changes after the 1970s related to French women's sexual behavior: (1) The legalization of contraception and abortion (1967 and 1975) on the one hand, (2) the democratization of higher education providing girls and women more opportunity, and greater access to employment, on the other. Access to modern contraception and abortion gave women more control over unwanted pregnancy and motherhood. Contraception also helped redefine the sexual responsibility between male and female parenting. Women acquire the ability to choose the moment that



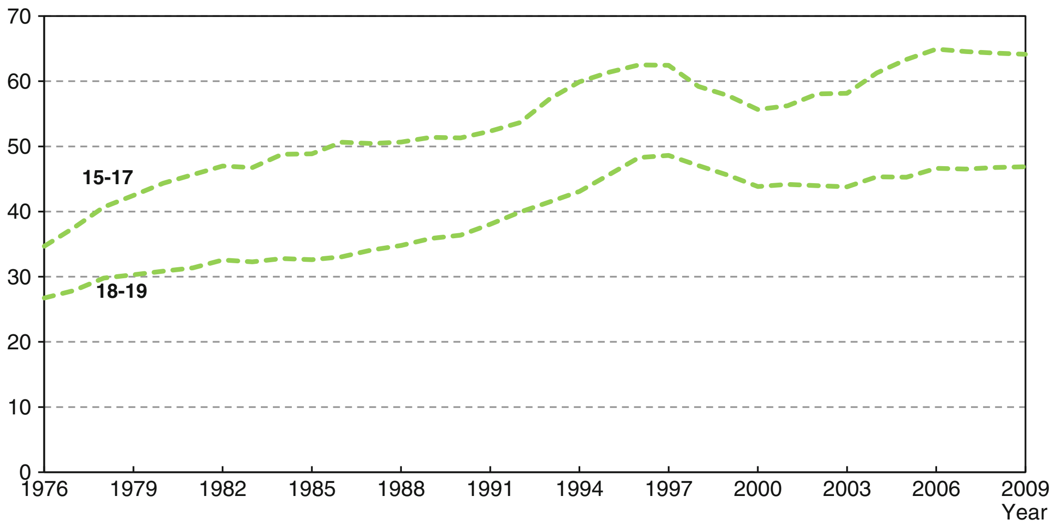


Fig. 5 **a** Trends in conception rates 15–19 since 1976. **b** Trends in the probability to have an abortion for 15–17 and 18–19 since 1976 [per 100 conceptions (births and abortions)]. *Sources* Blayo (1995), Rossier and Pirus (2007), Rossier et al. (2009), Vilain (2011)

they thought was appropriate to have a child ("a child if I want, when I want"). In addition to the need to be in a stable relationship, new conditions for giving birth to a child also were formalized. The new conditions included financial and material resources and independent housing for the family. Consequently, with access to higher education for women, and the emergence of the idea of career planning for women outside of domestic life (to which in the past they were often consigned), many young women made the decision to postpone pregnancy and childbirth

until they could afford to raise a family (Leridon 1998).

Conceptions have not increased among young women in France, but in case of pregnancy they decide more often to have an abortion (Prioux and Mazuy 2009). The average age at motherhood also echoes the access of women to a new status and the redefinition of their role in the public sphere, and this also may explain the increase in abortions in this age-group. Judging pregnancy as inappropriate during adolescence is the result of an interiorized norm that standardize the behavior of individuals without taking into account differences in personal stories of people. However, teenage pregnancies reflect multiple realities that are essential to our understanding the decision to have an abortion or to choose to become a parent.

The Different Types of Teen Pregnancy

Charlotte Le Van (1998), in her qualitative study on teen pregnancy, identifies five profiles of young women who became pregnant before they were 20 years of age.

1. Pregnancy as a "rite of passage." These young women have a strong desire to become pregnant and give birth to a child. It is a thoughtful decision on their part that facilitates the passage from adolescence to adulthood. It also is strong evidence of their love for their partner.
2. Pregnancy as an "S.O.S." In these cases, pregnancy is a "cry for help." The young woman is letting the adults in her world know that she is in distress. She is letting her family and those around her know that she is experiencing a period in her life where physical and social changes seem out of control. Because of the strong social stigma against "early" pregnancy, as soon as the young woman's pregnancy is known she becomes the center of attention and her "cry for help" is heard. Much like an attempted suicide by a child, the announcement of a pregnancy causes shock and excitement among her family and peers. These pregnant young women do not really want a child; they want the shock value that comes with getting pregnant.
3. Pregnancy "insertion." These young women are characterized by the young woman's desire for social recognition. Durand and colleagues (2002) prefers the term, "pregnancy adaptation," because many young women from disadvantaged communities know that they can increase their value as a person by becoming a mother. For many of these young women, where educational opportunities are limited or non-existent, motherhood may improve their quality of life and provide for their future. These young women adapt and make their decisions about motherhood based on the barriers they encounter during adolescence (Durand et al. 2002).
4. Pregnancy related to the young woman's "identity." Among these young women, pregnancy reinforces their view of themselves as competent caretakers of young children and infants. These young women most often have been in contact with children and infants since a young age (younger brothers and sisters, or other children staying in their home). These young women feel confident in their ability to deal with care for children younger than themselves. These young women also know that motherhood is a passage to adulthood, but also wish to further demonstrate their ability and their expertise caring for young children. They want the status and autonomy associated with maternity in their community.
5. "Accidental pregnancy." Unlike young women in the other four categories, pregnancies in these cases appear to have been caused by a failure of contraception. These young women are not expecting to get pregnant; they are surprised by the diagnosis. Without a real desire to be a mother, these young women often choose an abortion.

There is no an adolescent pregnancy, but many adolescent pregnancies. Although, in general, they are perceived as "unwanted", young women wanted to get pregnant. The other women can choose between keeping the pregnancy or have an abortion.

Continue or terminate her pregnancy: building decision

The decision-making process that results in an abortion or continuing the pregnancy must be made in a very short period of time (Donati et al. 2002). Determinants for parenthood is based on reproductive standard which include a stable relationship, adequate material and financial resources, and parents with an adequate trade or education. The complexity of the decision is such, however, that the life experience of each woman and her perception of things at the time of the pregnancy.

Several qualitative and quantitative studies (Berthoud and Robson 2001; Le Van 1998; Sihvo et al. 2003) show that in France, girls who carry their pregnancies to term are often from disadvantaged backgrounds (see Box 2).

Box 2: Regional Disparities

Contraceptive practices and fertility among adolescents in the overseas departments of France are very different from those of girls living in metropolitan France. As of March 2011, the overseas departments of France were the following: French Guiana in South America, Guadeloupe in North America (located in the Caribbean), Martinique in North America (located in the Caribbean), Réunion in Africa (located on the Indian Ocean), and the Mayotte in Africa (located on the Indian Ocean). It is obvious when examining the causes of adolescent pregnancy and early motherhood that the socioeconomic disparities that exist between these "two Frances" have a great influence on adolescent female sexual behavior and fertility.

Between 1994 and 2011, the fertility rates for females 15–19 in the French Overseas Departments (FOD) were still higher than those of metropolitan France. One reason for the difference is that women in the overseas departments give birth at a younger age than their French counterparts. These high fertility rates also come with high abortion rates among girls from FODs (Mazuy et al. 2011; Vilain 2011). The abortion rate before the age of 20 is two times higher than in metropolitan France and almost four times higher among girls 14 years of age and younger (Mazuy et al. 2011). While the conception rate among adolescent girls in FODs is significantly higher, the proportion of pregnancies terminated before 20 years is lower than in metropolitan France.

Higher abortion rates in the FODs are explained by a lack of inadequate contraception in these regions (Halfen et al. 2006), difficulties of accessing adequate contraception, and inappropriate information leading to more contraception failures (Moreau et al. 2010b). High fertility rates at 15–19 also can be explained by the fact that teen pregnancies are less stigmatized in FODs than in metropolitan France (Mazuy et al. 2011) and the timing of fertility is therefore more flexible.

The socioeconomic conditions are also very different in these regions. While only 18 % of the metropolitan women (18–34-year-olds) in 2007 did not have a secondary education, the proportion was 37 % in the FODs (Temporal et al. 2011). Similarly, while the unemployment rate was 23.7 % for the 15–24 age-group in metropolitan France in 2009, unemployment was more than 50 % for their counterpart in FOD and as high as 56.2 % in Réunion.

Much like in metropolitan France where the least educated girls, living in the most disadvantaged areas, are the adolescents who become mothers, in FODs there are a greater proportion of these girls. These numbers alone explain, to a large extent, the higher rate of fertility among girls living in FOD.

In light of this knowledge, it is clear that the material and financial constraints are rarely alone in determining the choice these girls make. Even in the case of a couple that are involved in a relationship, the length of time that the young people have been involved in a relationship before the pregnancy plays a major role in the decision to carry the pregnancy to term or not. A casual partner, for instance, does not have the same influence in the decision-making process as a boyfriend of several months. Most of the time the casual partner is informed of the pregnancy (Donati et al. 2002; Durand et al. 2002; Le Van 1998). The opinion of the partner is sometimes respected sometimes not. In cases where there is a disagreement on whether or not the girl should continue the pregnancy, a girl with a family with social, economic, and cultural resources is the one who makes the final decision (Donati et al. 2002).

Young women choose the partner that they consider ideal for starting a family: a partner who will be able to take on the responsibilities that goes with raising a family. As important, in France, having a child without a father is as socially unacceptable in adolescence as it is at any other age. In addition, the stigma of single motherhood and the anticipation of the material and financial difficulties involved in raising a child as a single parent may in many cases discourage the continuation of the pregnancy.

The second set of players in this decision process is the family (Donati et al. 2002; Montgomery and Casterline 1996). The categorical rejection of the pregnancy and motherhood for their daughter by the parents can create a difficult and frightening situation for the adolescent. On the contrary, when the idea of pregnancy and motherhood is "accepted early on" by the parents, the idea of continuing the pregnancy may seem less scary to the girl. Moreover, as it happens, mothers who support young girls and their desire to carry through with the pregnancy were themselves mothers at a young age. It is a family pattern of reproduction. This does not mean that the teen pregnancy will be better accepted because some mothers do not want their adolescent daughter "repeat the mistake they committed." That said, the reaction of the family at the announcement of the pregnancy—rejection or acceptance and assistance (for instance, the willingness of the family to share the burden of motherhood) especially of girls whose partner refuses to take on the role as father—plays a major role in the decision to continue a pregnancy (Donati et al. 2002).

The idea that peer group influence shapes behavior is often brought up as soon as one speaks of adolescences (Montgomery and Casterline 1996). Among these girls, pregnancy can appear as a means of emancipation from the family (Bozon 2009a; Galland 2004). Indeed, having the same experience at the same age tends to create strong bonds. In these cases, friends often play the role of first confidant when a girl finds herself pregnant. Knowing that statistically less educated girls become mothers sooner than their more educated counterpart illustrates the difference in the perception of pregnancy at a young age among the two groups. If a girl from a privileged social class becomes pregnant, her peer group will more often view her pregnancy as a major problem that will be harmful to her future. However, for pregnant girls from disadvantaged social groups, motherhood may have more advantages than disadvantages.

Peer groups have a strong influence on individual adolescent behavior. The reaction to friends faced with the announcement of a pregnancy can take many forms. Peers can initiate a move to an abortion or support a friend continuing her pregnancy. In these cases, friends can react with acceptance or rejection when a girl tells them of their pregnancy. Depending on the reaction of her peer group, a girl may reinterpret her pregnancy and the meaning of her pregnancy.

The last set of actors are healthcare professionals (i.e., school nurses, doctors of family planning or abortion center) that the girl must interact with before, during, and after the diagnosis of pregnancy. If the conditions of access to health care systems are not well known, moralizing and guilty attitudes from medical actors were reported by some young women who have had an abortion (Bajos et al. 2002).

All of these actors are themselves influenced by social norms.

In fact, in France, few studies on the disadvantages of being a teen mother have been conducted. By what means can we then consider that teenage pregnancies are necessarily correlated with social and economic difficulty throughout the life of the mother? Without more rigorous outcome studies, how can we say with any degree of accuracy that teenage pregnancies are the main factor for social immobility? Such a conclusion seems to be too hasty and reflect or justify cultural norms, which reject out of hand the idea of pregnancy and motherhood at an early age.

Conclusion

Since the 1970s, adolescent pregnancy has decreased in France. Even as the numbers fall, however, adolescent pregnancy is still attracting the interest of politicians and the media. Among these claims makers, adolescent pregnancy is defined as a "major public health issue." The "unwanted" character that we attribute systematically to the adolescent pregnancies seems to reflect their socially "undesirable" character (Durand et al. 2002). Such attitudes are not based on what is best for the adolescent but are based on a distorted view that adolescent girls who become pregnant are not complying with the accepted reproductive norms of French society (Le Den 2012).

The decline in age at childbearing and the fact that each life stage (e.g., graduation, professional career debut, parenting, ...) must be completed within a age group increasingly restricted have not made desirable teen pregnancies in our societies. The argument most often presented against adolescent pregnancies is adolescent pregnancy disrupts or ends an adolescent girl's education. As a mother, she would experience socioeconomic insecurity due to barriers preventing her from gaining adequate employment, and she would experience difficulties caring for a child. However, no data or research can actually be presented that justifies these assumptions or explain the influences of the social environment on precocious pregnancy. Often we do focus on the living conditions of these young women as they enter into motherhood based on the premise that they will need child-related care and services as they raise their child(ren). While it is true that the socioeconomic issue among women who have children later in life is the determining factor in childbearing, this is not the case for teenage mothers. The observation that socioeconomic stability is important to older women when they become mothers may not hold true for adolescent girls, since their life course is quite different at the time they become pregnant. The fact remains that adolescents who carry their pregnancy to term are a very specific group. They are profoundly affected by issues related to disadvantaged environments, their level of interest in obtaining an education and employment, and their perception of limited future prospects. For some of these girls, the birth of a child is a way for them to acquire social status.

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Adolescent Pregnancy and Parenthood in Germany

Martin Pinquart and Jens P. Pfeiffer

Keywords
Germany: adolescent pregnancy · Adoption · Abortion · Parents · Oral contraceptives · Sexual maturation · Risk factors · Financial assistance · Life management

Introduction

Sexual development is a normative developmental task in adolescence, and the majority of young people from Germany and other western countries become sexually active during this period (Krahé 2008). Becoming sexually active is often associated with pleasure and may have positive consequences for adolescent development, for example when being loved by a romantic partner. However, for some adolescents, it has long-term negative consequences, such as in the case of teenage parenthood, if the young people lack the personal and social resources for coping with these demands.

After giving an introduction into the historical context, we discuss antecedents and consequences of adolescent pregnancy in Germany. As sexual maturation and becoming sexually active are preconditions for adolescent pregnancy, we start with data on these topics. Because the lack of competent use of contraception is another precondition for pregnancy, we then provide data on the use of contraception and contraception failures of German adolescents. In the next part of this chapter, we focus on the prevalence and risk factors for pregnancy in German adolescents. We then review research on the two most frequent outcomes of teenage pregnancy—abortion and teenage parenthood. In the final part of the chapter, we discuss efforts in preventing adolescent pregnancy and supporting young parents and their children. We also provide conclusions for the improvement of prevention of adolescent pregnancy and services for adolescent parents and for future research in that field.

For some topics, we were able to rely on large empirical studies, most often conducted by or with the support of the German Federal Center for Health Education (Bundeszentrale für gesundheitliche Aufklärung—BZgA). For other topics, only small qualitative studies that provide some useful insights but do not offer representative data are available, especially high-quality studies on the evaluation of effects of prevention and interventions were lacking.

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Historical Context

Over many centuries, German norms about sexuality were shaped by religious commandments and prohibitions. Sexual relationships were sanctioned only within marriage with the goal of procreation. Pregnancies and motherhood outside marriage were considered as sins and led to draconian sanctions. Therefore, virginity before marriage was the main goal of sex education of adolescents during a time, in which each intercourse could result in pregnancy. Getting married was possible before reaching the age of 18 years. For example, in the eighteenth century about 2 % of the farm daughters of the principality of Saxonia were married at the age of 14 or 15 years. Male adolescents usually did not marry before the age of 18 years, except some politically motivated marriages among aristocrats (von Nell 1974). Until 1974, the official minimal age for marriage was 21 years for men and 16 years for women. However, women could ask the guardianship court for an exemption from this rule, for example when being pregnant. Today, the lowest age of marriage is 18 years for both partners, although according to § 1303 of the German Civil Code, a family court could grant an exception from the rule if one partner is at least 16 years old and the other is 18 years or older.

The rebellion of the 1968 movement against the social mores of the previous generation was associated with the hope that sexual liberalization would lead to political changes. Norms and laws about sexuality did become more liberal in (West) Germany. Changes in sexual norms and behaviors were also promoted by the introduction of the birth control pill. In June 1961, the first oral contraceptive became available in the western part of Germany (Jütte 2003). In the eastern part, oral contraceptives were introduced about 10 years later (Ahrendt 1991).

In response to this development, the Protestant Church developed liberal norms about sexuality. According to the Evangelic Church of Germany (EKG), sexuality and contraception are part of the responsibility of every Christian (EKD 1989). Pregnancy can cause unexpected conflicts, and pregnant women may see no other alternative than abortion. The mother-to-be has to decide whether or not to have the child because the life of the unborn child can only be protected with the mother's will but not against it (EKD 1989). In contrast, the religious commandments and prohibitions of the Catholic Church did not change much (Bischofskonferenz 2005). Premarital sex is still considered to be a sin, and contraception is still rejected. Nonetheless, as will be shown later, norms of the Catholic Church lost their influence on the sexual behavior of many (and probably most) young German Catholics.

A general decline in the influence of religion on sexual attitudes and behaviors is also based on the fact that the number of young church members has declined. According to the 15th Shell Youth Study (Gehrke 2006), 35 % of the 12–25-year-olds in Germany are Protestant, 31 % are Catholic, 5 % are Muslim (mostly the children and grandchildren of work migrants who moved to Germany in the 1960s and 1970s), 4 % are affiliated with other religions, and 25 % show no religious affiliation at all. The numbers of young people without religious affiliation increased slowly in the western part of Germany. In 1981, only 5 % of the young people from the western part of Germany had no religious affiliation, as compared to 12 % in 2006 (Gehrke 2006). As a result of the German separation and 40 years of socialism in the eastern part of Germany, the number of young people without religious affiliation in the eastern part of Germany is very high. In 2006, about 79 % of young people from that area showed no religious affiliation as compared to 12 % of their peers from the western part.

With regard to abortion, for a long time article 218 of the German penal code, which was set up in 1871 under the chancellorship of Otto von Bismarck, allowed abortions only for certain medical or ethical reasons. According to "indication" regulation [*Indikationsregelung*] that was introduced in 1976, abortion was permissible during the first 12 weeks of pregnancy if the pregnancy was the result of a criminal offence or if an abortion is advisable to protect the women

from serious and inevitable distress. The more liberal "time limit" regulation [Fristenregelung] was applied in the former socialist German Democratic Republic, where women were able to terminate pregnancies—without providing a reason—within the first trimester. After the German unification, a compromise had to be found. According to § 218a of the German Criminal Code that was introduced in 1993, abortion is not unlawful if (a) the pregnant woman requests the termination of the pregnancy and she obtained counseling at least 3 days before the operation; (b) the termination of the pregnancy is performed by a physician; and (c) not more than 12 weeks have elapsed since conception. Past this time limit, the termination of pregnancy performed by a physician with the consent of the pregnant woman shall only not be unlawful if, considering the present and future living conditions of the pregnant woman, the termination of the pregnancy is medically necessary to avert danger to life or danger of grave injury to the physical or mental health of the pregnant woman, and if the danger cannot reasonably be averted by other means, from her point of view. The pregnant woman being an adolescent or a young adolescent in particular would be insufficient to fulfill the criteria of a medical necessity for abortion after the 12th week of pregnancy (Rosenberger 2010). Pregnant teenagers of 16 years and older do not need parental consent for abortion. For 14–16-year-olds, the physician has to decide whether parental consent is needed or whether the adolescent can make a responsible decision on her own (BZgA 2009). Adolescents below the age of 14 need parental consent for an abortion.

Today, Germany has quite a liberal policy regarding sexuality. German adolescents are not socialized in abstinence-only education models, and oral contraception is available free of charge for young people below the age of 20. In addition, health care insurance pays for teenage abortions. The principle of compulsory insurance combined with the coinsurance of children ensures that practically all adolescents have insurance coverage.

Adolescent Sexuality and Pregnancy

Sexual Maturation and Timing of First Intercourse

Sexual maturity is a necessary precondition for pregnancy. German adolescents become sexually mature about 3 years earlier than 100 years ago (Starke 1997). In a representative study, Kluge (1998) observed a secular trend in the *acceleration* of the age at onset of *menarche that has declined from 13.5 years in 1981 to 12.2 years in 1994. The age of the first ejaculation has declined even further, from 14.2 to 12.5 years. In a recent representative study with 3,542 adolescents, 43 % of the assessed girls had their menarche at the age of 12 or earlier (BZgA* 2010*). In 1980, only 35 % had their menarche during that age interval. The percentage of boys who reported that they had their first ejaculation before the age of 12 increased from 7 to 13 %. An earlier sexual maturity has been associated with an earlier onset of sexual activities* (e.g., Hoier 2003).

In Germany, sexual relations between adolescents are common and widely socially accepted since the sexual liberalization in the 1960s and 1970s. The sexual revolution affected the timing of first sexual intercourse. In Germany, less than 20 % of women born between 1935 and 1950 had their first sexual intercourse before the age of 18. The percentage has increased to more than 70 %. An earlier timing of first intercourse is also found in German men, although the changes were less dramatic (Schmidt 2009). Results from repeated studies between 1980 and 2009 of the BZgA are summarized in Figs. 1 and 2. The percentage of sexually experienced adolescents increased between 1980 and the late 1990s. No systematic differences in the new millennium were observed in the 16- and 17-year-olds. However, the percentage of 14–15-year-olds sexually experienced adolescents declined in recent years. Sigusch and Schmidt (1973) found that in 1970 the average age at first sexual intercourse was 17 years and 9 months among German female adolescents. In the 1990s, Plies et al.

(1999) found a mean age at first coitus of 17.3 years in male and 17.1 years in female participants. In a recent study, the mean age at first intercourse was 16 years (Pinquart 2010). Of course, there is a large inter-individual variability. For example, in the most recent study of the BZgA (2010), 4 % of the sexually experienced female adolescents had their first intercourse at the age of 13 years or earlier, 19 % at the age of 14, and 25 % at the age of 15.

The sexual revolution also affected the conditions for having sexual intercourse. Giese and Siegusch (1968) compared sexual behaviors of students in 1912 and 1968. Almost all male students had sexual intercourse before getting married at both times. However, the circumstances changed dramatically. Whereas in 1912 most students had premarital sex with prostitutes, servant girls, waitresses, or other young women from a lower social class, students from 1968 had sex with young women of their own class, who were possible future wives. Female students did not have sex before marriage in 1912 but were in most cases sexually active before marriage in 1968.

Today, most German adolescents have their first intercourse in a steady romantic relationship. In the recent study of the BZgA (2010), 64 % of the sexually experienced female adolescents and 58 % of their male peers said that they had their first sexual intercourse in a steady relationship and another 28 and 24 %, respectively, reported that they knew each other well beforehand. Only 1 % of the girls and 3 % of the boys had their first sexual intercourse with a stranger. In another study, 67 % had a stable romantic relationship with their partner before having their first intercourse with him or her, and only 5 % of the adolescents reported that did not know each other before their first intercourse (Pinquart 2010). About two-thirds of the sexually experienced male 14–17-year-olds and three quarters of their sexually experienced female peers had one or two sexual partners so far. Only 21 % of the boys and 11 % of the girls had 3 or more partners. The earlier the first intercourse, the higher the number of partners (BZgA 2010).

The motives for having intercourse also changed over time. Whereas in 1970 80 % of the male adolescents mentioned sex urges as one of their main motives for having their first intercourse, the percentage declined to 40 % in 1990. A smaller decline was observed in female adolescents from 40 to 30 %. The percentage of male adolescents who would sleep with a girl they felt attracted to, no matter whether they loved her or not, declined from 17 to 2 %. The decline in this attitude of female adolescents (from 3 to 2 %)

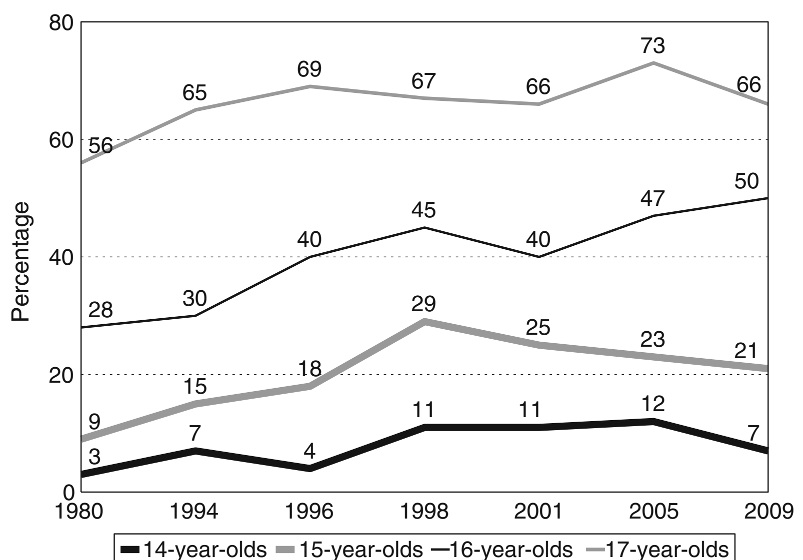

Fig. 1 Time trends in the percentage of German female adolescents who had their first sexual intercourse (BZgA 2010)

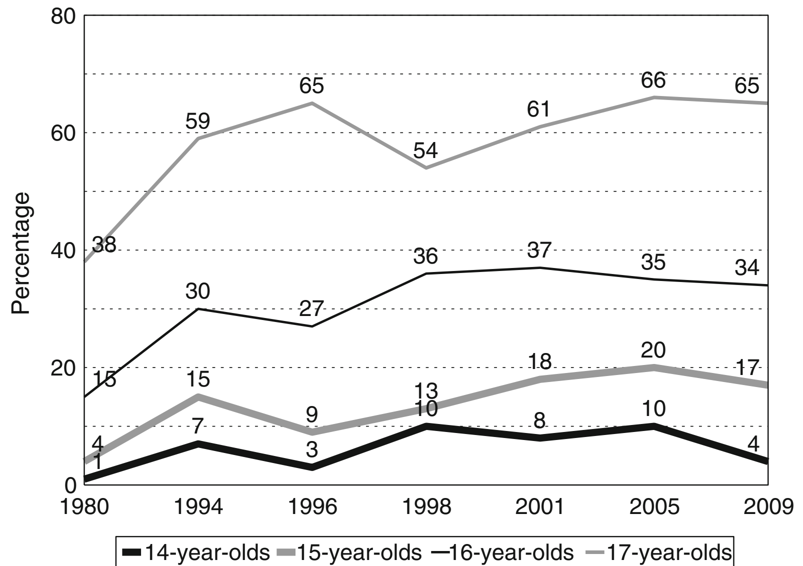

Fig. 2 Time trends in the percentage of German male adolescents who had their first sexual intercourse (BZgA 2010)

was not significant. The role of love for the romantic partner as a motive for having intercourse increased at the same time. The number of German boys who only wanted to have intercourse with someone they love increased from 46 % in 1970 to 71 % in 1990. No increase was observed in female adolescents because love was already their primary precondition for having intercourse in 1970 was (80 % versus 81 %) (Lange 1993; Schmidt et al. 1994).

Contraception

Oral contraceptives are free for adolescents until the age of 20, but they are only available by prescription. A parental consent is not necessary for this, unless the adolescent does not have the capacity to consent. However, some physicians may ask for parental consent, especially in the case of very young teenagers, because the promotion of sexual acts of teenagers is punishable according to German law (Haerty et al. 2005).

According to self-reports, most German adolescents know which options for contraception exist and how to use them. The percentage of knowledgeable adolescents increases with age. In a large-scale study with 14–17-year-old adolescents, only about one quarter of the respondents reported that they would like to know more about contraception (BZgA 2010). The wish for more information about contraception declined between 1980 and 2009 from 50 to 29 % in girls and from 46 to 25 % in boys, indicating an increase in knowledge over time.

Condoms are the most commonly used contraceptives, followed by oral contraceptives. In a study from 2009, 75 % adolescents used condoms and about 40 % oral contraceptives at their first intercourse. Unsafe methods of contraception were rarely used (BZgA 2010). Similar percentages of condom users (79 %) were observed in another recent study (Pinquart 2010). However, in both studies, 8 % of the German 14–17-year-olds did not use contraceptives at their first intercourse. An earlier age at first intercourse was associated with a lower probability of contraception (BZgA 2010; Pinquart 2010).

The percentage of German adolescents who used condoms and/or oral contraception at their first sexual intercourse increased between 1980 and 2009, whereas the percentage of adolescents who did not use any contraception declined (Figs. 3, 4).

Methods of contraception also change with increasing sexual experience. The use of oral contraception increases, whereas the use of

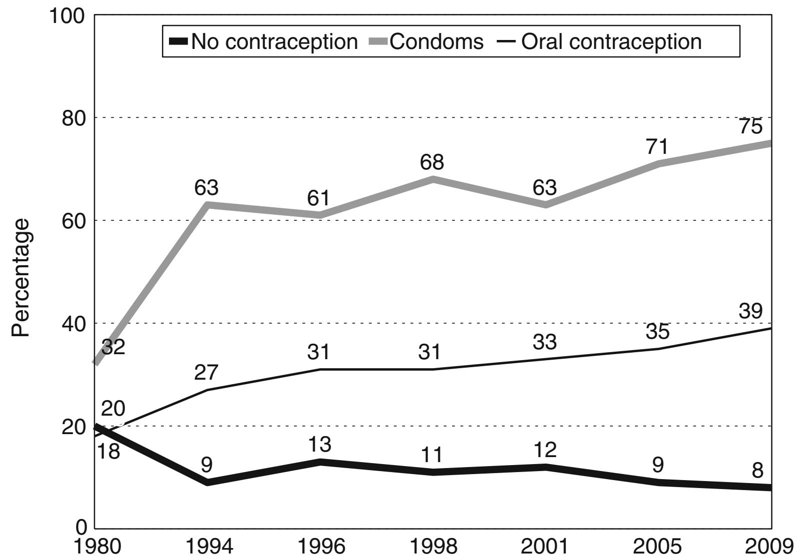

Fig. 3 Time trends in the use of contraception at first intercourse in German female adolescents and their intimate partners (BZgA 2010)

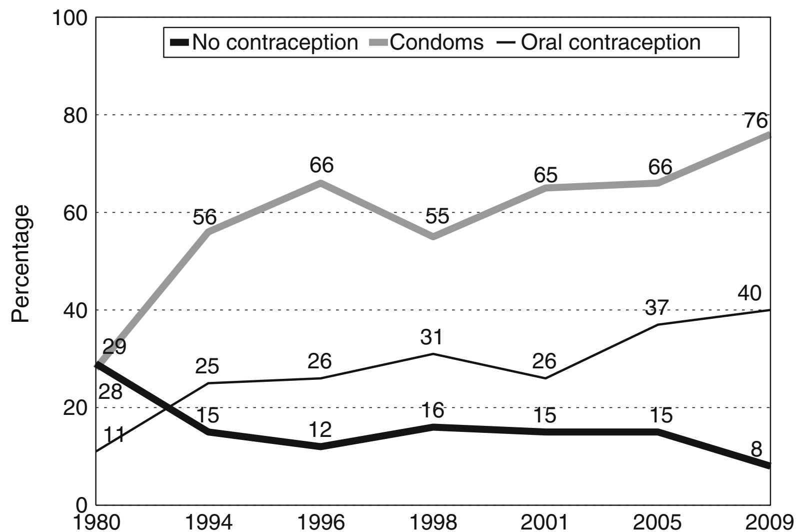

Fig. 4 Time trends in the use of contraception at first intercourse in German male adolescents and their intimate partners (BZgA 2010)

condoms, nonuse of any contraception, and the use of unsafe methods declined. Figure 5 shows the results of the BZgA study (2010) for girls without migration background. Similar results are found for girls with migration background and for boys, although condoms are still the most often used means of contraception for male adolescents at their last intercourse.

The BZgA (2010) study also asked adolescents who did not use contraception at their first intercourse for reasons for not doing so. Because the absolute numbers of adolescents in this group were quite low, results have to be interpreted with caution. On average, girls reported 2.5 reasons and boys 1.9 reasons. The most frequent reason was the fact that the first intercourse was too spontaneous so that they could not get contraceptives in advance. An optimistic bias that they or their partner would not become pregnant and loss of self-control because of being affected by alcohol or drugs were other prevalent reasons. It was notable that only 3 % of the girls mentioned a lack of information as reason for not using contraceptives (Fig. 6).

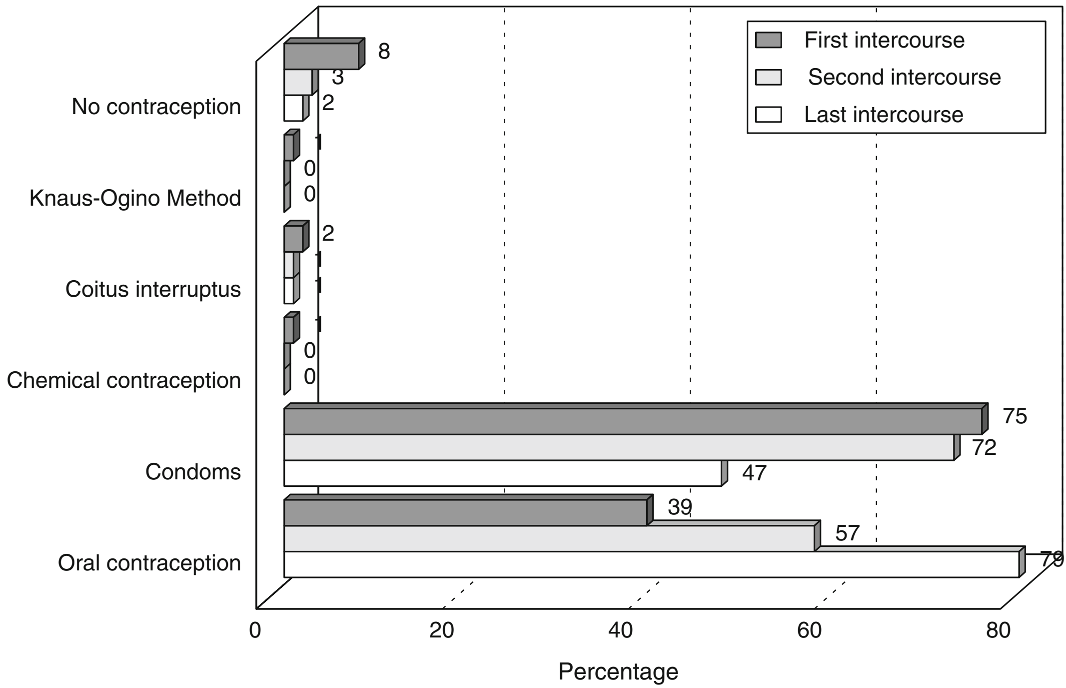

Fig. 5 Ways of contraception at first, second, and last intercourse in German female adolescents without migration background (BZgA 2010)

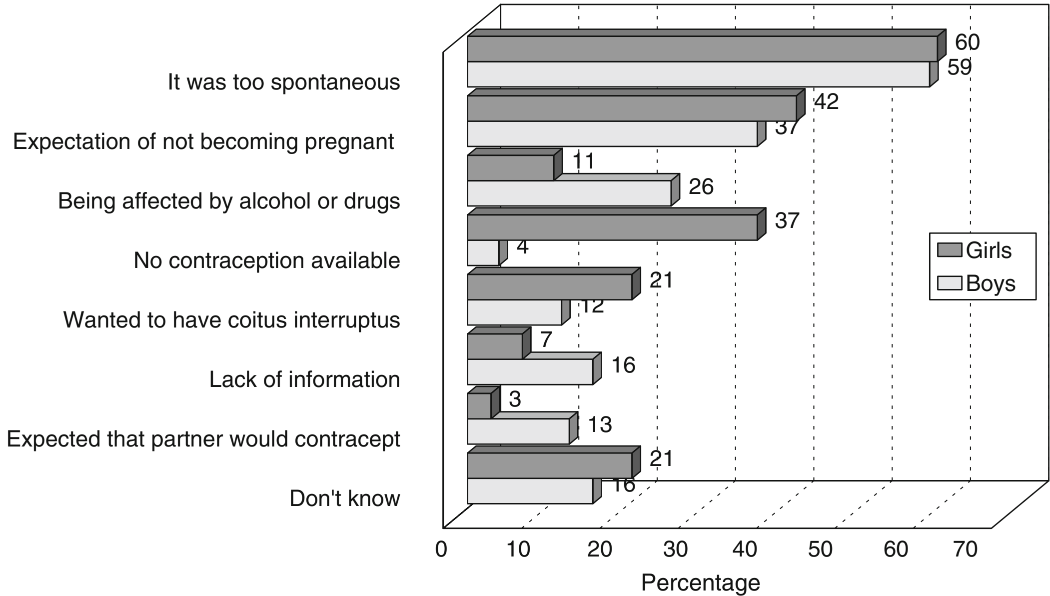

Fig. 6 Reasons for not using contraceptives at the first intercourse (BZgA 2010)

The reported reasons are similar when the adolescents were asked about their contraceptive behavior in general. However, forgetting to take the birth control pill was reported as another widespread reason for lack of contraception (BZgA 2010).

Despite the high prevalence of safe contraception among German adolescents, about 25 % of the adolescents said that they had at least once used coitus interruptus and up to 10 % that they had at least once used the Knaus–Ogino method. Coitus interruptus was more often used when the adolescents came from families with low educational backgrounds, and this association was stronger for boys (BZgA 2010).

Contraception failures are also quite common. About 22 % of the sexually experienced German adolescents without migration background and 18 % of those with migration background reported that condoms had burst or had been torn at least once. In addition, 57 % of sexually active girls without migration background and 56 % with migration background reported that they had at least once forgotten to take oral contraceptives in time (BZgA 2010).

Similar to regular oral contraception, emergency contraception is only available by prescription in Germany. On average, about 90 % of adolescent girls in Germany know the option of emergency contraception, and 12 % of the 14–17-year-olds sexually active female adolescents had already used this option (2 % even more than once; BZgA 2010). The use of emergency contraception has slightly increased since 2001 (9 % had used it at that time). In most cases, emergency contraception was used after problems with regular contraception (e.g., burst condom, forgetting to take regular oral contraceptives, doubts about the effect of the regular birth control pill due to vomiting or diarrhea; BZgA 2010). Interestingly, in a large study with pregnant adolescents (Schmidt et al. 2006; Matthiesen and Schmidt 2009), only half of them knew about the option of emergency contraception and how to get access to it. Another 23 % knew that this option existed but did not know how to access it, and 27 % did not know about this option at all. In said study, knowledge about emergency contraception was less widespread among the youngest participants (12–14-year-olds 36 %), Muslim adolescents (40 %), in adolescents from the eastern part of Germany (40 %), and in students from the lowest school track (45 %).

Adolescent Pregnancy

Given the easy availability of contraception and high rates of contraception usage, it could be expected that adolescent pregnancy is quite a rare event in Germany. This is, in fact, the case. Nonetheless, it is estimated that 2.4 % of German female adolescents become pregnant at least once before their 18th birthday (Schmidt 2009). Based on data from the Federal Statistical Bureau of Germany, the number of teenage pregnancies increased from 1996 (9,490) to 2001 (12,845) and declined thereafter (9,746 in 2009). The rates of pregnancy per 1,000 women between the ages of 15 and 17 years increased from 6.9 (in 1996) to 9.1 (2001) and declined to 7.9 in 2005 (Schmidt et al. 2006).

Long-term time trends of numbers of adolescent births are difficult to compare because the ways of computing of the Federal Statistical Bureau changed in 2000 (from only counting those births as adolescent births if the mother did not reach the age of 18 years in the year of giving birth to the exact age when giving birth to a child). Therefore, we provide separate comparisons from the period before and after the year 2000. Kontula (2007) reported that in Germany as well as in some other western European countries, adolescent birth rates declined at least fourfold between 1970 and 1998. The numbers of adolescent births in the recent years are shown in Fig. 7. These numbers increased between 2000 and 2002 and dropped to 4,126 in 2012. When we compare the number of adolescent births with the total numbers of births, less than one percent of all births refer to adolescent mothers. This percentage increased from 2000 (0.93) to 2003 (1.03) and declined thereafter (0.6 in 2012) (Statistisches Bundesamt 2013).

The observed increase in the numbers of adolescent pregnancies in the early 2000s may have been based, in part, on an earlier age of

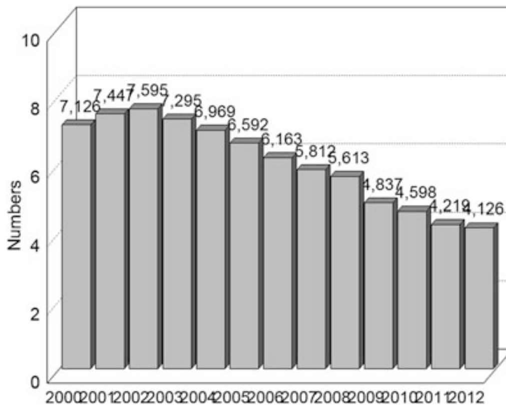

Fig. 7 Time trends in the number of births of female adolescents under the age of 18 years (based on Kluge 2005; Statistisches Bundesamt 2013)

sexual maturation and an associated earlier age at first intercourse (BZgA 2010). Alternatively, Schmidt (2009) and Schmidt et al. (2006) suggested that this may have been a statistical artifact in that not all cases of adolescent pregnancy may have been registered in the earlier statistics. A third explanation might be a decline in the usage of contraceptives, but studies of the BZgA do not support this suggestion (see Figs. 3 and 4).

In international comparisons, adolescent birth rates in Germany are quite low. For example, according to data for 18 industrialized countries from the Alan Guttmacher Institute, Germany had the third smallest rate of adolescent pregnancy. The adolescent birth rate of the USA was 5.25 times higher, and the rate in Canada was 2.8 times higher (Schmidt 2009). Kontula (2007) reports birth rates of 15–19-year-olds from 10 European countries from 1980 to the early 2000s. Across most of this interval, Germany had the second lowest birth rate in that age group (only the Netherlands had consistently lower rates). In 1995, Slovenia fell below the German rate, too. For the interval between 1990 and the early 2000s, comparative data were reported for 43 European countries. The birth rate of German teenagers was consistently located in the lowest third. In 1990, only 11 of the assessed 43 countries had lower birth rates for teenagers than Germany. In 2001, 14 countries had lower rates. At that time, Slovenia and Switzerland had the lowest rates (6 per 1,000 teenagers) and Bulgaria and Turkey the highest rates (45). The German rate was 13 per 1,000 teenagers. One reason for the relatively low German rate is the higher prevalence of secure contraception for German adolescents as compared to many other assessed countries (Schmidt 2009).

Risk Factors for Adolescent Pregnancy

Many German authors have suggested that teenagers often decide to get pregnant and have a child in order to overcome bad circumstances, such as escaping from conflicts with their parents or from a lack of good opportunities in the field of education and work. Other reasons might be to improve the relationship with their partner or finding purpose in life (e.g., Osthoff 1999; Häußler-Sczepan et al. 2005, 2008; Remberg 2003). In fact, Nickel (1999) found that adolescents from the lower school track were more likely to state that pregnancy would give their life a stronger purpose and that they would have a task in life. However, only 21 and 12 %, respectively, of adolescents from the lowest school track answered these two questions affirmatively.

A large study with 2,278 pregnant German teenagers who filled out a questionnaire between 2005 and 2007 in pregnancy counseling centers shows that in most cases the pregnancy was unwanted (Matthiesen 2008; Matthiesen et al. 2009; Schmidt et al. 2006). About 80 % of pregnant adolescents who attended these centers participated in the study. The mean age of the participants was 16.6 years (range 10.2–17.9), and three quarters of the respondents were 16 or 17 years old. About 10 % of the female adolescents were already pregnant for a second time, and 2.9 % had already given birth to a child, 2.3 % had had a miscarriage in the past and 4.8 % an abortion. About 90 % had a steady relationship with an intimate partner and about half of them asked for counseling in order to fulfill the legal requirements for abortion. About

33 % of the total group had not used any contraception at the coitus that led to pregnancy, and 2 % had used unsafe methods. These percentages were much lower than reports from the general adolescent population (2 and 0 %) (BZgA 2010). The remaining 65 % had used contraception (34 % condoms, 27 % oral contraceptives, 2 % used both forms) and, nonetheless, got pregnant. Thus, about two-thirds of the pregnancies resulted from failure to use contraceptives. In fact, more than 90 % of the adolescents reported that their pregnancy was unplanned (Schmidt et al. 2006). Additional qualitative interviews with 61 women showed large heterogeneity of conditions that led to pregnancy: From being totally careless to failure of competent use of contraception and a few cases in which it remained unclear why they became pregnant despite contraception. Some nonusers were frustrated by the previous use of contraceptives (e.g., due to weight gain after taking oral contraceptives or other side effects they experienced in the past; Matthiesen 2008).

Similarly, Ziegenhain et al. (2003) reported that 76 % of pregnant adolescents in their study said that their pregnancy was unplanned. Again, failures of contraception usage, such as forgetting to take the pill, were widespread. These numbers sharply contrast the beliefs (or prejudices) about widespread intentional pregnancies in that age group from experts in the field working with pregnant adolescents. Several risk factors for adolescent pregnancy have been identified in German studies.

Age: The risk for getting pregnant increases with age. For example, Schmidt and colleagues (2006) estimated that about 5 out of 100,000 12-year-old German girls get pregnant, as compared to 5 out of 1,000 15-year-olds and 12 of 1,000 17-year-olds.

Socioeconomic status: Unfortunately, information about the social situation of pregnant teenagers is not part of official German statistics. However, relevant data are available from a large empirical study. Adolescent pregnancy rates vary by school type. After the completion of elementary school, German pupils are separated into three different school types: a lower track (*Hauptschule*, completed after 9 years of schooling), a middle track (*Realschule*, completed after 10 years), and a higher track which offers access to university (*Gymnasium*, completed after 12–13 years, depending on the laws of the federal state). The selection of school tracks is based mainly on the students' performance during elementary schooling and students from higher school tracks have better career opportunities after graduating from school.

Schmidt et al. (2006) observed that the risk of female adolescents from the lowest school track of becoming pregnant was three times higher than the risk of students from the highest school track. Nonetheless, pregnancy was also a relatively rare event in female adolescents from the lowest school track as only 15 out of 1,000 15–17-year-olds were estimated to become pregnant. The risk for a second pregnancy in adolescence was also higher for female adolescents from the lowest school track (12.5 %) than for those from the highest school track (4 %) (Block and Schmidt 2009). One explanation for the differences by school track is the fact that girls from the lowest school track became sexually active earlier than their peers from other tracks (e.g., 7–8 months earlier than students from the highest school track) (Thoss et al. 2006). Another reason is the lower usage of safe contraception in students from the lowest school track. For example, the BZgA study found that female adolescents from the lowest school track were more than twice as likely not to use contraception at their first intercourse (13 %) than peers from the highest school track (6 %) (BZgA 2010). However, this difference was confounded with age differences at first intercourse. Finally, lower knowledge about emergency contraception in students from the lowest school track may have contributed to school track differences in the risk of becoming pregnant. The same study found that emergency contraception had been used by 17 % of female adolescents from the highest school track as compared to 7 % of their peers from the lowest school track.

The authors also compared pregnant adolescents who did and did not use safe contraception

at the time they got pregnant. Higher numbers of social disadvantages were associated with a higher risk for nonuse. This index was a sum variable that consisted of low educational attainment of the female adolescent and her partner and of unemployment of the target person's mother and father. Only 22 % of the female adolescents with none of these risk factors did not use contraception or used unsafe forms compared to 48 % of the group with the highest number of risk factors (Matthiesen 2008). Female adolescents with social disadvantages were also more likely to experience their second pregnancy (15.8 %) as compared to those without disadvantages (6 %) (Block and Schmidt 2009).

Religious affiliation: Given the strict prohibition of premarital sex by the Catholic Church, it could be expected that young Catholics have a lower risk for becoming pregnant than young Protestants or their peers without religious affiliation. However, Block and Schmidt (2009) found no evidence for lower rates of adolescent pregnancy in Catholic adolescents than in other adolescents. Catholic and Muslim pregnant adolescents were even somewhat less (!) likely to decide to give birth to their child (17 and 18 %) than Protestant adolescents (23 %) and those without confession (32 %), despite the fact that the Catholic Church considers abortion to be form of murder, making it a sin, and that any Catholic that obtains or takes part in an abortion is considered to be excommunicated from the Church (Bischofskonferenz 2005).

Family of origin: Some studies with small and non-representative samples reported that pregnant adolescents and adolescent mothers often come from families with high levels of conflicts and that many of them had lost an attachment figure, for example, due to parental divorce (e.g., Berger 1987; Noe 1994).

Characteristics of the intimate relationship: Three aspects of the intimate relationship were found to be associated with an increased risk for adolescent pregnancy (Matthiesen 2008). The first risk factor is the lack of effective communication about contraception. For example, some teenage girls did not communicate to their partners that they did not use oral contraception or that they would only be willing to have safer sex. Second, non-egalitarian gender relations increased the risk of unprotected sex of girls who in turn became pregnant. Above average risks were observed if the coitus was "male dominated" and the female adolescent felt pressured (61 % in that group did not use contraception or used unsafe methods), if the female adolescent came from a male-dominated foreign country (51 %), if she was Muslim (51 %), or if her partner was at least 8 years older (41 %). Finally, emotional distance between the intimate partners increased the risk for adolescent pregnancy. For example, out of those adolescents who reported that their first coitus with the particular partner led to pregnancy, 50 % had not used contraception or had used unsafe contraception. Out of those who did not have a steady relationship with the particular partner, 48 % had not used any contraception or used unsafe forms. These percentages were significantly higher than the average percentage of nonusers or users of unsafe methods (35 %).

Migration background: The term migration background refers to the question whether the adolescents and/or one of their parents was born outside of Germany. Migration background per se is not a risk factor for adolescent pregnancy, but the combination of migration background and being sexually active. In the large study by Schmidt et al. (2006), young people with migration background were not overrepresented among pregnant teenagers. Two opposed trends explain the lack of differences: Female adolescents with migration background have their first intercourse later than other adolescents, but they are less likely than their peers to use safe forms of contraception when becoming sexually active. For example, in the most recent study of the BZgA (2010), 37 % of female adolescents with migration background were, according to their self-reports, virgins as compared to 26 % of female adolescents without migration background. However, 9 % of sexually active female adolescents with migration background used

unsafe contraception or no contraception at all as compared to only 2 % of female adolescents without migration background.

Previous pregnancy: Female adolescents who had already been pregnant in the past had a risk of becoming pregnant again during adolescence that was twice as high as female adolescents who had not been pregnant before (Block and Schmidt 2009). Thus, at least some of them have risk factors that are stable over time.

Regional differences: Birth rates of teenagers are higher in the eastern part of Germany than in the west. For example, at the time of the German reunification in 1990, the birth rates of 19-year-olds were three times higher in the east (63 births per 1,000 women) than in the west (19 births per 1,000 women) (Pötzsch 2005). The east–west difference is still visible but has declined over time. The east–west difference in 1990 can, in part, be explained by differences in the social policy of the former socialist German Democratic Republic and the Federal Republic of Germany. For example, due to housing shortages in eastern Germany, having a child increased the chance of getting their own flat and moving out of the parental home. In addition, much higher numbers of cheap day care facilities were available which allowed for combining motherhood with education and work. More than 20 years after the German unification, the availability of day care facilities is still higher in the eastern part of Germany. Norms of earlier parenthood may still be passed on from the parental generation to their adolescent children, but higher present rates of adolescent pregnancy in eastern Germany might also reflect a lack of alternative positive social roles (due to lower availability of apprenticeships and higher rates of unemployment).

In another study, Walther (2004) observed higher rates of teenage pregnancy in regions with higher percentages of welfare recipients ($r = 0.63$), with higher unemployment rates ($r = 0.67$), with higher percentage of school dropouts ($r = 0.46$), and with higher levels of urbanization ($r = 0.29$).

Adoption and Abortion

If pregnant adolescents feel unable to care for their child, there are two options, abortion (in the first 12 weeks of pregnancy) and adoption. As some adolescents notice their pregnancy too late for an abortion (Schmidt and Mix 2009), adoption may be a good choice for them. We did not find representative data on the numbers of German teenagers who put up their child for adoption. In a study by Barchmann (2009) with 100 adolescent mothers and 100 adult mothers, 5 out of 200 children were put up for adoption immediately after being born, all of them having adult mothers. According to the German Federal Statistical Office, a total of 3,888 children were adopted in Germany in 2009, 2,050 of them having single biological mothers and 1,175 being at an age of below 3 years when being adopted (Statistisches Bundesamt 2010). Given the fact that less than 1 % of all births were adolescent births and 4,837 adolescent mothers gave birth to a child in that year, it can be concluded that few adolescent mothers put their child up for adoption. Thus, in the case of not being able or not wanting to care for a child, the large majority of pregnant adolescents decide for abortion.

In fact, a similar number of German adolescents decide for abortion and for giving birth to their child. For example, the ratio of the number of adolescent abortions and the number of adolescent births was 0.89 in 2000, 1.13 in 2004, and 1.01 in 2009 per 1,000 births (see, Figs. 7 and 8). According to national statistics, the number of abortions by German adolescents increased between 1996 and 2004 and declined thereafter (Fig. 8). Similar trends are observed when relating the numbers of abortions of adolescents to the total number of abortions. In 1996, 3.6 % of all abortions referred to adolescents up to 18 years of age: The percentage rose to 6.1 % in 2004 and declined to 3.6 % in 2012. The abortion rate of German adolescents is four times lower than in the USA, 6 times lower than in France, and 8 times lower than in the Netherlands (Vögele 2006).

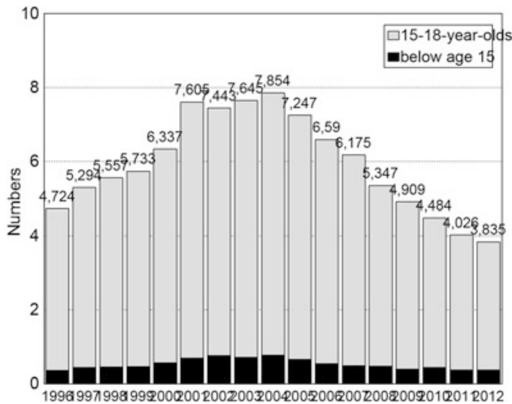

Fig. 8 Time trends in abortions of German adolescents (Statistisches Bundesamt 2013)

The younger the adolescents, the lower the numbers of abortions: For example, only 4 adolescents 10–11 year of age in 2004 had an abortion, as well as 11 adolescents who were 12-year-olds, 143 adolescents who were 13-year-olds, 621 adolescents who were 14-year-olds, and 1,418 adolescents who were 15-year-olds. Most adolescent abortions (5,657 of the 7,854 cases) were registered in girls 16- and 17-year-olds (Häußler-Sczepan et al. 2008).

Vacuum aspiration is used in about 80 % of the adolescent abortions—a number slightly higher than in abortions with adults (Schmidt and Mix 2009). Medication-based abortion (Mifegyne®; RU 486) has been available in Germany since 1999. However, it is rarely used by pregnant adolescents because their pregnancy is often noticed rather late, and this method can only be applied in the first 7 weeks of pregnancy.

Schmidt and Mix (2009) asked 60 former pregnant adolescents about their reasons for having an abortion. The most prevalent reasons were that parenthood would have serious negative consequences for their own development (82 %; e.g., finishing school) and that they would not have enough resources for rearing a child (73 %; e.g., money, own flat). Other reasons were the lack of a stable romantic relationship, not wanting to lose personal freedom, or—in very few cases—being pressured by their parents or their partner. Only one-third of the adolescents decided for abortion without inner conflicts/ambivalence. Inner conflicts of the other adolescents usually remained—with fluctuating intensity—until abortion or even beyond. About 40 % experienced conflicts between motives for abortion and moral values. The others experienced conflicts between anticipated positive and negative aspects of parenthood. About 2–3 months after abortion, approximately 80 % of the initially highly conflicted adolescents had solved their conflict and were satisfied with their decision (that is with having abortion), while the remaining 20 % still doubted whether they made the right decision. About one quarter of the respondents said that they would give birth to a child if they would become pregnant again. A large number of adolescents experienced the immediate time before abortion as the most stressful experience, associated with anxiety and dejection (Block 2009), such as fears about possible physical consequences of the procedure (e.g., injuries or pain). The abortion itself was usually less distressing for them, and almost two-thirds were completely satisfied with the medical care.

The experience of abortion was associated with behavior changes, at least in a larger number of the female adolescents: In the study by Schmidt and Mix (2009), about half of them reported a lower coitus frequency, often due to fears of getting pregnant again. About 70 % of those who had sex after the abortion showed improved usage of contraception. As the adolescents were interviewed 2–3 months after abortion, it remained unclear whether these changes are stable over time.

Adolescent Parents and Their Children

Adolescent parents have to cope with a lot of new demands that, for them, emerge much earlier than for other parents, such as caring for their child, running a household and securing one’s livelihood. At the same time, they have to solve the developmental tasks of adolescence, such as finishing school, preparing for a career,

and gaining autonomy from their parents. Whereas other young people can solve these developmental tasks in succession (e.g., starting a career, followed by leaving parental home, building a steady romantic relationship, and becoming parents), adolescent parents have to solve many tasks simultaneously. Adolescent parenthood is often associated with backward steps with regard to solving the developmental tasks of adolescence. For example, young people may have to leave school before graduating or give up their apprenticeship, they are no longer able to maintain some social activities with their peer-group or experience a lack of understanding by many peers. In addition, instead of gaining autonomy from their parents, they often become more dependent on them when needing financial support or having to move back to the parental home. Thus, adolescent parenthood is associated with high personal costs, especially for adolescent mothers. These costs are most obvious in the field of education and work.

Education and work: In a qualitative longitudinal study with 36 adolescent mothers that started during pregnancy (the mean age at the first time of measurement was 17 years), Friedrich and Remberg (2005) observed that 25 % of the young mothers dropped out of school during pregnancy or after giving birth to a child, and only 22 % of these mothers re-entered school in the first 2 years after giving birth to a child. Seventeen percent of the total sample had not completed school 2 years after giving birth to their child. Another study reported that 40 % of teen mothers had not graduated from school, whereas most others (50 %) completed the lowest school track that only offers very limited career opportunities (Thiessen and Anslinger 2004).

Friedrich and Remberg (2005) observed that 2 years after giving birth to their child, 42 % of the mothers were in the work force (vocational training or being employed), while 47 % were at home (neither employed nor in the educational system). Most teenage parents in that study had not changed their general career aspiration, but they planned to finish their education and start a career after taking a more or less long break for child care. However, a subgroup felt that their career plans could no longer be fulfilled and reduced their career aspirations or even gave them up completely. A few others even started developing career plans because of their pregnancy and parenthood in order to become independent from welfare benefits.

Material situation: Young mothers are at increased risk for poverty. For example, Thiessen and Anslinger (2004) reported that 35 % of the assessed young mothers received social welfare assistance as compared to 9.5 % of the total population. High rates of welfare recipients were also found in the study by Friedrich and Remberg (2005), in particular if the mothers were not in a steady relationship.

Housing: Friedrich and Remberg (2005) observed that during pregnancy about one-third of the respondents lived with their parents or the parents of their boyfriend and a similar number had their own home. Other ways of living were mother–child homes or other forms of supervised living. Two years after giving birth to their child, more than two-thirds of the mothers had their own home.

Social situation/intimate relationship: Greven (2008) compared the social situation of 237,058 German primiparous mothers, 3,842 of them being adolescents. Data were collected around birth. Adolescent mothers were more likely to have no intimate relationship at the time of the interview (58.7 %) than older mothers (18.4 %). In a study with 100 adolescent and 100 adult patients from a birth clinic, 97 % of the adolescents had no such relationship at present, as compared to 62 % of the control group members (Barchmann 2009).

Two years after giving birth to a child, only 39 % of the young mothers from the study by Friedrich and Remberg (2005) still had an intimate relationship with the father of their child. However, 42 % had a new intimate relationship.

Mental health: Unfortunately, almost all available German studies with teenage parents did not assess mental health. In a small sample with adolescent mothers, Ziegenhain et al. (2003) observed that depressive symptoms were widespread (average scores were at the 70th

percentile of a depression scale). However, because these adolescent females were recruited with the help of service agencies for young mothers at risk, this study probably overestimated the prevalence of depressive symptoms.

Life management/Coping with the new role: In the past, pregnancy during adolescence and teenage parenthood has often been described as severe maturation crisis (Berger 1987). However, these authors referred to non-representative samples of teenage mothers of children in psychiatric treatment. Available recent studies show a large variability and that some German adolescents cope with parenthood quite well. Friedrich and Remberg (2005) reported that many young mothers have strong feelings of responsibility for their child and are able to organize different roles in the field of motherhood, their own education, and intimate relationship. About 30 % of their sample coped quite well with the new role. They felt more mature after giving birth to a child, were able to organize their daily life, and balance their own needs and the needs of the child. If they had a romantic relationship, they got sufficient support from their partner. In total, this group was satisfied with their role. A second group of similar size was defined by the authors as precarious motherhood. In this group, motherhood led to serious problems for the mothers and/or the child. For example, mothers felt overwhelmed by the excessive demands and lacked relevant abilities and psychological stability. They showed neglectful behavior or even aggression toward the child. Adolescent mothers without romantic partners were overrepresented in this group. The third group (40 %) experienced positive and negative aspects of parenthood (e.g., blocking of previous life goals and having a new meaningful role) and found these aspects difficult to integrate. They sometimes felt overwhelmed by the demands of parenthood but showed less negative consequences than the second group. Due to the small sample size, the results are difficult to generalize.

Health behaviors and child health: Health-related behaviors during pregnancy affect the health of the child. A central question is whether pregnant adolescents care less for their health (and for the health of the unborn child) than pregnant adults. Barchmann (2009) compared data from 100 pregnant adolescents (mean age at birth $M = 16.5$ years, range 13–17 years) with 100 pregnant adults (18–35 years). In this study, 44 % of the adolescents reported that they had smoked during pregnancy, as compared to 18 % of the control group. Based on a much larger sample size (birth clinics data from 237,058 German primiparous mothers, 3,842 of them being adolescents), Greven (2008) observed that 39.8 % of the adolescents were smokers as compared to 15.1 % of the older mothers.

As a general recommendation, German pregnant women should have at least 10 pregnancy examinations. Some 57 % of the pregnant adolescents in the study by Barchmann (2009) did not have the expected number of pregnancy examinations, as compared to 39 % of pregnant adults. More than 50 % of the adolescents did not have their first pregnancy examination until after the first 12 weeks of pregnancy. This number was much lower for the pregnant adults (21 %).

Does this lower level of health care translate to higher numbers of complications during pregnancy and at birth? Haerty et al. (2005) compared data from 46 adolescent birth and 96 adult births at the University Hospital of Munich. They found no significant differences with regard to biological risks, such as premature birth and low birth weight of children of adolescent mothers. However, the lack of significant differences may have been based on a small sample size.

In another study with 100 pregnant adolescents and 100 pregnant adults, Barchmann (2009) observed that complications during pregnancy—such as gestosis, anemia, and bleedings—were just as common in pregnant adolescents as in pregnant adults. Preterm deliveries (before the 37 week of pregnancy) were slightly more prevalent in pregnant adolescent, but the difference did not reach statistical significance. The numbers of complications at birth did not differ between both groups. Pathological APGAR scores were slightly more

prevalent in the control group, but this difference was insignificant. However, the average birth weight was significantly lower for children of adolescent mothers (3,275 vs. 3,435 g). In addition, pathologies in the early postnatal period were more prevalent in children of adolescent mothers (43 vs. 22 %; and a higher probability of icterus in particular, 26 vs. 16 %).

Klapp (2003) reported that the Berlin perinatal study found an increased rate of premature infants for adolescent mothers (9.9 %) as compared to adult mothers (7 %). Furthermore, Greven (2008) reported that 10.9 % of the infants of adolescents were born prematurely. In the total population, only 7.2 % of the children were premature babies. In addition, children of adolescent mothers had lower birth weight than children of 18–36-year-olds. About 9.1 % of these children had low birth weight (<2,500 g) as compared to 5.7 % of children of 18–35-year-old mothers. Finally, another study showed that differences in birth weight and risk for early birth between adolescent mothers and older mothers are no longer significant after controlling for between-group differences in smoking, relationship status, and educational aspirations (Bohne-Suraj and Reis 2009).

In sum, although the results of available studies are, in part, inconsistent, the existing data indicate that—similar to studies from other countries—pregnant adolescents from Germany do less for their own health and for the health of their child than pregnant adults. Preterm births and low birth weight are more common in teenage pregnancies, but these differences are small and only become significant in large samples.

In a study on families who sought psychological help, Berger (1988) observed that children of adolescent mothers show depressive and psychosomatic symptoms more often than children of adult mothers. In another study with patients from a psychiatric hospital, 59 % of children of adolescent mothers received a diagnosis of emotional or behavioral disorders (Bohne-Suraj and Reis 2009). However, representative German data are lacking on that topic.

Public Policy

With regard to public policy, we start with initiatives for the prevention of pregnancy, followed by services for pregnant adolescents as well as for adolescent parents and their children. If available, we include data on the evaluation of the effects of these initiatives and services.

Pregnancy Prevention

In principle, the prevention of adolescent pregnancy could focus on each step in the chain of risk factors, such as reducing risk factors for early sexual maturation (obesity in particular), delaying the timing of the first intercourse, reducing the number of sexual contacts, and improving contraceptive behavior. However, most German initiatives focus on the last risk factor.

School-based sex education: Sex education is seen as the most important form of pregnancy prevention (Häußler-Sczepan et al. 2005, 2008). Schools are the main place of sex education. Other forms include information brochures and Web sites on the Internet.

In the early 1960s, the first guidelines for sex education at schools were implemented in Hamburg and West Berlin. In 1968, the Conference of the Ministers of Education and Cultural Affairs of the (western) German federal states adopted general recommendations for sex education at all German schools. According to these recommendations, sex education should not be a topic of a singular subject, such as biology or religion, but a topic of interdisciplinary education. Themes, such as sexual behaviors, contraception, and abortion, should be addressed in sex education until grade 9 or 10. The federal states developed guidelines and framework curricula for implementing sex education at their school according to these recommendations. Rules for sex education were less formalized in the former German Democratic Republic, but general hints for sex education existed in the curricula of biology (beginning with 5th graders), German literature

as well as History and Civic classes (only with regard to gender roles). In 2002, the recommendations of the Conference of the Ministers of Education and Cultural Affairs were annulled and each German federal state now has its own guidelines and/or curricula. However, not all schools may follow these guidelines and rules to the same extent (for a comprehensive overview, see Hilgers et al. 2004).

Hilgers et al. (2004) compared sex education in the German federal states. Starting from primary school, topics of sexuality are implemented in the curricula of the schools. Contraception is an explicit topic of the curricula of all but one federal state (Bavaria did not include this topic); although the time of approaching this content varies between grade 4 and grade 10 (most federal states implement the topic in grade 5 or 6). All but two federal states included abortion in their curricula, but they differ regarding whether abortion should be seen as generally wrong or as a meaningful option in the case of an unwanted pregnancy. Almost all federal states conceptualize sex education as interdisciplinary topic. Only in the federal state of Bavaria, biology and religion are seen as the leading subjects of sex education. Parents should be informed about the contents and methods of sex education. However, based on court decisions, they have no right to forbid the participation of their child. Adolescents often report that sex education at school did not sufficiently address some relevant topics, such as emergency contraception (Remberg and Weiser 2003).

In the field of sex education, many German schools cooperate with health practitioners. For example, the Medical Society for Health Promotion of Women (Ärztliche Gesellschaft zur Gesundheitsförderung der Frau e. V.) supports school-based sex education and reaches about 60,000 adolescents per year (Gille 2005).

Infant simulators (Baby Think It Over® infant simulators) have been used in Germany since 2000. This simulator articulates hunger and other supply requirements and reports exactly how it was cared for (a computer registers these care activities). It does not only register how promptly the "parents" reacted toward its needs but also registers misuse, such as shaken baby syndrome or broken neck. Nowadays, most German advice centers for pregnancy counseling work with infant simulators. These simulators are most often used as part of school curricula (in the lowest school tracks in particular). Some youth welfare services (e.g., dormitories for adolescents at psychosocial risk) and centers for children with special needs also work with these simulators.

In the last decade, the number of persons who work with these simulators has continuously increased. About two-thirds of them are social workers and about 25 % teachers. About 90 % of the multipliers received advanced training in working with these simulators. They most often use infant simulators for pregnancy prevention (about 90 %), help with life planning (about 90 %), and prevention of child abuse (about 75 %; Spies 2008). Role overload and failure with the mother role are supposed to act as a deterrent. Some multipliers also combine the use of infant simulators with peer education and introduce teenage mothers who report on their experiences and problems.

In an evaluation study without a control group, Spies (2008) found that the participating adolescents feel overwhelmed. The respondents experienced failures when trying to master the excessive demands of their new role. Six month after the parent practice, they did not have clear memories of the learning contents of the program but remembered the number of broken necks and the percentage of cases that met (or did not meet) the demands of the baby. The attitudes about whether to get a baby during adolescence did not change. However, all but one adolescent already had a negative attitude in this regard at the beginning of the project.

The use of infant simulators has been criticized because the excessive experience of one's incompetence in meeting the infant's demands may undermine adolescents' general self-efficacy beliefs, in particular in the case of underprivileged adolescents who often experience failures in other areas of their life.

Sex education brochures: Service providers have developed sex education brochures. For

example, the German Federal Center for Health Education used questions that adolescents asked on the Internet platform "loveline" (www.loveline.de) for developing such brochures. However, brochures alone have a very limited effect. In an experimental study, Krahé et al. (2005) observed that reading a sex education brochure was insufficient to affect variables relevant for adolescent condom use, such as intentions and general attitudes toward condom use. Additional motivational strategies were necessary for change.

Electronic and print media: In the most recent study of the BZgA on adolescent sexuality, 36 % of female adolescents and 26 % of their male peers prefer using journals as a source of information about sexuality, 36 % of girls and 24 % of boys preferred free information brochures, and 27 % of girls and 26 % of boys reported that they prefer using the Internet. Print media was more important for sexually inexperienced adolescents (BZgA 2010).

Starting in 1963, the most widespread German magazine for teenagers ("Bravo") has been answering reader's letters about sexuality. This service is now supplemented by a Web page (http://www.bravo.de/dr-sommer). The Internet platform "loveline" that is run by the BZgA offers information about love, intimate relationships, sexuality, and contraception (http://www.loveline.de). It includes an online lexicon, frequently asked questions, surveys, news, knowledge-based games, and chats. About 500,000 people per year visit the Web site, and about 160,000 adolescents use the chat/forum. The family counseling agency *Pro Familia*'s (https://profamilia.sextra.de) Web site "Sextra" offers online counseling and information that were sent to about 13,000 of those who requested it in the year 2010.

In 2009, a documentary soap by a private broadcasting company "Erwachsen auf Probe" [Adult on trial] that was based on the British TV documentary "Baby Borrowers," featured some adolescent couples starting off to attempt at looking after a baby for a few days. The official goal of the TV documentary was to sensitize teenagers about imprudent pregnancy by showing them the difficulties that would arise. The documentary was harshly criticized by the Federal Psychotherapeutic Association, the Children Protection Alliance, and others because during these days the infant was separated from his or her biological parents and became distressed.

Support for Pregnant Adolescents

Counseling and education: Advice centers for pregnancy conflict counseling or pregnancy counseling exist all across Germany, although there are no specialized advice centers for pregnant adolescents. As already reported, participating at pregnancy conflict counseling is a legal requirement for abortion. It offers information about legal aspects, social assistance for pregnant women and for mothers (e.g., financial assistance from state), costs and funding for abortion, medical information about abortion procedures, and help with emotional and social conflicts, and with life planning in the case of abortion or parenthood. Counselors are required to be open to all possible outcomes.

Advice centers that are run by the Catholic welfare agency only offer pregnancy counseling and do not provide the attestation that would be needed for abortion. In addition to counseling centers, online information for pregnant teenagers is provided by the German Federal Center for Health Education at the Web site http://www.schwanger-unter-20.de.

All advice centers offer help for getting access to state benefits and visits of authorities or referrals to other specialists. Block (2009) reported that more than two-thirds of pregnant adolescents evaluated the counseling experience positively. Critiques referred to the large age difference between the adolescent and the counselor and to the bias of some counselors who preferred a particular solution (abortion or giving birth) rather than promoting a dialogue that takes all outcomes into account without bias.

In order to get access to some sources of support, pregnant adolescents have to visit public authorities. Friedrich and Remberg (2005) found that pregnant adolescents felt more

accepted when asking for services of the youth welfare office than when asking for services of the (non-age-specific) social welfare office.

Family education centers offer classes for expectant mothers, for example with regard to antenatal gymnastics, preparation for birth, preparation for breast feeding, and others. Because less than one percent of all pregnancies refer to adolescents, these centers usually do not offer special classes for pregnant adolescents.

Antenatal care: As for other pregnant women, regular antenatal care for pregnant adolescents is paid for by the health care insurance.

Material support: Maternity allowance (a maximum amount of 385 Euro per month) is paid by the health care insurance in the last 6 weeks before giving birth to employed pregnant women. Thus, most pregnant adolescents do not receive this money. If pregnant women do not have sufficient income, they can receive public welfare benefits for buying maternity wear and basic equipment for new parents. Pregnant teenagers can also apply for a non-recurring financial support for basic equipment and housing from the Foundation “Mother and Child—Protection of Unborn Life.” The amount of this support differs considerably between the German federal states, and there is no legal entitlement to this subsidy. Church-based advice centers for pregnant women may also have their own social fund for supporting pregnant women.

Services for Young Mothers and Parents

Counseling: Basic social security is the most common topic of counseling for adolescent parents, followed by school-/education-related topics, questions about partnership, child care, general future planning, and legal advice (Häußler-Sczepan et al. 2005, 2008). According to experts from the field of counseling, the most important support needs of adolescent parents are educational counseling, adaptation of modes of vocational training to the needs of young mothers, financial/material support, offering child care facilities, and housing for teenage mothers and their children/assisted living. Friedrich and Remberg (2005) observed that most teenage parents used counseling services only once or twice (e.g., when searching for material support), but most of them would have needed them over a longer period.

Material support: Since 2007, German parents receive parental benefits (Elterngeld) during the first year after childbirth (and for an additional 2 months if fathers take paternal leave for that time). Parents who were not in the work force before the birth of the child receive a minimal amount of 300 Euros. In addition, parents receive child benefits (Kindergeld)—in 2013 184 Euros per month for each child. Combining parent and child benefits, adolescent mothers receive 484 Euros in the first year of life for their child. During this time, some teenage parents may have more money than they had before, although this amount may be insufficient for running their own household and has to be supplemented by welfare benefits for the poor. When parental benefits end, adolescent parents have to apply for welfare benefits as long as they have no other sources of sufficient income. Children of teenage mothers also have the right to receive alimentation (child support) from their fathers, the amount depending on his income level. If the father does not pay or is not able to do so, the youth welfare office pays the child support.

Special housing/assisted living: According to the Social Code volume 8 on child and youth services, single mothers or fathers who care for a child under the age of 6 years of age have the right to attend an appropriate type of accommodation as long as they need this support because of their personality development. During this time, they should get help with continuing with or starting school or occupational training or finding a job (§19). Of course, this service is not restricted to adolescent parents. For example, in 2009, 17.7 % of the residents of mother–child facilities in Catholic sponsorship were between 14 and 17 years of age ($N = 147$) and another 27.1 % were between 18 and 20 years of age ($N = 225$) (Winkelmann 2010).

The percentage of adolescent residents (<18 years) varied between 14.5 % (in 2007) and 23.9 % (in 2000). The law does not pertain to young couples with children. Not surprisingly, this service is in most cases used by mothers rather than fathers.

In the so-called mother–child homes, mothers and their children usually live in mother–child groups. They have one or two rooms for themselves and their child and common rooms for the whole group. Services include support with child care, finishing school, career entry, solving financial problems, visit to the authorities, partnership, household, and spare time. The services also include crisis intervention and relief from excessive demands and cooperation with other service providers. Teenage mothers usually live in these mother–child homes between one and 3 years (Wallner 2010).

Help with finishing education and starting a career: Most schools and centers for vocational training are not well prepared for adolescent parents. According to the Law for Increasing Day Care (Tagesbetreuungsausbaugesetz), young mothers who still go to school or are in vocational training have the right to a nursery place, although no sufficient numbers of places might exist in their community. An amendment of the German Vocational Training Act from 2005 allows reducing the weekly duration of training by 25 % without reducing the total duration of the vocational training, although this option is not yet used very often (Stauber 2010).

Only few pilot schemes for help with finishing school or starting a career are available, such as the Bremer Förderketter Junge Mütter (Support chain for young mothers from Bremen; Pregitzer and Jones 2004; Thiessen and Anslinger 2004) which includes the cooperation of school, youth welfare services, and kindergarten. For example, a project school has a day care center and individualized curricula are developed for each young mother so that they fit her previous knowledge level. Social work helps with life planning and career planning, and with developing social competence (e.g., parenting education). Another program was developed for 16–20-year-old mothers who have finished school and who are preparing for an apprenticeship and job. The program combines internships, classes to increase knowledge that are relevant to their future job (overcoming deficits in knowledge and in career-relevant abilities), and day care for the infants. It is supposed to help with making career decisions and with starting a career. At the end of the program, they receive help with finding an apprenticeship or job.

Parenting education for adolescent parents: As in other developed countries, parenting education is offered for couples, but these programs are usually not developed for the special needs of adolescent parents. A model project by Ziegenhain and co-workers focused on video-based parenting education for adolescent parents. The goal was to increase knowledge about child development, parental self-efficacy beliefs and sensitivity. The intervention was relationship based, focused on video feedback of mother-infant interactions, and gave suggestions on how to improve the behavior. The results of this study reveal that the relationship-based intervention improved maternal sensitivity during the babies' first 3 months compared to a group of adolescent mothers who only received an intervention based on counseling and compared to a group of adolescent mothers without any intervention. Although the intervention effects declined in the first 3 months after the end of the intervention, there still was a significant effect at follow-up (Ziegenhain et al. 2003, 1999).

Conclusions

In the final part of this chapter, we will provide a general evaluation of teenage pregnancy in Germany and provide suggestions for future research, policy, and programs. In an international comparison, German rates of teenage pregnancy, births, and abortions are quite low. Given this fact and the further decline of these numbers in prior years, we conclude that prevention works quite well. Although we do not believe that every pregnant teenager is one too many (because some of them make a well-informed decision and cope

quite well with their new roles) (Friedrich and Remberg 2005), the fact that most teenage pregnancies are unwanted and have considerable costs for the young people and society, there is room for further improvement.

Conclusions for Policy

With regard to prevention of adolescent pregnancy, we conclude, first, that further improvements of sex education are needed. As about one quarter of the German 14–17-year-olds reported that they wanted more information about contraception (BZgA 2010), as contraception failures are widespread among pregnant adolescents (Schmidt et al., 2006; Matthiesen and Schmidt 2009), and about 50 % of the pregnant adolescents did not have information about emergency contraception (ibid.); such better knowledge of contraception could reduce the rate of adolescent pregnancy. Given the fact that 4 % of sexually experienced female adolescents have their first intercourse at the age of 13 or earlier (BZgA 2010), contraception should be a topic of sex education as early as grade 5 or 6. Thus, curricula of sex education of about half of the German federal states (Hilgers et al. 2004) would have to be revised, as they only include this topic in grades 7–10 or do not explicitly mention it at all. The importance of earlier sex education can also be derived from the fact that younger adolescents were less likely to use safe contraception than older adolescents (BZgA 2010). Regular contraception and emergency contraception should be a main topic of sex education in all schools.

Second, with regard to the content of education about contraception, the high prevalence of contraception failures (Schmidt et al. 2006; Matthiesen and Schmidt 2009) indicate that adolescents should be recommended the combined usage of oral contraceptives and condoms. This could reduce the negative effects of single contraception failure and the prevalence of adolescent pregnancy. Alternatively, forms of contraception that need low compliance could be developed.

Third, in contrast to many other countries, emergency contraception in Germany is only available by prescription. Difficult access to emergency contraception, such as time-consuming procedures if one has to go to a gynecologist or to a hospital, was one (but not the only) reason for unwanted pregnancy in the study by Matthiesen and Schmidt (2009). Free availability of emergency contraception would therefore be another important step in further reducing the rate of teenage pregnancy. In 2013, the Federal Council of Germany voted for this solution.

Fourth, because lack of effective communication about contraception was often observed in pregnant adolescents (Matthiesen 2008), measures for improving communication abilities and assertiveness could contribute to a reduction in teenage pregnancy. The promotion of life skills is part of three German prevention programs with a focus on sex education (for overview, see Vierhaus 2009), but their effects on use of contraception or risk for pregnancy have not been evaluated as yet.

Fifth, with regard to work with pregnant adolescents, studies on health care (Barchmann 2009; Greven 2008) indicate that efforts are needed in order to reduce smoking during pregnancy and increasing the regular use of pregnancy examinations. Higher degrees of cross-linking between psychosocial services for pregnant adolescents and gynecologists may be one way to reach this goal. In addition, as the age difference between adolescents and pregnancy counselors and gynecologists sometimes impairs effective communication (Block 2009), training of counselors and medical staff in the work with adolescents may help to improve the use and the effects of these services. In addition, available advisory services may be supplemented by peer counseling.

Sixth, because motherhood in adolescence is a risk factor for school dropout and poverty (Friedrich and Remberg 2005; Thiessen and Anslinger 2004), more efforts are needed to increase the compatibility of teenage motherhood with education, vocational training, and work. The model projects that combined individualized

curricula, internships, availability of child care, and counseling worked quite well and should be disseminated as regular services across the whole country (Pregitzer and Jones 2004; Thiessen and Anslinger 2004). In addition, increasing the availability of child care facilities would help young mothers in entering the work force.

Seventh, because special accommodations (such as mother–child homes) are only available for single mothers and fathers according to the German Social Code, this service is inappropriate for supporting adolescent couples and their children. Thus, teenage family homes as a form of assisted living would be highly recommended.

Conclusions for Future Research

As reported in this chapter, some recent high-quality studies with large samples are available on adolescent sexuality (such as the repeated studies of the BZgA) and on the situation of pregnant teenagers (Matthiesen et al. 2009). Nonetheless, more research is needed with regard to other relevant topics.

First, large quantitative studies are needed on the situation of adolescent parents and their children. They should provide data on adolescent and adult roles (e.g., education, employment), support use, health care, parenting, parental psychological health, and child development. Comparison groups of adult parents and adolescents without children are needed. For example, because teenage pregnancy is more common in socially disadvantaged groups (Block and Schmidt 2009; Schmidt et al. 2006), some of the observed problems of adolescent mothers with finishing school and getting a job might be explained by their lower school track or other social risk factors rather than by adolescent parenthood. The relative effects of parenthood and of other risk factors still have to be determined. The collection of longitudinal data would be recommended for assessing the process of coping with the demands of parenthood.

Second, despite the availability of studies with pregnant adolescents, we still do not know much about predictors for abortion versus giving birth to a child. In addition, because only a limited number of risk factors for adolescent pregnancy have been assessed in the available German studies, more research on risk factors is recommended. For example, do impulsivity, social competence, future-related expectations, and other psychological variables play a role? This knowledge would have implications for the future development of prevention and support programs.

Third, high-quality studies are needed in the field of evaluation of pregnancy prevention programs and of support services for pregnant adolescents and young parents. At best, these studies need to have sufficient sample sizes and a randomized design that compares the intervention condition with treatment as usual or alternative prevention programs. Because numbers of adolescent pregnancies and adolescent births are rather low in Germany, multicenter studies are recommended.

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Adolescent Girls and Health in India

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Keywords

India: adolescent anemia · Adolescent well-being · Birth injuries · Chronic poverty · Contraception usage · Malnutrition · Maternal and perinatal mortality · Sex workers · Transition to adulthood

Introduction

The term adolescence broadly refers to the period between 10 and 21 years of age. This age range is not fixed. World organizations such the World Health Organizations (WHO) and the United Nations (UN) prescribe different age ranges. The period of adolescence is defined by changes in social roles as well as biological characteristics. The experience of marriage, changes in residence, social networks, and accommodations to new familial power structures during adolescent years negatively influence the physical and mental health of adolescents. In addition, in high-fertility societies such as India, young women may face enormous pressure to begin childbearing. The adjustments adolescents are asked to make to the world around them demand adult supervision and support. In the absence of adequate support, adolescents are likely vulnerable to oppression, and poor physical and mental health. Threats to physical and mental well-being unfortunately have long-lasting effects (Cherry et al. 2001). Focus on adolescent well-being and investment in their future is essential for social stability and sustainability.

India has the largest population of adolescents in the world. Of the 1.2 billion adolescents aged 10–19 years worldwide, 243 million, roughly 20 %, live in India (United Nations 2010). Female Indian adolescents suffer from several social inequalities because of their gender. This chapter focuses on the female adolescent in India. Among the many social, economic, and physical changes that characterize the transition from childhood to adulthood, this chapter highlights the social aspects.

India is comprised of 28 states and seven union territories. The states are highly diverse with respect to levels of social and economic well-being. This diversity influences the state of adolescence in India. The objective of this chapter is to provide an account of adolescent well-being at the national and state levels.

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With regard to Indian religions in 2000, Hindus accounted for about 80 %, Muslims for about 13 %, Christians approximately 2 %, and the rest accounted for religions such as Buddhism, Jainism, and Sikhism. As the majority of the population is Hindu, the social context of the problems experienced by a majority of adolescents in India is deeply influenced by the cultural and religious practices among the Hindus. Until the middle of the last century, the Hindu practice of child marriage was very common. Child marriages sometimes occur, even today, among toddlers. Child marriages involve a formal marriage performed during childhood. The child bride continues to live with her parents until she comes of age when she is then moved to her husband's residence (Banerjee 1998).

Child marriages are still common though their number is declining (Caldwell et al. 1983). Raj et al. (2009) found 44.5 % of women aged 20–24 years of age were married before the age of 18 years, 22.6 % were married before the age of 16 years, and 2.6 % were married before the age of 13 years. Teenagers are more likely to not use contraceptives before first childbirth, and also to experience repeated childbirth in less than 24 months and multiple unwanted pregnancies.

Within marriage, often during adolescence, the birth of a son is a cause for celebration, while the birth of a daughter is often followed by benign neglect of the needs of the mother as well as her infant girl. Because males are preferred, sex-selective abortions are common even today. The female infant mortality rate of 71.1 per 1,000 live births is lower than the male infant mortality rate of 74.8 per 1,000 live births, but the child mortality rate is considerably higher for girls (37 deaths per 1,000) than for boys (25 deaths per 1,000) (IIPs 2000). Girls are taken from school when they reach menarche. When young girls become pregnant before marriage, community reaction is swift and horrific, sometimes resulting in the murder of the mother. In general, we argue in this chapter that adolescents in India face several barriers to a mature and supportive transition to adulthood. This is particularly true for adolescent girls.

Vignette–Kamla

Kamla is an 18-year-old girl from the remote village Phaphamau, India. Phaphamau is located on the banks of the Ganges river near Allahabad city and is economically driven by the wholesale and retail market for vegetables, grains, and clothes. Growing up, Kamla lived in a 1-room Kutcha (roofed with tin and plastic) house with her mother, father, 5 younger brothers, and an older sister, sharing a communal toilette facility. Her father worked as a laborer at a brick kiln, and mother had a fruit and vegetable stand in the local retail market. Kamla's sister Bina was skilled in sewing and worked as a tailor's assistant at age 12. Education and/or apprenticeship was emphasized for boys, whereas household duties were emphasized for girls. Kamal's bothers completed high school, while Kamla and her sister did not attend past fourth grade. Therefore, household cooking, cleaning, knitting, and sewing were the skills the girls had to learn before they hit puberty. Kamla's parents believed that ability to count money and write some Hindi was enough of education for a girl.

By the age of 12, Kamla was married to a man named Suresh. At the time, Suresh who lived in the same village was a 32-year-old widower with four children from his previous marriage. Kamla's parents believed that Suresh would be a suitable match for their daughter as he made a decent income as a construction worker. Although Kamla was hesitant about the marriage, she was raised not to question her parent's decision. She knew going against their wishes would cause her

family to be shunned by the community. Additionally, Kamla had heard stories of girls that went against the marriage rules being severely ostracized. After her marriage, she would visit her natal family frequently until she started her periods at the age of 15 and went to live in her in-laws home.

Within months, Kamla was pregnant with her first child. She had heard about family planning, but nobody including her husband or in-laws ever discussed it at home. Her husband had the power to use contraception or not. She felt very sick and weak during her first pregnancy. A local mid-wife delivered her firstborn at home. She remembers going to the hospital only a couple of times during her first pregnancy, as the hospital was not close to the village. Getting to the hospital was not easy, as it took a whole day to get to Allahabad. Once she got there, the family had to wait in line for a long time. Her second pregnancy at the age of 17 ended in severe labor complications resulting in the death of her child during birth. Now, she lives with her bedridden mother-in-law and her first child and husband. Her husband, though is still employed, does not have steady work owing to a slump in the housing construction industry.

In India, the period of adolescence has not been precisely determined. In spite of legal definitions of adolescence, which state a precise age interval, the demarcation between childhood and adolescence remains culturally undefined. Adulthood is preceded by a prolonged period of childhood. Childhood is idealized as a playful, carefree stage of development. Ancient Indian texts such as the Ramayana and Mahabharata, for example, portray the epic heroes as being childish, yet cognizant of Dharma, being able to distinguish right from wrong. Folklore on Lord Krishna narrates in great detail the mischievous nature of the child in the presence of forgiving mothers and female adults. However, on an occasion when the community is threatened, the child Lord Krishna rises to the occasion to save the community from the effects of evil so that 'righteousness' may prevail.

In the Ramayana, there is an extensive section titled the 'Balkhand,' which describes Rama's childhood days. It describes Rama, as being obedient and respectful toward his parents and teachers and that there is very little sibling rivalry. As Rama grew, he spent much of his time under the tutelage of great teachers. Apart from the references in Indian epics to the period of adolescence, unfortunately, there are very few folk narratives that describe in detail an ideal adolescence. In particular, for young girls, the brief period of transition to adulthood marked by the onset of 'menarche' was seen as a time of learning and preparation for marriage and motherhood. In the great Indian legal text 'Laws of Manu,' a young girl is supposed to obey her father. In the social control of adolescent sexuality, both mother and father took active roles.

Against the backdrop of an ideal adolescent stage indicated above, Indian children grow up in a collectivistically oriented culture and are also socialized by members of the extended family (Karkal 1991). When there are infants at home, older children may spend a considerable amount of time caring for them (Nuckolls 1993). Age also plays a crucial role. Older members have more authority within the family than do younger ones. Because of a collective orientation, the magnitude of sibling rivalry among children appears to be low (Beals and Eason 1993). Several factors, such as the collective orientation, involvement of the extended family in familial affairs, and age gradation in authority with respect to socialization, facilitate an environment for strict disciplining of children. Almost all adult family members, especially female adults, are involved in the supervision and socialization of children. It is likely that

structural factors such as family size and family composition may also play a role in the extent of disciplining (Sandhu and Bhargawa 1987).

Male children especially are often disciplined using corporal and other forms of harsh punishment. Nagging, swearing, and scolding are very commonly used (Ross 1961). Reward and punishment strategies are less frequently used than physical punishment. The style of parenting is therefore mostly authoritarian (Saraswathi et al. 1999). Throughout the course of socialization, children are often told the distinction between right and wrong behaviors. As a result, as children reach adulthood, they develop a strong sense of righteous duty, supervised, enforced, and maintained by a network of extended family. Topics related to sexual development are never raised. Children are socialized to regard sexual thought as unnatural and that it should be avoided as much as possible. Strict socialization with regard to sex is imposed more on girls than on boys.

Sexual restraint and virginity are believed to be important for entry into marriage. With the decline in the number of child marriages, the period between age at menarche and marriage is one of strict control and supervision in order to restrict the possibilities of sexual contact. Even in urban areas, the likelihood of premarital sexual contact is limited. Thus, it appears that premarital adolescent sexual activity is less of a problem in India than it is in other countries. In India, perhaps 10 % of adolescent pregnancies occur outside of marriage. Because of social control and a lack of social interaction among the sexes, the incidence of premarital sex appears to be negligible. When a girl becomes pregnant out of wedlock, she is often ridiculed and ostracized (Pal et al. 1997). From a social survey that will be described later in this chapter, we found that the average age at the start of menstruation was 13.1 years of age. This is based on responses from only 43 of the 50 respondents. We found very little evidence of premarital sexual activity. However, the extent of supervision and social control over sexually mature children is likely to diminish with low socioeconomic status. Low socioeconomic status is more likely to contribute to decreasing control over a child's socialization in urban areas than in rural areas (Joshi and Tiwari 1977).

Issues of parental control over sexual socialization of female adolescents are compounded by changes in the age at marriage. The singulate age at marriage for females increased from 16.1 in 1961 to 19.7 in 1998–1999 (Desai and Andrist 2010). On the one hand, an increase in age at marriage is accompanied by an increase in the duration between age at menarche and age at marriage. With the increase in this duration over the last 50 years, parental responsibilities for supervision and sexual socialization have also increased. On the other hand, even at the current age at marriage of nearly 20, for most young Indian women, the transition to motherhood takes place in their teens. In the state of Assam, one-third of all girls below the legal age of 18 years for marriage are married.

Thus, most of the problems of adolescent reproductive health and well-being occur within marriage, and therefore, social relationships that are forged through marriage influence female adolescent reproductive health and well-being. Since adolescent fertility is accompanied by concerns for health and social well-being of the teen mother, measures of the extent of adolescent fertility provide a preliminary assessment of existing reproductive health problems among adolescent girls in India.

Adolescent Fertility: A Profile

The population of India is very young with about one-fifth in the age group of 10–19 years. About 200 million in 2000 were in the adolescent age group of 15–19 years. Adolescents gave birth to about 15 million children in 2000. The adolescent population is growing rapidly and is expected to stabilize at a peak level of 215 million in 2020. Several types of social and economic disparities characterize the adolescent population. Most important of them is education. About 40 % of female adolescent had no education compared to 17 % of males in 1999 (Kessler et al. 2005). In this section, we examine

the level as well as a few sociodemographic correlates of adolescent fertility in India.

The analysis for this section is done using three data sources: The National Family Health Survey; India Human development survey; and survey data. The 2005–2006 National Family Health Survey (NFHS-3) is the third in the NFHS series of surveys. The Ministry of Health and the Family Welfare Government of India conducted the NFHS surveys. The Ministry selected the International Institute for Population Sciences (IIPS), Mumbai, for conducting NFHS-3. The NFHS-3 interviewed 124,385 women aged 15–49 and 74,369 men aged 15–54 to obtain information on population, health, and nutrition in each of India's 29 states. The survey is based on a sample of households that is representative at the national and state levels. NFHS-3 interviewed all women aged 15–49. The survey provides trend data on key indicators and includes information on several new topics, such as HIV/AIDS-related behavior, attitudes toward family life education for girls and boys, and the use of Integrated Child Development Scheme (ICDS).

The India Human Development Survey (IHDS) is a nationally representative, multi-topic survey of 41,554 households in 1,503 villages and 971 urban neighborhoods across India. Two one-hour interviews in each household covered health, education, employment, economic status, marriage, fertility, gender relations, and social capital. Fieldwork began in November 2004 and was completed by October 2005. IHDS was designed to complement existing Indian surveys by bringing together a wide range of topics in a single survey. This breadth permits analyses of associations across a range of social and economic conditions pertaining to adolescents (Desai et al. 2008).

The adolescent survey data were obtained from a non-random sample of 50 female adolescent school children aged 15 or more attending selected schools in an Indian metropolitan city. In India, adolescent fertility is directly associated with marriage. Table 1 presents the proportion of adolescents married by state.

The study provides data on both married adolescents. Data are available for both male and female adolescents, facilitating comparisons of entry into marriage of both males and females. In all Indian states, the proportion of married females 15–19 years is greater than the proportion of married males 15–19 years. On average, the proportion of married female adolescents is about six to seven times greater than the proportion of married male adolescents. Since only very small sample sizes are available for most of the North Eastern states, no specific conclusion can be made about the marriage rates among female adolescents in those states. Excluding these states, low rates of marriage are found in the well-established states of Kerala, Tamil Nadu, and Punjab. These three states have both a low proportion of married female adolescents as well as a low mean number of children. The two factors combine to provide a conducive environment for transition to low fertility levels.

Data from NFHS 2005 suggest that the average number of children born to currently married 15–19-year olds is about 0.55 (See Table 2).

Table 2 suggests that the starting of family in India, even today, occurs during adolescence. By age 29, most women will have achieved the replacement fertility level of two children. Toward the end of the reproductive career, during the 45–49 age range, the average number of children increases to 4.02, almost twice the replacement level.

Table 3 presents the average number of children 15–19 years of age have a state of residence at the time of the interview. The trimmed mean excludes outliers at the specified level of 5 %. The average varies from 0.15 in Tamil Nadu to a high of 0.80 in Bihar. The average number of children in Bihar at one extreme is almost 5 times higher than the average number of children in Tamil Nadu. Almost all states with an average of more than 0.50 are situated in the northeastern part of the country with the exception of Rajasthan. On the other hand, southern states such as Tamil Nadu, Kerala, and a few states in the north such as Himachal Pradesh and Punjab have an

Table 1 Proportion married among 15–19-year olds by states and territories of India in ascending order for females*

State	Married	
	Male	Female
Nagaland	*	*
Sikkim	1.4	*
Goa	*	*
Assam	0.3	0.5
Himachal Pradesh	0.8	0.6
Mizoram	0.7	*
Arunachal	1.2	*
Gujarat	2.4	1.3
Jammu & Kashmir	0.7	3.3
Manipur	*	4.2
Meghalaya		4.6
Tamil Nadu	0.2	6.4
Punjab	1.2	6.7
Uttaranchal	1.9	7.4
Delhi	1.2	7.7
Kerala	0.3	9.6
Jharkhand	2.5	14.1
Tripura	*	14.1
Karnataka	1.1	14.7
Maharashtra	1.1	15.3
Uttar Pradesh	2.3	15.9
Orissa	2.3	16.1
Chhattisgarh	4.6	16.8
Haryana	4.2	17.0
Bihar	3.1	17.6
Andhra Pradesh	1.3	19.2
West Bengal	3.1	23.6
Madhya Pradesh	7.1	25.7
Rajasthan	5.7	26.5

(IHD data, 2005: Desai et al. 2008)

Table 2 Total children ever born to currently married women—NFHS-2005

Five-year age groups	Number of children
15–19	0.55
20–24	1.45
25–29	2.32
30–34	2.96
35–39	3.46
40–44	3.76
45–49	4.02

Table 3 Mean and trimmed mean number of children to 15–19-year olds by state and territories of India—2005 (Arranged in ascending order of 5 % trimmed mean)

State	Mean	5 % trimmed mean
Tamil Nadu	0.15	0.08
Himachal Pradesh	0.20	0.09
Goa	0.17	0.09
Kerala	0.27	0.15
Punjab	0.26	0.16
Andhra	0.28	0.18
Tripura	0.29	0.20
Delhi	0.35	0.24
Maharashtra	0.37	0.25
Sikkim	0.35	0.26
Gujarat	0.39	0.27
Orissa	0.37	0.28
Uttaranchal	0.39	0.30
Karnataka	0.48	0.31
Jammu & Kashmir	0.43	0.32
Haryana	0.41	0.32
Assam	0.41	0.32
Manipur	0.43	0.34
West	0.44	0.34
Madhya Pradesh	0.47	0.34
Mizoram	0.48	0.41
Nagaland	0.52	0.43
Meghalaya	0.53	0.44
Chhattisgarh	0.59	0.45
Rajasthan	0.62	0.50
Arunachal	0.63	0.53
Jharkhand	0.73	0.62
Uttar Pradesh	0.76	0.63
Bihar	0.80	0.69

Table 4 Proportion of adolescents (15–19-year olds) with at least one child ever born by number of antenatal visits—NFHS-3

No. of visits	Frequency	Percentage who had antenatal visits
0	426	19.8
1	182	8.4
2	436	20.2
3	369	17.1
4 or more	741	34.5
Total	2,154	100.0

average number of children less than 0.28, far less than the Bihar average. Kerala, Tamil Nadu, and Punjab are clearly in the forefront of a transition to low birth rate. It appears that there are regional disparities associated with adolescent fertility in India. This disparity will be further explored using a number of other indicators associated with adolescent fertility.

Table 5 Current contraceptive method use among currently married 15–19-year olds—NFHS-3 (2005)

Method	Percentage
Not using	86.3
Pill	2.6
IUD	0.5
Injections	0.1
Condom	3.8
Female sterilized	0.9
Abstinence	3.2
Withdrawal	2.5
Total	100.0

Table 6 Percentage using contraception among currently married 15–19-year olds by states and territories of India—2005 (Arranged in ascending order)—NFHS-3

Jammu	4.8
Bihar	5.4
Maharashtra	6.3
Meghalaya	6.4
Andhra	6.7
Punjab	6.8
Himachal	6.9
Jharkhand	7.0
Kerala	7.8
Orissa	7.9
Mizoram	8.3
Haryana	8.6
Uttaranchal	9.0
Rajasthan	9.2
Karnataka	10.0
Chhattisgarh	10.3
Gujarat	11.2
Nagaland	11.8
Madhya	13.0
Tamil	13.7
Uttar	14.6
Manipur	18.8
Arunachal	19.1
Goa	19.6
Delhi	19.7
Sikkim	23.1
Assam	28.2
Tripura	34.9
West	39.4

One of the indicators of safe pregnancy is the number of antenatal visits. NFHS-3 data present a discouraging observation in this regard. About 9 % of the 15–19-year olds in the NFHS-3 sample had at least one child (children ever born). However, nearly 20 % of them never had an antenatal visit (See Table 4).

Nearly 50 % of them had only two or fewer visits. Thus, adolescents in regions such as the northeast not only begin child bearing early but also have inadequate medical care increasing the likelihood of undesirable outcomes such as infant mortality and maternal mortality. Table 5 presents data on the level of contraceptive use among female adolescents.

A very high proportion, nearly 86 %, does not use contraception. About 6 % use traditional methods such as periodic abstinence and withdrawal. A low level of contraceptive use may be either due to unavailability of contraceptives or because of a desire to have children. A detailed state-wide breakdown of contraceptive use estimates are given in Table 6.

On average, about 14 % of adolescents use contraception. The states with level of contraceptive use higher than the national average are Uttar Pradesh, Manipur, Arunachal Pradesh, Goa, Delhi, Sikkim, Assam, Tripura, and West Bengal. Contraceptive use among adolescents is highest in West Bengal and lowest in Bihar. The states with the lowest mean number of children, such as Tamil Nadu, Kerala, and Punjab, have contraceptive use levels below the national average.

The preconditions for transition to low fertility are an increase in years of schooling among adolescents and late age at entry into marriage. Late age at marriage is perhaps less important as adolescents stay longer in school to complete desired levels of education, entry into marriage is likely to be delayed. For this reason, an increase in years of schooling among adolescents is strongly associated with declining fertility, increases in modern contraceptive use, and well-being.

Almost all the states, except Rajasthan, with mean years of education among female adolescents with less than secondary school, about seven years, are in the north and northeastern region of the continent. Bihar has the lowest mean level of education among female adolescents. All the states with eight or more years of education are in the southwest region comprising Kerala, Goa, Tamil Nadu, Andhra Pradesh, and Maharashtra. The other states with high mean level of education are Haryana, Punjab, Himachal Pradesh, and Delhi. The difference in mean years of education between adolescent males and females is related to variance in status differentials. When male adolescents enjoy significantly higher levels of education than females, it is often due to cultural biases in favor of the male child. Table 7 suggests that in states where the mean level of education for females is 7 years or lower, significant education differentials tend to exist either in favor of males or in favor of females. However, when mean level of female education is 8 years or higher, the differential tends to be small and slightly in favor of males.

The states where high level of female education coexists with minor male–female education differences are Punjab, Uttaranchal, Delhi, Maharashtra, Tamil Nadu, Goa, Himachal Pradesh, and Kerala. Here again, a large number of states from the southern region, Maharashtra, and a few states in the north such as Punjab, Delhi, and Himachal Pradesh show gender parity in terms of education. This parity is yet another advantage over the high mean level of education, both likely to influence adolescent fertility and also well-being.

In general, the northeast region has poor levels of education compared to the south, southwest, and a few northern states enjoying relatively higher level of education among adolescents. The rest of the country may be placed in between (a middle region) the two regions with high and low levels of adolescent education. Thus, it is likely that fertility transition will occur in the south, southwest, and a few northern regions first, and finally the northeastern regions proceeded by the states in the middle region.

Apart from education, income levels influence adolescent fertility and also well-being. The economic status of the adolescent's household is measured using the wealth index which is a

Table 7 Mean and 5 % trimmed mean number of years of education among 15–19-year-old females by states and territories of India—NFHS 2005

State	Mean	5 % trimmed	Difference
Bihar	4.82	4.68	0.90
Rajasthan	5.02	4.87	1.90
Jharkhan	5.18	5.05	0.20
Arunachal Pradesh	5.31	5.25	−0.20
Chhattisgarh	5.98	5.95	1.20
Uttar Pradesh	6.22	6.17	0.90
Orissa	6.24	6.23	1.20
West	6.28	6.30	0.70
Tripura	6.43	6.50	−1.20
Assam	6.65	6.70	−0.60
Meghalay	6.97	6.86	−0.30
Sikkim	6.89	6.97	−0.50
Madhya	6.96	6.98	1.30
Gujarat	7.17	7.24	1.30
Nagaland	7.16	7.27	0.50
Jammu & Kashmir	7.29	7.40	0.70
Manipur	7.67	7.86	0.70
Mizoram	7.73	7.88	−0.10
Karnataka	7.74	7.88	0.60
Haryana	7.89	8.04	1.20
Punjab	7.90	8.06	−0.10
Uttaranchal	7.96	8.11	0.00
Andhra	8.01	8.15	1.30
Delhi	8.22	8.38	0.30
Maharashtra	8.65	8.86	0.10
Tamil Nadu	9.32	9.52	0.10
Goa	9.53	9.74	−0.10
Himachal Pradesh	9.75	9.91	0.30
Kerala	10.50	10.55	0.00

*Difference between male and female mean number of years of education estimated using IHD-2005 Data: Desai et al. (2008)

composite of information on 33 household assets and housing characteristics, such as ownership of consumer items, type of dwelling, source of water, and availability of electricity. The index was composed specifically for the NFHS-3 survey. Table 8 presents the mean wealth index values arranged in ascending order by state.

The lower end of the wealth index distribution, below the mean 3.5, is made up of states such as Chattisgarh, Jharkhand, Orissa, Tripura, Bihar, and Assam. The upper end is composed of Himachal Pradesh, Punjab, Sikkim, Goa, Mizoram, Kerala, and Delhi. Other states fall in between these two groups. The wealth index is correlated positively with female education (0.611, $p < 0.01$) and negatively with number of children (−0.615, $p < 0.01$) and proportion of female adolescents married (−0.592, $p < 0.01$).

To further investigate the social context of adolescent well-being at the state level, indicated by low likelihood of marriage and few children, we factor-analyzed all the variables thus far discussed in relation to adolescent fertility. The variables factor-analyzed are as follows:

Table 8 Mean and 5 % trimmed mean of wealth index among 15–19-year olds by states and territories of India (Arranged in ascending order of 5 % trimmed mean)—NFHS-3

State	Mean	5 % trimmed
Chhattisgarh	2.49	2.43
Jharkhand	2.53	2.48
Orissa	2.56	2.51
Tripura	2.86	2.85
Bihar	2.90	2.89
Assam	2.95	2.94
West Bengal	3.11	3.12
Arunachal Pradesh	3.11	3.12
Uttar Pradesh	3.11	3.12
Rajasthan	3.14	3.16
Madhya Pradesh	3.16	3.18
Karnataka	3.22	3.25
Tamil Nadu	3.41	3.45
Manipur	3.47	3.50
Jammu & Kashmir	3.66	3.70
Meghalaya	3.64	3.71
Nagaland	3.65	3.71
Uttaranchal	3.67	3.74
Gujarat	3.70	3.77
Haryana	3.74	3.80
Andhra Pradesh	3.77	3.86
Maharashtra	3.85	3.95
Himachal Pradesh	4.01	4.09
Punjab	4.07	4.15
Sikkim	4.16	4.24
Goa	4.19	4.28
Mizoram	4.10	4.29
Kerala	4.23	4.32
Delhi	4.47	4.55

Table 9 Levels of female adolescent reproductive health by states of India

Level 3	Level 2	Level 1
Bihar	Meghalaya	Sikkim
Rajasthan	Assam	Maharashtra
Jharkhand	Karnataka	Mizoram
Uttar Pradesh	Tripura	Punjab
Chhattisgarh	Nagaland	Delhi
Madhya Pradesh	Gujarat	Tamil Nadu
Orissa	Uttaranchal	Himachal Pradesh
Arunachal	Manipur	Goa
Haryana	Jammu & Kashmir	Kerala
West Bengal	Andhra Pradesh	

mean number of children, mean number of years of schooling, mean wealth index value, mean percent of female adolescents married, and difference in the mean level of education of male and female adolescents. Factor analysis yielded one factor score based on the composite of all the variables, and the states were then rank-ordered using the factor score scale values. The distribution was divided into approximately three equal groups composed of 9–10 states as presented in Table 9.

The group labeled 'level 3' is composed of states where the aggregate level of adolescent well-being is the lowest. These states have a high proportion of married adolescents, low level of education, high levels of gender inequality with regard to education, low level of wealth index value, and large mean number of children. The group labeled 'level 1' is composed of states where adolescent well-being is highest in the country. Kerala, Tamil Nadu, Punjab, Maharashtra, and Delhi are the most likely to experience further reductions in adolescent fertility. Declining fertility among adolescents is strongly correlated with levels of adolescent well-being.

Medical Issues

Pal et al. (1997) conducted a retrospective study of the obstetric behavior and outcomes in 80 teenage pregnancies in Simla. They found 27.5 % of the teenagers suffered from anemia, 28 % from intra-uterine growth retardation, and 15 % from hypertension. The most common form of anemia in India is iron deficiency anemia. Available estimates suggest that almost 1 % of young women (15–24) are infected with HIV (Santhya and Jejeebhoy 2003). A large proportion of pregnant adolescents suffer from poor fetal growth, obstetric risks, maternal and infant mortality, literacy, and school dropouts (Bhatia and Chandra 1993). In India, adolescents suffer from very high maternal morbidity risk in addition to a very high perinatal mortality rate (IIPS 2007). Gynecological problems such as hypermenorrhea, hypomenorrhea, menorrhagia, and dysmenorrhea are reported by almost 40–45 % of adolescent girls (Chakravarthy 1989). A majority of adolescent girls have no knowledge of menstruation (Gupta 1988). Reproductive tract infections are also very common (Ramasubban 1995). Infants born to adolescent mothers are likely to suffer significantly lower birth weights than infants born to mother 20 years or older. Kushwala et al. (1993) report that 67.3 % of all live births to adolescents in their study sample were of low birth weight. Congenital anomalies and birth injuries were seen in 13 % of all newborns.

Discrimination is a major influence on malnutrition among adolescent girls. Adolescent boys are favored over adolescent girls. This discrimination influences the allocation of resources within the family. Adolescent girls often receive a poor share of family resources for health expenditures such as nutrition and medical care. Adolescent girls internalize this discrimination and as a result suffer low self-esteem. The SERC (1998) survey found that in Uttar Pradesh, a majority of adolescent girls felt that they were a burden on their families. When poverty is combined with discrimination, outcomes can be harsh on the lives of adolescent girls in particular. One of the horrific outcomes of this disadvantage is the trafficking in adolescent girls (Sibnath 2005). Girls living in slums are particularly vulnerable to trafficking. In the metropolitan area of Calcutta alone, more than one million children and adolescents live in slums. Nearly 60 % of sex workers in Delhi brothels were found to be adolescent girls (Debabrata 1998). The proportion of trafficked adolescent girls is highest in West Bengal (Sibnath 2005). Moreover, almost all parents of the trafficked girls were illiterate and about 90 % of these girls were sexually abused during childhood (Sibnath 2005). According to Indian crime statistics, about 25 % of all reported rape cases in 1990 involved children and adolescent girls (Sivaraman 1998).

Another outcome of chronic poverty is the burgeoning population of street boys and girls.

There are no highly reliable estimates available on the number of street children in the country. One estimate suggests that 11 million children live on the streets, and there are more than 44 million child laborers in India in all (Karkal 1991). Young women who live in the street are more likely to be trafficked, raped, and victimized. Patro (1997) found two cases of HIV in a small sample of 14 street children. Another two had syphilis.

In sum, Indian adolescents face several health risks. About 9 % of the 15–19-year olds in the NFHS-3 sample had at least one child ever born. Nearly 20 % of the adolescent mothers never had an antenatal visit. In addition, a large proportion of them also experienced pregnancy without adequate medical care, increasing the likelihood of undesirable outcomes such as infant and maternal mortality.

A very high proportion, nearly 86 %, does not use contraception. Indian adolescents suffer from a very high maternal morbidity risk and perinatal mortality rate. Reproductive tract infections are common. Infants born to adolescent mothers suffer significantly lower birth weights than infants born to mothers 20 years or older. Congenital anomalies and birth injuries are commonly seen among adolescent mothers.

Discrimination is a major cause of malnutrition among adolescent girls. Adolescent boys are favored over adolescent girls. This discrimination influences allocation of family resources. Adolescent girls often receive a poor share of family resources for health expenditures such as nutrition and medical care. Adolescent girls are also less likely to receive an education than are boys. Thus, higher education among adolescent girls remains restricted in a few states such as Sikkim, Maharashtra, Mizoram, Delhi, Tamil Nadu, Himachal Pradesh, Goa, and Kerala. Young girls trapped in poverty are more likely to be sexually exploited and trafficked. About 25 % of all reported rape cases in 1990 involved adolescent girls and children. In West Bengal, the proportion of trafficked adolescent is the highest.

In light of all disadvantages adolescent girls suffer from, programs and policies are immediately necessary to protect adolescent girl's health in India. Education that focuses on common reproductive health problems, contraception, and pregnancy care is necessary to curb the current levels of infant and maternal mortality. Significant inputs into improving adolescent health cannot be made without improving literacy and eradicating discrimination against girls both in public and private spheres.

Adolescent Policy

Though the adolescent population accounts for a large proportion of the Indian population, this segment has been neglected at the policy level. As a result, there are very few policies and programs targeting adolescents. On a positive note, support for this traditional neglect has declined significantly in recent years. There is not only an active discussion in policy circles for designing programs for the adolescent, but also a few initiatives such as the Reproductive and Child Health (RCH) programs have already been launched.

Perhaps, the most prominent of all the governmental programs for adolescents in the area of reproductive health is RCH, which began in 1996. Services are provided through an existing network of primary health care centers in India. The major part of the program includes the prevention and management of unwanted pregnancy, services to promote safe motherhood including emergency obstetric care, services to promote child survival, prevention and treatment of respiratory tract infections (RTIs) and sexually transmitted diseases (STDs), and establishment of an effective referral system, reproductive services for adolescent health, sexuality, gender information, education, and counseling. Thus, the RCH Program is related to all aspects of safe motherhood and child survival. The program also provides contraceptives,

gynecological services, as well as cancer screening for adolescents and young women.

Integrated Child Development Services Scheme

The scheme was initiated in 1975 and represents one of the world's largest and most unique programs for early childhood development. The program attempts to break the cycle of malnutrition, morbidity, reduced learning capacity, and mortality. Six types of services are provided: supplementary nutrition, immunization, health checkups, referral services, preschool non-formal education and nutrition, and health education. Nutrition and health services are available to all women above the age of 15 years. The scheme services are rendered essentially through the 'Anganwadi' worker (sex worker) at a village center called 'Anganwadi.' The ICDS scheme covers almost 80–90 % of the blocks in the country. There is also an increasing focus on girl children under the scheme.

The ICDS scheme has also spearheaded a special intervention for girls 11–18 years of age to meet their special nutrition, education, and skill development needs. In 2000, this scheme enrolled nearly 3.9 million adolescent girls in 507 blocks throughout the country. The scheme has two subsets of target groups: the Girl-to-Girl program for adolescent girls aged 11–15 and the other focusing on reaching adolescent girls aged 11–18.

Two specific schemes to prevent dropout among young adolescent girls are the District Primary Education Program and the Baika Samriddhi Yojana, which began in 1977. The Department of Education has adopted specific strategies designed to promote girls' enrollment and retention in school. As of 2000, nearly 220 districts in 15 states were covered under the program. The states of Baika, Samriddhi, and Yojana provide financial assistance to the newborn mother in the form of grants and investments through postal services toward the education of the girl child. The deposits will mature and will be paid to the girl if she remains unmarried until she became 18.

The National Service Scheme (NSS) is a student-oriented program primarily focused on personality development and community service. The NSS engaged more than 1.6 million students in 2000, including students from senior secondary. Several non-governmental organizations (NGOs), such as SUTRA, ADITHI, and Prerana have programs in India in the area of adolescent reproductive health. Much of this program is supported by international organizations such as the United Nations, United States Agency for International Development, United Nations Fund for Population Activities, World Bank, and World Health Organization.

SUTRA provides a range of services to adolescents with a focus on empowerment. It is based in the hilly region of Jagjit Nagar, Himachal Pradesh. It runs several programs to sensitize and empower adolescent girls (13–20 years old) on gender issues related to health, violence, and economic independence. In 'Awareness Generation Camps,' female adolescents are taught physiology and made aware of the structure of patriarchy and its implications for her ability to exercise her rights as a woman. They also conduct several 'Leadership Development and Capacity Building' workshops to improve political awareness and self-confidence.

ADITHI, established in Bihar in 1988, has been working on issues of adolescent girls aged 10–18 since 1995. It has initiated campaigns specifically for securing legal and social rights for women, focusing specifically on adolescent girls aged 11–18. It has established a number of awareness centers (called Kendras) for building communities where men and women have equal status. All adolescent girls are encouraged to participate in the work of the Kendras, enabling participating young women to learn the concepts of rights and to build self-confidence. In Bihar, there are now nearly 20 Kendras in about 20 villages where adolescent girls are disproportionately disadvantaged compared to girls in other states.

Prerana is a grassroots organization with considerable financial, technical, and managerial resources working on community-based models of distribution of contraceptives, and life skills for adolescent girls and boys. Prerana has

involved more than 15,000 adolescents in vocational training, non-formal education, life skills, and family life education during the last two decades. Prerana now operates in 43 self-sustaining centers in six villages, mainly in Bihar.

In general, most non-governmental organizations tend to be located in urban areas at the neglect of the rural adolescents. Even in urban areas, where the NGOs serve, their impact is limited, as most of them tend to be small-scale operations limited in their capacity for outreach. In addition, the ability to outreach is constrained by the presence of a pervasive negative and conservative attitude against providing reproductive health services to adolescents. Female adolescents are expected to be sexually ignorant and inactive, requiring very little reproductive health services. In order to circumvent this problem, many NGOs have devised integrated methods of providing services most often in general health service settings. With this method, adolescent health services are offered along with vocational training classes, tutoring classes, in camps, and in classrooms (http://www.cedpa.org/images/ENABLE%20pubs/India%20ARH.pdf; Accessed 24 July 2010).

In spite of the mounting evidence of poor adolescent health, especially in the area of reproductive health, there is no public policy to promote sex education and reproductive health knowledge among adolescents. A number of proposals such as the ‘adolescent education programs’ were presented in the parliament in 2009. The parliamentary committee on petitions rejected them stating that sex education is against the social and cultural ethos of the country. They instead recommended education in naturopathy and Ayurveda (Indian system of medicine) as desirable knowledge for the young to possess rather than sexual knowledge. Adolescents have very little access to systematic knowledge on contraception and contraceptive use. Nearly half the girls enter into marriage with very little knowledge of sexuality.

In addition to health policies elsewhere, there are no social welfare policies for improving adolescent reproductive health. A few policies under the rubric of ‘social defense’ provide protection and assistance to women who are trafficked. These programs are often designed and implemented by state governments. Therefore, there is wide variation in the provision of assistance under the policy across states. A few states such as Tamil Nadu have recently taken more progressive steps in specifying program goals many of which target adolescent reproductive health. The following is a list of items under the Tamil Nadu 18-Point Program for women and children’s welfare.

1. Improving the health of adolescents, especially adolescent girls
2. To liberate women from the shackles of early and frequent child bearing
3. Eradication of female feticide and female infanticide
4. Social Welfare 340
5. Reduction in low birth weight
6. Elimination of vaccine for preventable diseases
7. Prevention of disability in early childhood and early detection and intervention
8. Early childhood care and development (ECCD): Focus on parenting role and responsibilities during the first 3 years of life
9. Reduction in Infant Mortality
10. Reduction in severe and moderate malnutrition among 0–3-year-oldchildren
11. Elimination of micronutrient deficiencies
    a. Elimination of Vitamin A deficiency
    b. Elimination of iodine deficiency disorders
    c. Reduction of anemia in children, adolescent girls, and pregnant women
12. Popularizing girl child protection scheme and improving the status of the girl child
13. Make all hospitals and maternity centers women and children friendly
14. Prevention and early child identification of heart diseases and free open heart surgeries for children
15. Elimination of child labor
16. Ensuring 8 years of schooling for every child
17. A safe drinking water supply and better access to sanitary facilities at all schools and child care centers

18. Raising women's literacy and status
19. Empowerment of women through self-help groups.

Conclusion

In general, the characteristics of the teenage pregnancy problem in India are different from the nature of teen fertility problem in the West. One difference is that most teenagers become pregnant within marriage. There are also regional differences in the magnitude of the problem of teenage pregnancy within India. Most teenage girls are poorly educated and have lower level of education compared to teenage boys. In almost all of the states in the north and northeastern region of the continent, except Rajasthan, the mean years of education among female adolescents is less than secondary school. Meanwhile, all states with 8 or more years of education are in the southwest region comprising Kerala, Goa, Tamil Nadu, Andhra Pradesh, and Maharashtra. Even in states where the mean level of female education is 8 years or higher, the educational gap between girls and boys tends to be small but in favor of boys.

In general, most teens grow up in poverty. Proportions of teens at the risk of poverty in states such as Chattisgarh, Jharkhand, Orissa, Tripura, Bihar, and Assam are much higher than in the rest of the country. Teenage pregnancy is correlated with poverty. Indian states such as Kerala, Tamil Nadu, Punjab, and Maharashtra where adolescent well-being is higher than in the rest of the country, teenage fertility tends to be low.

Adolescent girls suffer from low self-esteem as they are discriminated against in their own family settings. Growing up in poverty and discriminated against, they become vulnerable to sex trafficking. Newly married teens have very little power to control their fertility. The decision to have a child is often made by the husband and in-laws. Growing up in poverty, teenagers face several health risks during their first pregnancy. In spite of the risks they face, only a few seek medical care. Nearly 20 % of the adolescent mothers never had an antenatal visit. Finally, there is no public policy in India to promote neither sex education nor reproductive health knowledge among adolescents. A number of proposals such as the 'adolescent education programs' were presented but never passed in the parliament in 2009. There are a number of reproductive health programs. These programs reach only a very small proportion of pregnant teenagers.

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Sociocultural Context of Adolescent Pregnancy, Sexual Relationships in Indonesia, and Their Implications for Public Health Policies

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Keywords

Indonesia: adolescent pregnancy · Cohabitation · Contraception · Informal sexual information · Low female status · Maternal morbidity · Postpartum fecundability · Premarital sex · Sexual and reproductive health · Sociocultural context · Virginity · Youth sexual culture

Introduction

Adolescent pregnancy is very common in Indonesia, but only considered to be a social problem by the general populace in those relatively rare instances where it takes place outside marriage. In contrast, there has long been great concern within Indonesian medical circles with a range of medical consequences associated with (such primarily marital) adolescent pregnancy and the political obstacles that prevent health practitioners from addressing the sexual and reproductive health (SRH) needs of unmarried adolescents.

We structure this chapter in terms of four broad sections: firstly, an introduction to the profile of this enormous archipelago; secondly, a contextual review of some of the basic parameters of adolescent fertility, marriage patterns, age of first intercourse, contraceptive use, and educational levels; thirdly, an elaboration of the youth sexual culture that shapes the nature of adolescent pregnancy in Indonesia; and fourthly, a concluding discussion of the nature of, and obstacles to, appropriate contraceptive service provision for adolescents. Throughout the chapter, we seek to shed light on these processes and debates by recurrent reference to the key themes of Indonesian culture and policy. Thus, the chapter seeks to move from context, to a richer exploration of sexual lifestyles, and to policies and programs that seek to enhance youth SRH in Indonesia.

Profile of Indonesia

The Republic of Indonesia encompasses an archipelago stretching along the equator, which consists of approximately 17,000 islands, with a total population now over 236 million, and

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located between Asia and Australia. There are five major islands: Sumatera in the west; Java in the south; Kalimantan and Sulawesi in the middle running along the equator, and Papua on the east bordering New Guinea. Other important islands include Maluku in the north, and Bali and Nusa Tenggara in the south. The Indonesian archipelago forms a part of the 'Pacific Ring of Fire,' which is prone to earthquakes, tsunamis, and volcanic eruptions. A tsunami in December 2004 killed more than 150,000 people in Indonesia, with most casualties in the province of Aceh.

Indonesia is the fourth most populous country in the world, with around 300 ethnic groups; approximately 45 % of the population are Javanese, 14 % Sundanese, 7.5 % Madurese, 7.5 % Coastal Malays, and 26 % classified as others. The large number of islands and the variety of ethnic groups with their own local languages across such a wide area has given rise to a diverse culture that the country recognizes in the national motto of 'Unity in Diversity' (CBS and Macro-International 2008a). The national ideology of *Pancasila*, which seeks to foster national integration, explicitly expresses the goals of toleration, diversity, and plurality. However, unfortunately outbursts of ethnic and religious conflict and violence have occurred in particular localities (Vatikiotis 1994).

Indonesia has experienced several political shifts since proclaiming its independence in 1945 and has also faced several political problems caused by ideological, ethnic, and racial differences. The first political period under Suharto was characterized by considerable political conflict and deepening economic stagnation (Fryer 1970). When a new era began with the establishment of the New Order government in 1965, Indonesia made substantial progress, particularly in stabilizing political and economic conditions (Vatikiotis 1994; CBS and Macro-International 2008a).

In 1998, Indonesia entered its worst economic crisis since its independence, when the economic growth rate dropped to minus 13 % (CBS and Macro-International 2003) and the political situation become unstable in several regions. During this period, the highly centralized New Order regime collapsed and was replaced by the recent and continuing Reform Era. For the first time in Indonesia's history, the president was elected directly through general election in 2004. At the same time, based on Law No. 22 1999, decentralization to regional government was enacted by giving fuller autonomy to the district (municipalities and districts) level. With some limited exceptions, the local government has responsibility for all decentralized central government ministries at provincial and district levels. In line with this change of paradigm from centralized to decentralized government, family planning affairs have also been handed over to district government. The fundamental change of political paradigm has also been made by the National Family Planning Coordinating Board (BKKBN) at central level to reformulate their strategic management, and vision and mission (CBS and Macro-International 2008a).

According to the Basic Health Survey of 2009 (Ministry of Health 2009), the population of Indonesia was about 236 million with a population growth rate that has declined from 1.98 % between 1980 and 1990 to 1.49 % between 1990 and 2000. It is projected to decline further between 2000 and 2010. It was also estimated that 42 % of the population lived in urban areas and 58 % in rural areas (CBS 2002). Almost 59 % of the total population lives in Java, which covers only 7 % of Indonesia's total land area. In contrast for instance, only around 1 % of the country's population lives in Papua, which makes up approximately 19 % of the total land area of Indonesia (CBS and Macro-International 2008a).

In terms of population structure, there were more than 30 million people aged 10–24 years. Adolescents (10–19 years old) comprise 19.3 % of Indonesia's population, with adolescent boys accounting for 19.9 % and adolescent girls for 18.8 %. The Indonesia Demographic Health Survey (IDHS) 2007 shows that Indonesia is in a demographic transition from a younger to an older-aged population structure (CBS and Macro-International 2008a). The proportion of

the population below the age of 20 has decreased from 51.9 % in 1970 to 38.5 % in 2005. Simultaneously, the population above 60 years has increased from 5.2 % in 1970 to 7.3 % in 2005. Changes in the age structure result mainly from a decline in fertility rates. Findings from 2002 to 2003 of IDHS indicate that there has been a steady decline in fertility from 5.6 children per woman in 1970 to 3 in 1991 to 2.6 per women in 2001–2002 (CBS and Macro-International 2008a).

Although 85 % of the Indonesian population is Muslim (the largest Muslim population in the world), it is not a 'fundamentalist' Muslim country (Arkoun 2003; Masqood 1994). It has a much more tolerant form of Islam than is found in many other parts of the Muslim world (Hefner 2002). However, Islamic values and teaching have an important place in the lives of many of its people (Ford et al. 1997). Many people combine their formal Islamic identity with a range of practices and beliefs drawn in different parts of the archipelago from for instance, animism, mysticism, and meditational disciplines. The remainder of the Indonesian population are primarily Christian, but with smaller proportions from other religions. Javanese in particular take pride in their cultural traditions of self-control and tolerance and preserve a strong social hierarchy through both their behavior and language (Hull et al. 1977). These cultural tendencies are further elaborated below with reference to their influence on the expressions of Javanese youth sexual culture (Fig. 1).

The Broad Context of Indonesian Policy to Address Adolescent Pregnancy

In terms of adolescent pregnancy, Indonesia's concerns with fertility are intertwined with a whole list of associated social and health consequences, such as unwanted pregnancy, maternal mortality and morbidity, abortion, and STDs (including HIV/AIDS). The government of Indonesia has faced great difficulty in attempting to develop programs and policies to deal with the reality of SRH problems, particularly those for young people (Utomo 2002). Although the government has started to provide SRH information to young people, it is more commonly in response to concerns about HIV/AIDS, rather than unwanted pregnancy or unsafe abortion (Utomo 2003). The major criticism of such programs is that they only run sporadically and reach only small numbers of young people. The SRH needs of unmarried young people have been largely ignored by existing health services (Utomo 2003).

There is much debate within Indonesia concerning the most effective socially and culturally desirable SRH education and services for young people (Ford and Siregar 1998). The diverging perspectives between what may be described as 'moralistic' and 'pragmatic' groups often impede the implementation of youth SRH programs (Ford and Siregar 1998). Conservative perspectives argue that premarital sexual activity is simply socially unacceptable and that unmarried

Fig. 1 Indonesian Archipelago

young people should not be provided or 'contaminated' with sexual health education, because it is believed that such education programs lead to increased sexual activity among young people. The liberal view in Indonesia argues that while premarital sexual activity is not necessarily socially desirable, it nevertheless does take place, and needs to be properly addressed by health and educational services (Ford and Siregar 1998). There are many informal sources of sexual information and images, including films and pornographic materials, which are easily accessible to young people in Indonesia. However, this information is often designed to stimulate and titillate rather than educate young people on sexual matters (Jones 2001).

As noted above, Indonesia is currently undergoing a radical transition through tumultuous changes toward greater social openness and debate, concomitant to the fall of the authoritarian 'New Order' in 1997. The current relaxation of censorship and control provides the opportunity for more open expression between conservative and liberal Islamic groups in a contestation of sexuality. While more liberal sexualized images and literature are becoming available in the Indonesian media, conservative groups have hit back, for instance in criticism of supposedly erotic *dangdut* dance/music and the publication of the controversial 'Playboy' magazine, even though the Indonesian version is less explicit than the original. The recently passed anti-pornography law has been used to attack public figures accused of placing video sex scenes over the Internet to the public recently (Dipa 2011).

Prior to a fuller discussion of the wider sociocultural context related to adolescent pregnancy, it is important to discuss some aspects related to pregnancy among the young, including adolescent fertility, proximate determinants of fertility, changes in marriage patterns, estimates of premarital intercourse, contraception use, premarital pregnancy, and abortion.

Adolescent Fertility/Pregnancy

The issue of adolescent fertility is of course important for a range of health and social reasons. Adolescent childbearing has well recognized potentially negative demographic and social consequences (Blum 1991). Children born to very young mothers face increased risk of illness and death (CBS and Macro-International 2008a). Adolescent mothers, especially those under aged 18, are more likely to experience adverse pregnancy outcomes and maternity-related morbidity and mortality than more mature women. In addition, early childbearing limits an adolescent's ability to pursue educational opportunities (CBS and Macro-International 2008a).

It is important to note that although Indonesia has been fairly successful in reducing total fertility, much more limited progress has been made in addressing maternal mortality. Furthermore, short of mortality, there is a much greater problem of maternal morbidity that blights the lives of many women of poor backgrounds in Indonesia. Siregar's study of maternal morbidity in West Java showed that such health vulnerabilities were strongly associated with a young age of pregnancy, poor nutrition and associated anemia, and low female status within the conjugal unit (Siregar 1999) (Tables 1, 2, 3).

Age of first marriage and intercourse are generally used as proxy measures for the beginning of exposure to the risk of pregnancy. The Indonesian Demographic and Health Survey (IDHS) 2007 has collected information on the timing of first sexual intercourse for women and men (CBS and Macro-International 2008a). The IDHS 2007 shows that data of age at first intercourse was not so different from age at first marriage, as age at initiation of sexual intercourse coincides with marriage. In Indonesia, marriage is closely associated with fertility because the overwhelming majority of births occur within marriage (CBS and Macro-International 2008a). However, since premarital sex is considered socially unacceptable, there may

Table 1 Adolescent-specific fertility rate (per 1,000 live births) and total fertility rate Indonesia, 1991–2007

Age	1991	1994	1997	2003	2007
15–19	67	61	62	51	51
20–24	162	147	112	131	135
Total fertility rate	3.0	2.9	2.8	2.6	2.6

Source IDHS (CBS 1992, 1995, 1998; CBS and Macro-International 2003, 2008a)

Table 2 Maternal mortality rate (per 1,000) and maternal mortality ratio (per 100,000 live births) in 2003–2007

Age	2003	2007
15–19	0.08	00.10
20–24	0.19	0.12
Total (age 15–49)	0.24	0.18
Maternal mortality ratio	307	228

Source IDHS (CBS and Macro-International 2003, 2008a)

Table 3 Maternal morbidity (percentage of last births with complication during pregnancy) in 2003–2007

Complications of pregnancy	2003	2007
Premature labor	1.9	2.4
Excessive vaginal bleeding	1.9	2.7
Fever	0.5	1.0
Convulsion and fainting	0.4	0.4
Fetus in breech position	n.a	1.3
Swelling	n.a	0.3
Hypertension	n.a	0.4
Dizziness	n.a	0.4
Other	4.0	4.0

Source IDHS (CBS and Macro-International 2003, 2008a)

be a lack of accurate data available on, and possible underestimation of the proportions of women and men who engage in sexual activity before, and later, outside of marriage. Teenagers who have never married are assumed to have had no pregnancies and no births (CBS and Macro-International 2008a).

The IDHS 2007 data also show that 9 % of Indonesian women aged 15–19 have begun their childbearing. Compared with the results of the IDHS 2002 survey, there has been only a small decline in the proportion of adolescents who have begun childbearing, from 10 % to the current level of 9 %. It shows that the level of early childbearing is still substantial in Indonesia particularly in rural areas. There is an inverse relationship between early childbearing and educational and socioeconomic levels in Indonesia (CBS and Macro-International 2008a). The delay of first birth as a result of an increase in the age at marriage has contributed to a decline in fertility. The median age at first birth has increased from 20.4 for women 45–49 to 22.5 years at women age 25–29, indicating this gradual change (CBS and Macro-International 2008a).

Proximate Determinants of Fertility

Bongaart's proximate determinants model TFR = Cm × Cc × Ca × Ci (Bongaarts and Porter 1983) was used to estimate the relative importance of key factors contributing to fertility decline in Indonesia. The impact of the indices for marriage, contraception, and postpartum fecundability were estimated, respectively.

The model was used with (potentially maximum) total fecundity (TF) average of 15.3 and the Indonesian TFR of 2.6 in 2007. The index of abortion in the model was set at 1.0–0.5 due to lack of data availability as recommended by Bongaarts and Porter (1983) for the countries with TFR less than three. This result indicated that the estimated contraceptive index (Cc) was 0.45 therefore contraceptive use has had the highest role in reducing the effect of fertility in Indonesia by 55 %. This confirms that the major determinant of fertility in modern times in Indonesia is the use of contraception to regulate fertility since Indonesia has officially accepted nationwide family planning since 1970.

Based on the results of IDHS in 2007, the age-specific proportion of married females was counted as 0.72 and age-specific marital fertility counted as 2.4×10^3, thus the estimated index of marriage (Cm) was 0.865, indicating that the inhibiting effect of (non and delayed) marriage on fertility is 13 %. The contribution of the index of marriage on fertility was due to delayed entry of women into marriage due to acquisition of higher level of education.

In terms of the index of postpartum infecundability (Ci), IDHS 2007 data showed that the mean duration of breastfeeding is estimated to be six months. The estimate index of postpartum infecundability (Ci) is 0.84, which means the contribution of postpartum infecundability in reducing fertility due to breastfeeding is 16 %.

Changes in Marriage Patterns

Given that most adolescent pregnancy in Indonesia takes place within marriage, it is important to review the recent trends in marriage. As in every country of Asia, both men and women are marrying later than they did in the past (Cleland and Hobcraft 2011). However, the rise of age at marriage in Indonesia has been less obvious than in many other countries (Jones 2001). In particular, in some rural areas people still favor early marriage and relatively large numbers of children. Jones (2001) found that age at marriage for females has traditionally been very young, especially in rural areas of West Java and among the Madurese population of East Java. In the past, some of the reasons for acceptance of early marriage and births of many children were the need for sharing the burden of taking care of their parents when these parents had become elderly; and the need for contributing toward the family income and welfare. So a high value was placed on the status of being married and negative value on the status of being single (Achmad et al. 1999). In such traditional settings in Indonesia, a girl who is not yet married after reaching a certain age (for instance age 16) will be derogatively referred to as an 'old maid,' encouraging some parents to 'marry off' their daughters at very early ages. Although a very young age at marriage for females still characterizes certain ethnic groups and geographic regions of Indonesia, in all cases the median age is rising (Jones 2001).

IDHS 2007 data show there has been substantial change in the age of marriage for women. The data show that 19 % of women aged 45–49 married at age 15 were compared with 9 % of women aged 30–34, and less than 7 % of women aged 20–24 were married by that age. Nevertheless, there continues to be a relatively substantial number (2 %) of women aged 15–19 who were married by aged 15. The National Basic Health Survey 2010 results also show that early marriage (under aged 20) of women is still high (4.8 % of aged 10–14 and 41.9 % of aged 15–19) especially among rural areas in some provinces in Indonesia. In general, urban women marry more than two years later than rural women (21.3 years compared with 18.7 years). Age of first marriage also increases with level of education and socioeconomic status of the family (CBS and Macro-International 2008a).

Some studies also show that there has been a strong positive association between education and age at marriage for females. In West Java, the economic and cultural changes among this previously early marrying population have led to a quite rapid rise in female age at marriage. Young village women nowadays are frequently employed in factories well away from their homes, traveling daily to this work (Jones 2001).

In one recent study, 90 % of such factory women stated that they had the right to marry the man they loved as long as their parents agreed, and all said that marrying under the age of 20 was bad for women (Jones 2001).

People living in urban areas and with higher levels of education are much more receptive to proven scientific findings (for instance regarding health) and outside influences (good and bad) as compared to those living in rural areas. They believe that children now are costly commodities because providing for their food, clothing, school fees, and other school-related costs is expensive. The Javanese context is particularly interesting because historically both women's position and marriage pattern have been somewhat distinctive. Javanese society traditionally has incorporated some major bases of power and independence for women, including economic participation, property rights, and a matrifocal bias in relationships and residence. Culturally, women are considered clever, good financial managers, and equal economic partners in marriage (Malhotra 1997).

Marriage in Java has traditionally been initiated by parents and takes place at early ages for both genders, but more so for women. Since the 1960s, Javanese marriage patterns have changed more with respect to marriage arrangements and divorce patterns than with respect to the timing of marriages. Malhotra (1997) concluded that there are certain bases of gender equality within the traditional system of Javanese marriages. His finding indicated the emergence of gender differences in the urban middle class that are entirely absent in rural Java. Family class and status seem to hold very strong relevance in the urban context for the marriages of daughters, but not at all for sons (Malhotra 1997). Women in the urban setting are much less likely to engage in work before marriage than their rural counterparts, but even for those who do, employment does not seem to be serving as a means of independence or alternative to marriage. Urban Javanese women are more likely than their rural counterparts to attend school and have had a say in their choice of a spouse; they also were less likely to be economically independent (Hollander 1997; Malhotra 1997).

Premarital Sexual Intercourse

Sex before marriage is a relatively uncommon practice and against social norms in Indonesian society, though the rising numbers of adolescent premarital pregnancy indicate that the norm is under increasing pressure. Indonesia Young Adult Reproductive Health Survey (IYARHS) 2007 shows that very few unmarried adolescents admitted having unwanted pregnancies, because pregnancy among unmarried women is socially unacceptable and not sanctioned by religion, therefore such data is not available for Indonesia (CBS and Macro-International 2008b).

Although on a social normative level, premarital sexual intercourse is considered improper behavior for both men and women, in reality social discrimination and stigmatization are more strongly reserved for women, reflecting the 'double standard' found in most Asian countries (Cleland and Ferry 1995). This 'double standard,' however, is much less pronounced in Indonesia than for instance in Thailand (Ford and Kittisuksathit 1994). In Indonesia, premarital sex is also disapproved of for males. IYARHS 2007 showed consistently that the percentage of young men and women aged 15–24 who admitted having sexual intercourse was only 2.7 % of females and 14.2 % of males. Since premarital sex is considered culturally unacceptable for both genders so a strong association between young people's attitude toward premarital sex and their sexual behavior may be expected. The IYARHS 2007 data shows that 22 % of young females and 44 % males aged 15–24 considered premarital sex personally acceptable, perhaps indicating not only the potential for, but also actually higher than the fore-noted admitted, levels of sexual intercourse experience (CBS and Macro-International 2008b).

Sex outside marriage at an early age is very likely to occur in the absence of adequate knowledge of reproductive health and safe sex increasing the risk of unwanted pregnancy, the complications of abortion (illegal in Indonesia), STIs, and HIV/AIDS. Some studies found that SRH education can delay sexual debut, and thus decreasing premarital pregnancy and other

problems including sexually transmitted infections (STIs) and HIV/AIDS (Ford et al. 1992).

Since many ministries have carried out their own SRH-related programs with different focuses and targets, more integrated sexual reproductive health policy needs to be developed as a national plan that can provide direction to SRH education programs that are suitable for the needs of young people (Achmad and Xenos 2001).

Contraceptive Use

The current level of contraceptive use is important for measuring the success of National Family Planning Programs (NFPP) in Indonesia. The objective of NFPP is to institutionalize the norm of the 'small, happy, and prosperous family' with new vision 'all family participate in FP' with a mission to create small, happy, and wealthy families. The concept of the small family promotes regulation of birth intervals and number of children in the family through the use of contraception methods (CBS and Macro-International 2008a).

IDHS 2007 data show that more than 60 % of married women are using contraception, with 57 % of them using modern methods such as injectables, pills, and implants. Traditional methods are no longer popular among married Indonesian women. Among modern methods, injectables are the most commonly used for both currently married and ever married women. Urban women are relying more on IUDs, condoms, and female sterilization; while rural women more commonly use injectables and implant methods. Women aged 15–19 and older women aged 45–50 are less likely to be using contraception than the women in mid-childbearing ages (20–39) (CBS and Macro-International 2008a). With respect to the younger age group, this highlights the point that for many an early first pregnancy is considered highly desirable within marriage. Since premarital sexual relationships are culturally unacceptable in Indonesia, so contraception services are unavailable for unmarried young people. We address the obstacles and progress being made to make such services available to unmarried adolescents in the final section of the chapter on programs and policy.

Premarital Pregnancy and Abortion

Premarital pregnancy and abortion remain highly stigmatized and isolating experiences for single women in Indonesia. Government family planning services are not legally permitted to provide contraception to single women or men and their access to reproductive health care is very limited. Women who experience unplanned premarital pregnancy face personal and familial shame, compromised marriage prospects, abandonment by their partners, single motherhood, a stigmatized child, early cessation of education, and an interrupted income or career (Bennet 2001).

Young women were only able to legitimately continue premarital pregnancy through entering a marriage. Given elective abortion in Indonesia is illegal, and a legal abortion is almost impossible to quantify for, many girls and women, out of necessity, resort to abortion to avoid compromising their future because they are not married (Bennet 2001). Most induced abortions were conducted for unmarried young women, because they have limited knowledge and access to contraception in preventing unwanted pregnancy (Hasmi 2001). Although, they strongly feel that abortion is a sin, many of them consider abortion preferable to continuing with the pregnancy if a man refused to take responsibility for the pregnancy or rejected marriage as a solution. They often argued that causing personal and family shame, having a child out of wedlock and raising a fatherless child, were greater sins than abortion (Bennet 2001). There has been a continuing debate about legalizing abortion in Indonesia (Hull et al. 1993); however, the religious and cultural opposition is so strong that it looks unlikely to pass in the medium term.

Having alluded to a range of key parameters pertaining to adolescent pregnancy in Indonesia, we now turn to a richer exploration of the nature of youth sexual culture that shapes such risk.

Sexual Culture of Young People in Indonesia

There is widespread recognition of the social variability in sexual forms, beliefs, ideologies, identities, and behavior, and the existence of different sexual cultures across the Indonesian archipelago. For instance Acehnese and Minangkabau people have Sharia law to regulate their sexuality. The application of Sharia law in Aceh has increased since the award of greater political autonomy to the province. Thus, in Aceh, the Sharia police seek to prohibit youth sexuality by publicly caning or whipping young men and women caught and suspected of engaging in sex with a premarital partner (Afrida 2007). By contrast in more moderate Java, there is a cultural expectation of socio-personal self-regulation; whereas, Balinese people regulate their forms of sexuality in terms of the Hindu religious strictures. Sexuality has a history, or more realistically, many histories, each of which needs to be understood both in its uniqueness and as a part of an intricate behavioral patterns (Longmore 1998).

The current sexual culture in Indonesia with regard to young people may be usefully understood as interplay of traditional and modern (liberal view) pressures and tendencies. As noted above, the trend toward increasing premarital sexual intercourse is also partially related to the increasing duration of full time education and delays in the age of marriage (Ford and Kittisuksathit 1996). Although the majority of young people still express the traditional values of sexual behavior by disapproving of sexual activity before or outside marriage, some of them are only approving if the couples planned to marry. Yet, the number of teen pregnancies and abortions has been increasing throughout the country since young people have limited knowledge and access to contraception services to prevent their premarital pregnancy (Adioetomo and Achmad 2002).

In the past, it has often been assumed that sexual activity has only increased among urban youth. However, a qualitative study conducted in South Kalimantan by anthropologists from the University of Indonesia suggests that there was no significant difference between urban youth and those of rural areas (Murdijana 1998). Moreover, youth perceptions of pregnancy, abortion, and family planning were the same in urban and rural areas (Murdijana 1998).

Courtship in Indonesia does not involve long-term cohabiting sexual relationships (Bennet 2001). Cohabitation before marriage is considered indecent in Indonesia (Bennet 2001). The derogatory term *kumpul kebo* meaning 'a group of buffaloes' is used to describe couples who live together prior to marriage. Cohabitation is interpreted as deviant and dangerous because of its independence between motherhood and marriage (Bennet 2001). This form of sexual transgression from the hegemony of sexual ideology is particularly offensive because it threatens corporate identity, which includes considerable investment in the ideals of female virginity prior to marriage and the containment of female sexuality within marriage (Bennet 2001).

The value of virginity in conservative Indonesia is regarded as crucial for marriage. Virginity is primarily a concern for the girl's family, which bears the consequences when she bears a child (Utomo 1999). Virginity is valued in those societies in which bastardy has serious deleterious outcomes for families (Abramson and Pinkerton 1995). As expected, virginity is highly regarded among both women and men. Almost all women and men say that it is important for a woman to maintain her virginity (98–99 %). This perception does not vary much by age or residence. However, women and men with less than primary education are slightly less likely than educated respondents to uphold the crucial importance of a woman's virginity (CBS and Macro-International 2008a).

Sociosexual Lifestyles of Unmarried Young People in Indonesia

A map of Indonesia proportionate to size of population would show Java as the most densely settled island, with over 60 % of the total population, but only 6 % of the land area. The

Javanese is the ethnic group that dominates the center of the island (approximately 45 % of total population) (CBS 1995). They comprise the largest single ethnic group not only in Indonesia, but also in Southeast Asia as a whole (Hugo et al. 1987). Although over 90 % of the Javanese are Muslim, today the culture blends in a syncretism, drawing on historic layers of Hinduism and Buddhism, as well as more ancient Animist roots. Islam has generally taken a fairly liberal form, termed *Abangan* in Java, although there is also a more ‘purist’ form known as *Agama Islam Santri*.

Sexual health vulnerabilities emerge from the complex interaction of sexual culture and sociohealth policy response (Ford and Kittisuksathit 1994) within the specific context of place. Javanese culture and the social changes occurring within Central Java, shape both the expressions of sexual lifestyles and the contested debates concerning appropriate protective sociohealth response (Shaluhiyah et al. 2007).

Exploring the sexual lifestyles of youth (aged 18–24 years of age) in Central Java, with particular reference to SRH vulnerabilities and the implications for policies and programs in the Urban Health System means seeking to understand the nature of sexual behaviors in terms of broader meanings associated with more general social and leisure tendencies. The patterns of findings identified are thence discussed and interpreted with reference to wider social and lifestyle theory.

Prior to presenting the key findings on the parameters of the youth sexual culture and their associations with broader sociosexual lifestyles in Central Java, some contextual reference is made to prior research into sexuality in Indonesia and some core notions of Javanese culture.

Mysticism has been described as the essence of Javanese culture (Mulder 1998). It permeates Javanese life and its vocabulary. Some Javanese words are sometimes hard to understand in all their shades of meaning. *Eling* is another one of these frequently used terms that are difficult to translate precisely (Mulder 1998). The word can only be understood by looking at its context. Javanese will understand it intuitively. Basically, *eling* means’ remember,’ *eling* also means being conscious of the consequences of our actions and our individual responsibility. Therefore, *eling* in its basic meaning is of great importance to the concept of self-awareness and is considered of great importance in Javanese philosophy (Mulder 1998).

In terms of Javanese cultural values, to be Javanese means to be a person who is civilized and who knows his manners and his place (Koentjaraningrat 1989). The individual serves as a harmonious part of the family or group. Life in society should be characterized by harmonious unity, ‘rukun*’* (Mulder 1998). The language, which is used mainly with the family, is an important part of the process called Javanization (being Javanese). The Javanese language has three levels, each with its own vocabulary, prefixes, suffixes, and etiquette. *Ngoko* or low-Javanese language is the language used at home. *Krama* is a much more elegant and refined language and is used to talk to people of high-social status. *Madya* or middle-Javanese is a less refined language than *krama*. It is used by farmers, the working-class and in situations where *krama* sounds too formal.

The Javanese concept of life describes life as a series of hardships and misfortunes. They always teach their children to be in a continuous state of *eling* and *prihatin*, or‘ forever feeling concern’ (Koentjaraningrat 1989). They should develop an attitude of accepting the hardships and misfortunes of fate willingly. The elements of Javanese culture in which the symbolic system finds the most expressive manifestation in the everyday life of Javanese society are language, art, religious beliefs, rituals, magic, and numerology (Koentjaraningrat 1989). In terms of the aspects of sexual relationship, the language, religious beliefs, and concepts of life and values are probably the dominant symbols and factors, which may affect youth Javanese sexual culture. In terms of youth sexuality, the key point is that the special emphasis on mindfulness in Javanese culture is expected to be applied as self-control regarding sexual impulses and interactions. Transgression of such capabilities will result in a loss of respect within developing sexual relationships. The display of vulgar behavior lacking Javanese sensibilities has a

social impact in Central Java, which corresponds to what Bourdieu (1991) has described within Western culture as a loss of cultural capital, with negative implications for social worth and potential relationship development.

The Basic Parameters of Sexual Health Risk

The basic pattern of level of sexual experience in Indonesia is relatively low in comparison with some other cultures such as Thailand or Brazil (Ford et al. 1992; Ford and Kittisuksathit 1996; Ford et al. 2003) with, for instance, only around 22 % male and 8 % female university students engaging in premarital intercourse (Ford et al. 2007). A large-scale comparative survey (2,000 person sample survey) of the sexual lifestyles of factory (low income) and university (middle class) youth revealed very little difference between the findings for the two groups, which in turn highlights the primacy of the impact of the shared Javanese culture. The pattern was basically one of relatively low levels of premarital intercourse, but (of concern) very low levels of contraceptive precautions within such activity (Ford et al. 2007).

This study sought to explore Javanese youth sexuality within the wider context of values and leisure lifestyles. Cluster analysis (Bijnen 1973; Lawson and Todd 2002) was undertaken separately for males and females, upon a wide range of variables including attitudes to premarital intercourse, contraception, condom use, sexual techniques, pornography, homosexuality, and gender. The ensuing analysis at the level of four basic clusters showed strong associations of sexual lifestyles to leisure lifestyles, traditional modern tastes and religiosity. Across the overall clustering, the scale, which most strongly discriminated between the different clusters, was a series of items pertaining to social activity, including going to parties, nightclubs, dating, staying away overnight, and alcohol consumption. This dimension relates in Indonesian culture to the concept of *gaul*, which corresponds to a sense of young people who pursue a more open, socially active lifestyle, as against the opposite who lead more closed, restricted, introverted lifestyles, who are termed *kurang gaul* (Ford et al. 2007). The more *gaul* clusters expressed the more liberal sexual attitudes and behaviors; although, it is important to note that these are not the liberal recreational sexual lifestyles found among youth in many other parts of the world (Ford 1992). The general point here is that youth sexual lifestyles in Java are closely related to wider social activity, dress and leisure behaviors, which cohere with religiosity, traditional and modern values, and sense of self-identity. In terms of tastes and identity within the pluralist culture of Indonesia, *gaul* youth associate themselves with a range of globalizing cultural trends and influences, while *kurang gaul* are more likely to express a sense of solidarity with the wider Muslim world (Ford et al. 2007).

In order to convey some greater sense of the feelings involved in, and the gendered and interactional nature of, youth sexual culture, we present some qualitative findings from a recent study of Javanese university students (Shaluhiyah 2006). To understand why (in this case) university students choose and value certain manners and acts within their sexual relationships, and the importance they attach to their choices, we have to explore in more depth the nature of their sexual interpersonal relationships. In turn, their sexual behaviors are more generally located in networks of relationships and perceptions of relevant cultural discourses (Chaney 1996) as briefly noted above.

The Nature of Javanese Youth Interpersonal Sexual Relationship

In order to understand the nature of sexual interactions of Javanese students, case studies using in-depth interviews were an appropriate mode of data collection for sensitive topic areas such as the respondent's actual sexual experiences. This section discusses the way the sexual aspect of romantic relationships begins. It includes the importance of the first sexual experience to the young couple, the possible sexual pathways on

which couples travel, and the partners' decisions to become sexually involved. Other areas of inquiry were related to strategies to initiate and negotiate sex, the possibilities to communicate and discuss safe sex within relationships, the attitudes about consequences of sexual activity, and the attitudes toward condom and other contraceptives use.

In earlier Javanese tradition, first intercourse was most likely to occur in adolescence within marriage. These days, adolescence is now an extended period before marrying, and there may be contact with the stimulus of sexually explicit material through videos, magazines, and the Internet, especially since censorship has been relaxed. So, perhaps there are increasing levels of sexual experimentation, including sexual intercourse, among young people as a consequence of these factors.

According to American sociologists, a couple's first sexual intercourse experience and later sexual interactions often follow a sexual script that dictates social and sexual conduct (Sprecher and McKinney 1993). These are influenced by aspects of the sexual scripts that the couple has learned both from society and their own interactions (Sprecher and McKinney 1993).

As noted above, Javanese young people's first premarital sexual intercourse most often occurred within a serious and long-term dating relationship. It is a usually a spontaneous or unplanned event, occurring at a men's boarding house or at the home of the young women, which did not include contraceptive practices. Nonetheless, there was a young man who commented that sexual interactions among young students were not always spontaneous. They were sometimes planned, for example, staying overnight together in a hotel.

> Finally after my boyfriend has expressed his wishes to propose marriage to me next year and he also has given me an engagement ring personally, then I could not reject making love to him. The day after he gave me the ring, we celebrated our personal engagement by sleeping together in a hotel and we had sexual intercourse. At that time I was quite sure that he was my husband to be. Therefore, I had the courage to make love to him. (Heni, female, age 20)

Gender differences have also been found in some aspects of the sexual script during first intercourse, especially in emotional reactions after the first intercourse. These gender differences were not very large. Case studies have shown that the emotional reactions of young women were more likely to be guilty ones. Young women experienced more negative or less pleasant reactions to first intercourse than did young men. They described their first sexual intercourse as extremely painful and disappointing. A participant of the case study described her feelings after first intercourse.

> After having made love for the first time I felt sorry and cried. It seemed that I had lost everything. Apparently the uneasy feeling still exists. I was afraid that his respect for me had deteriorated because my relationship with him had been restricted, so that I had to obey him. I was frightened that he would act arbitrarily to me. I also worried about being pregnant, although we used a condom. I didn't really enjoy making love for the first time due to a number of different reasons, such as feeling fear, anxiety, terror, all mixed up together. That made me disappointed and I suffered from pain instead of the feeling of sensuous enjoyment. (Heni, female, age 20)

Although both men and women described feelings of fear and anxiety surrounding their first intercourse, it was often not a pleasurable experience for females. Young men's emotional reactions after first intercourse included feeling more responsible in terms of continuing their relationships. If their girlfriend became pregnant, the young men would be under substantial pressure from his girlfriend's parents to marry their daughter immediately.

In many cases, a dating relationship does not always involve a sexual relationship when the partners have different expectations of and goals for the relationship. Traditionally, young men prefer to engage in sex earlier than young women do in relationships. Young women tend to wait until they feel ready to engage in premarital sex (Sprecher and McKinney 1993). As discussed earlier, in Javanese cases, young men also asked to have sex earlier than young women, but they never forced it if their girlfriends did not feel ready (such use of pressure

would show a face-losing loss of self-control in terms of Javanese values). Women preferred to include sex in their love relationship if they believed that their relationships would continue and marriage was guaranteed. The reasons most frequently mentioned by young women for resisting sex were practical ones, such as a fear of being pregnant, and not wanting to have a promiscuous relationship. When the relationship had developed over a period of time and held the prospect of a formal committed relationship (marriage), young women believed, to a greater degree than men, that being sexually rejected would be uncomfortable and unexpected. Thus, they tended not to refuse their partners' demands.

The majority of sexually experienced young students were still actively dating their sexual partners. The data also showed that the frequency of sexual intercourse among dating couples was mostly low (less than twice a month). The case study findings were also consistent with the survey. There was a wide range in the frequency of sexual intercourse among sexually experienced dating couples. While some dating couples had regular sexual interactions with their steady partners (most often twice a month), the majority of them had sexual intercourse only incidentally or not at any definite time. A minority did not continue to have sexual intercourse. Some couples commented that the main constraints or inhibiting factors were fewer opportunities and less privacy to do so. Some couples also mentioned that they actually wanted to stop their sexual behavior because of the intensity of sinful feelings at behaving in a socially unacceptable way. Apparently, both genders were scared about personal performance, acceptability, and the possible negative outcomes of having intercourse.

Women wanted to continue having sexual intercourse in order to maintain their steady relationship, perhaps because they felt they had already lost the most valuable thing in that relationship—their virginity. Therefore, they felt that they needed to be tied to the higher quality of the relationship. Somewhat surprisingly, the case studies indicated that women felt that men were somewhat more reluctant in later intercourse than first intercourse. It was apparently the young men who felt more anxiety and responsibility about the possible outcomes of intercourse.

For the young women, premarital pregnancy was feared, primarily because it was evidence of 'sinful behavior' and a 'traumatic accident.' Some young women knew siblings who had had traumatic experiences because of unwanted pregnancies. All parents would be extremely disappointed by a daughter's premarital pregnancy, because it would entail a loss of a family reputation and enduring shame, but the disappointment did not extend to extreme punishments. Most young women's parents would try to convince the young man and his family, hoping that he would be responsible and marry and care for their daughters and the child. The main options for young women facing premarital pregnancy would be firstly to consider marriage and secondly to seek a termination. If the couple did not feel emotionally and financially ready to take the responsibility of having a child, both sets of parents (man's and woman's) would look after their child. It is interesting to note that premarital pregnancy was blamed on both the young man and woman. As a result, not only the couple but also the families would bear the consequences of the premarital sexual activity of their children.

Probably, the most disturbing issue to emerge from the discussions concerned the use of ineffective forms of contraception during sexual intercourse with love partners. Most young men in the group discussions commented that 'coitus interuptus' or withdrawal was the most popular method to prevent pregnancy. The discussion revealed a widely varying level of knowledge and awareness of SRH, including contraceptive issues, among young students. Only a minority was well informed. Many were confused about particular issues such as reproductive health matters, and some had very little idea about sexual diseases.

A young woman described her knowledge of how to prevent pregnancy:

> My friend told me to prevent pregnancy the girl should squat and jump after intercourse in order to remove the sperm from the vagina. (Nana, female, age 22)

Young man gives a similar opinion:

> In order to prevent pregnancy, usually the couple tried to combine many contraceptive methods. Besides using BL technique or withdrawal, they also use the calendar system and drink pineapple after intercourse to kill the sperm (Prayit, male, age 22).

Many premarital sexually active young students rely on the highly ineffective method of 'coitus interuptus.' The main reason for nonuse of condoms was that, although condoms were widely available and accessible, young students believed that the service was primarily for married people. For the unmarried, buying a condom was very embarrassing. Strong cultural barriers exist which make it difficult for young students to acknowledge being sexually active and hamper the provision of such services for the unmarried.

Very few young students seemed to have much understanding about SRH, such as how contraceptive methods worked and how conception happened at the moment of sexual unions. Consequently, interpretations of the perceived level of risk in terms of an unwanted pregnancy or sexual disease are often difficult when the knowledge about those contraceptive methods and reproductive health matters are incomplete.

One female student in the case study describes this very effectively.

> We never got the information about health, especially on SRH. We just get it from television. Moreover, I am not interested in attending seminars on sexual health; I thought that it was not my subject of study. (Ika, female, age 20)

According to these students, the low level of knowledge in terms of SRH is caused by a lack of adequate information provided to the young students by the government health services. At present, there is no practical effective sex education in schools. Indeed, the main source of sex information is discussions about the knowledge of sexuality among friends and in the mass media, primarily through the Internet, and pornographic materials. These are, of course, not ideal for shaping the behavior of young unmarried people. Thus, it is important to fully and explicitly inform young people of the risks and options they face within a carefully structured, school sex education setting, which also provides the opportunity to discuss values. Such a perspective is supported by a number of international studies, which indicate that explicit sex education does not encourage sexual experimentation or irresponsibility (Ford et al. 1992). Furthermore, a the strong demand for adequate information was expressed and indicated in enthusiastic discussions on sexual health matters, such as contraceptive devices, pregnancy, and STDs, during the Central Java study focus group discussions.

Programs and Policies Addressed to Adolescent Sexual and Reproductive Health in Indonesia

In line with Indonesia's commitment and response to the ICPD, the National Committee on Reproductive Health was formed in 1998. The National Committee on Reproductive Health is divided into four task forces: on safe motherhood, family planning, ARH, and elderly reproductive health. The role of the National Committee is to provide directional policies and intervention strategies, to monitor the task force activities, and to facilitate collaboration with other sectors or institutions. Since decentralization was enacted, by giving full autonomy to district level; subsequently local government has responsibility of implementing and addressing reproductive health issues. In fact, many local governments have limited capacity and resources to maintain and implement these programs.

Although the government of Indonesia has committed itself to implementing the SRH programs as mandated by ICPD in 1994; the implementation of the ARH program nationally has not been considered. Various ARH activities have been conducted sporadically in a few provinces, sponsored by foreign agencies, GO, and local NGOs. Some of the private schools (which are perhaps more progressive than the public ones) have tried to introduce sex

education through a school-based curriculum and peer-based programs, which are undertaken by some NGOs have been launched to reach adolescents to provide basic information on sexuality and reproductive health. These indicate that young Indonesians are amply capable of addressing sex education matters in a mature and open manner (Ford and Siregar 1998). The problem is that most policy makers are in the forefront of opposition to the provision of sex education in schools or to allowing young people to have accessibility to reproductive health services (Utomo 2002).

There are two current models of SRH implementation programs covering youth's SRH needs. The first are the clinical-based and outreach programs; the second are the community and group empowerment programs to reach adolescents in rural areas, and the referral system programs for handling youth problems (Hasmi 2001). The clinical-based model is mainly developed and undertaken by local NGOs, particularly by the Indonesian Planned Parenthood Association (IPPA/PKBI), which has recently renamed their clinics 'youth centers.' The youth centers, which are already developed in many provinces, are organized and managed by trained young people who provide services including counseling, hotline services, basic medical services, group discussions, and other supportive activities. The IEC activities in school and community settings have also been the main concern of youth centers in providing appropriate and relevant information on SRH. Some centers have attained a considerable improvement in terms of sustainable services and programs. However, because the centers offer programs that are considered merely as part of the social services, the continuity of the services is greatly dependent on financial support from various organizations, including local and international agencies (Hasmi 2001). The other weakness of the youth centers is that their coverage has generally been limited by resource constraints, including the limited number of qualified persons to run the centers. It is, therefore, important to note that to reach such large populations in resource-limited settings means that cost-effectiveness and sustainability are of paramount importance (Hasmi 2001). The second model is run and initiated by the government and emphasizes empowering the community in rural areas. The Family Planning Coordinating Board (BKKBN) has launched a parent–education program in two Java provinces and has produced separate parent–education curricula for younger and older adolescents covering reproductive physiology, family relationships, contraception, and other topics. This program has been carried out through parents' groups, which hold a series of meetings to discuss the content of the curricula, and to review parents' experience in discussing these issues with their children. Other adults, including religious and youth-group leaders, are also using the curricula to discuss these issues with young people (Hughes andMcCauley 1998).

The BKKBN has also been empowering their cadres at village level to become involved in providing information to adolescents on SRH. Although initially the main tasks of the cadres are to provide services concerning family planning matters for married women, such as providing contraception and counseling programs; they are now expected to disseminate information on SRH for adolescents, through empowering their parents. PIK-KRRs (Centers of information and counseling on adolescent reproductive health) located in subdistricts have also been developed by BKKBN since 2001. The PIK-KRR programs are to provide adolescent with information and counseling on reproductive health in particular with sexuality, HIV/AIDS, and drug abuse. The activities are organized and managed by and for adolescents at district level with the support and guidance between BKKBN and other-related sectors. Currently, there are estimated to be approximately 5,284 PIK-KRR programs across the country, which means every subdistrict has at least one PIK-KRR. Again, since decentralization was enacted, these programs are mostly depending on the priority of districts' concern with SRH of young people.

The other model that has been initiated by Ministry of Health under health center program is called PKRR (center of adolescent

reproductive health). This program has been run by health center staff and provides counseling, information, and services particularly related to sexuality and reproductive health of unmarried youth including pregnancy problem and contraception. Unfortunately, not all health centers have such a program because of limited trained staff resources and other cultural barriers. Some survey findings suggest that many ARH program run by health centers were underutilized by young people because of lack of information, inconvenience, and unfriendly services to the young people.

The State of Ministry of Women Empowerment has conducted a small-scale project on reproductive health for female adolescents in two provinces, Jakarta and West Java. This project was remarkably successful and involved many key people such as students, parents, teachers, local authorities, and religious leaders participating and discussing these issues. Furthermore, there was much enthusiasm from the participants mainly young women who wanted to learn about SRH-related topics. Unfortunately, this project is being phased out and is only on a 'trial' stage, so the need for strong financial and political support from the government to continue such programs is of paramount importance.

The Ministry of National Education has also been quite successful in providing IEC on SRH for young people though it is out of school programs. Unfortunately, the implementation of these programs in schools has become a 'hidden agenda'(Utomo 2002) (Fig. 2).

The government of Indonesia has faced great difficulty in developing policies to deal with the reality of the SRH problems, particularly for young people. Conservative/moralistic perspectives sometimes confuse the reality of the situation, especially with regard to adolescent reproductive health problems (Jones 2001). They are unwilling to accept the actual situation being faced by many adolescents—that adolescents and young people are sexually active and that therefore problems of unwanted pregnancy, abortion, STDs, and HIV/AIDS need real solutions (Jones 2001).

There have been many policy documents issued by the government that focus on HIV/AIDS prevention programs. For instance, the National Strategy on Management of HIV/AIDS in Indonesia was published in 1993; the instructions of the Minister of Education and Culture of Indonesia on HIV/AIDS prevention through education were issued in 1997; the Ministry of Education and Culture in Indonesia issued guidance on HIV/AIDS prevention through education in 1997 (Utomo 2003). These policies were developed and initiated by the Ministry of National Education, because of the worrying increase in the risk of HIV/AIDS among young people. Although there is not any specific mention of SRH in school settings, these policies mention that youth is a priority target group. The subject of sexuality is also included in the IEC materials. Unfortunately, the implementation of these policies into the national agenda is faced by many cultural and political constraints. Therefore, it is still in question whether these programs will be implemented nationally in the future (Utomo 2003). However, sporadic ARH programs have been undertaken through small-scale projects by the NGOs and have been supported by the government.

There was a significant shift for ARH in Indonesia in the year 2000. The Minister of Women Empowerment and the head of BKKBN advocated a remarkable policy that pregnant students should be provided with an opportunity to finish their schooling; they should not be expelled from school, but should be given leave from school during pregnancy (Utomo 2003). This policy was expected to give an opportunity for pregnant students to continue their education and career development and to reduce the incidence of premarital abortion (Utomo 2003). Again, some religious, community, and political leaders disapproved of these statements. They assumed that such policies would give the opportunity or encourage young students to become freer in sexual activity.

Since 2004 Ministry of National Education published 'HIV/AIDS prevention strategy through Education program' that integrated into school curricula of junior and senior secondary

Fig. 2 The summary of existing ARH activities, by the government and NGOs

Institutions	Activities	Coverage
The BKKBN (The Family Planning Coordinating Board)	• Program *Bina Keluarga Anak dan Remaja* (BKR) or "Programme support for families and adolescents". This project trains parents about ARH in order to improve their ability to talk to their children about these issues	Jakarta, Yogyakarta, and West Java provinces
	• ARH education is in 21 primary schools, 67 middle schools, 66 high schools and 25 vocational schools. • PIK-KRR (center of information and counseling of ARH) run by peer educator	All provinces and districts
Department of Health	Reproductive health information in schools and youth groups in communities such as *Karang Taruna,*	Jakarta, Yogyakarta, East Java and Central Java
	• PKRR (center of ARH services) 'Youth clinics' in health centers to provide counseling, information on nutrition, STIs and AIDS and reproductive health related topics.	Some districts in Java, Kalimantan, Sumatera, Sulawesi, etc
Department of Education	• Develops modules for IEC on ARH inschools and out-of-schools • ARH concepts have been integrated intobiology, religion and sport and health, guidance and counseling subjects	It is expected to implement it as part of the national curriculum in schools
Department of Social Welfare	• Trains peer educators from youth organizations at village level (*karang taruna* and scouts) •	Pilot project/ small scale project
Department of Religion	• Youth activities through mosques, youth organization and *pesantren* (Islamic boarding schools). Activities include supporting positive youth relationships, discussing reproductive health, providing TT immunization, iron supplements, etc. Activities such as counseling, basic	Some of provinces
	medical services, hotline discussion and other supportive activities, through youth mosque groups	
The State of Ministry of Women Empowerment	• Strengthening and empowering female youth groups in reproductive health problems and decision-making. Empowering them to be facilitators in reproductive health programs in the community.	Jakarta and West Java (small project)
NGO (IPPA)	• Youth centers provide services such ascounseling, discussions, hotline services,basic medical services and peer group training.	Almost all provinces
NGO (UNESCO)	• ARH subjects integrated into school based education, peer-based programs in community.	Small project/only certain provinces

"Sources: the information cited in Utomo (2003) and Hasmi (2001)"

schools, and trained teachers were mandated to carry out this activity. Although this policy was national in scope, by decentralizing the HIV education to province and district level responsibility, the result varied widely depending on the commitment of local authorities and their view of the perceived threat.

Ministry of National Education decree No. 39, 2008 on Guidance and Supervision of student activities was enacted, which includes HIV

and drug abuse prevention are mandatory activities within existing curricula and cocurricular activities such as school health efforts, pupil intra-organizations, and student scouts. By collaborating with UN agencies (UNICEF, UNESCO, and UNFPA) and NGOs, Ministry of National Education has published training manuals on SRH, HIV, and drug abuse prevention for teachers in junior and senior secondary schools. Due to limited resources, however, the distribution and utilization of this important material is very limited (UNESCO 2010).

Since intersectoral collaboration among ministries is rarely realized and Ministry of Health, Ministry of National Education, BKKBN, Ministry of Women Empowerment, and Ministry of religion run their own programs, inevitably ineffective programs are often the result. Actually, HIV, sexuality, and reproductive health are subject of interest to young people, unfortunately only limited numbers of teachers have received comprehensive in-service training in these subjects. Many young people were not satisfied with what they learned from textbooks, so they look for SRH information in popular media or Internet without supervision.

To conclude this review of the development of SRH services for adolescents in Indonesia, it is clear that from the efforts of the past three decades there is considerable public and social health expertise in, and understanding of, the type of programs that are urgently needed. Several examples of high-quality programs that have been developed, tested, and implemented have been outlined above. Nonetheless, and especially in light of the demographic and geographic enormity of the archipelago, such programs have as yet had only limited contact with the vast adolescent population. While the Republic of Indonesia does face budgetary constraints, it has shown repeatedly that it does have the capability to implement such health-enhancing programs. The key point is that political opposition from conservative Islam, and the very fear of such opposition, has for decades paralyzed the mass implementation of appropriate SRH services for unmarried adolescents.

Future policies and programs development should be addressed, and consider ways of maintaining young people's positive norms and values in line with existing culture and religion in each province by enhancing self-efficacy and life skills through school-based sexual reproductive health education and services (Suryoputro et al. 2007). Advocacy should also be conducted continuously to address environmental constraints that impede the adoption of positive sexual health (Suryoputro et al. 2006).

Conclusion

In conclusion, in Indonesia, adolescent pregnancy *within marriage* is extremely common and socially acceptable. Furthermore, while the total fertility has dramatically declined in Indonesia in recent decades, there are still continuing substantial problems of maternal mortality and morbidity related to early age of pregnancy, partly because the timing of first childbirth has only been slightly delayed. In contrast, adolescent pregnancy *outside marriage*, and if not leading to marriage, is widely considered culturally unacceptable and has grave personal and social consequences especially for the young woman.

During this same period of recent demographic change, however, there have been major social changes taking place across the archipelago, which have important impacts upon young people's sexual lifestyles. It is axiomatic that concerns with adolescent pregnancy need to be considered in terms of the particularities of culture and place. Thus, we have attempted to provide some insights into the nature of Indonesian youth culture, with specific reference to pertinent elements of Javanese culture. While not all ethnic groups across the archipelago hold Javanese values, there is widespread-shared antipathy toward casual and premarital intercourse. Nevertheless, reference has also been made to a process of widening pluralization of youth sexual lives reflecting broader social changes in values and leisure lifestyles. Thus,

among the more liberally inclined strand (*gaul*) of Indonesian youth, there are increasing levels of premarital (but generally not casual) sexual intercourse. This transition clearly warrants the provision of appropriate SRH services. This demand has also been given some urgency for many Indonesian health practitioners by the advent of the parallel threat of HIV transmission. Similarly, just as effective premarital pregnancy preventing educational and health service programs have been rejected on conservative 'moralistic' grounds, so potentially HIV preventing public promotion of condom use has repeatedly been held back by such religio-political forces.

We have stressed that sexuality is a highly contested arena of contemporary Indonesian cultural politics, and this contestation is no more hotly debated, than with respect to youth sexuality. The very process of recent democratization and decentralization has facilitated wider and more open debate on sexual matters, and greater polarization has emerged (or at least become more explicitly articulated) between liberal and conservative positions. Furthermore, this decentralization of power and social and health service decision-making holds out the potential for more diverse social and public health strategies in different localities. For instance, we briefly noted the more draconian methods of regulation of youth behavior based upon Sharia law employed in Aceh, in contrast to the more tolerant strategies in Central Java. Thus, Indonesia in many ways exemplifies family planning programs that have successfully facilitated the overall fertility decline and has never been able to come to terms with or address the growing needs of the premarital, sexually active adolescents. What is so striking about Indonesia as a case study of adolescent SRH is that while the specific contraceptive needs of adolescents have been recognized in Indonesian medical discourse for decades, and numerous materials have been developed and small-scale initiatives tested, very little seems to have been achieved in making such potentially beneficial services universally available in a way that can assist the mass of Indonesian youth.

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An Iraqi-Specific Perspective on Adolescent Pregnancy

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Keywords

Iraq: adolescent pregnancy · Birthrate · Family-arranged marriages · Gender parity · Maternal and child health · Patriarchal values · Risks of early pregnancy · Polygamy · Millennium Development Goals

Abbreviations

COSIT	Iraq Central Organization for Statistics and Information Technology
CFSVA	Comprehensive Food Security and Vulnerability Analysis (United Nations World Food Program)
CSO	Iraq Ministry of Planning Central Statistical Organization
ECCE	Early Childhood Care and Education
IAU	Interagency Unit in United Nations Assistance Mission for Iraq
IBC	Iraq Body Count project
ICMMS	Iraq Child and Maternal Mortality Survey
IFHS	Iraq Family Health Survey
ILCS	Iraq Living Conditions Survey
IOM	International Organization of Migration
INPC	Iraq National Population Commission
I-WISH	Iraq Woman Integrated Social and Health Survey
ICPD	International Conference on Population and Development
KRSO	Kurdistan Region Statistics Office
MDG	Millennium Development Goals
MICS	UNICEF Multiple Indicators Cluster Survey
MOH	Iraq Ministry of Health
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
SRSG	Special Representative of the UN Secretary-General
STI	Sexually transmitted illness
UN	United Nations
UNAMI	United Nations Assistance Mission for Iraq
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
WFP	World Food Program
WHO	World Health Organization

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Introduction

Iraq is an Arab country bordering Syria to the northwest, Turkey to the north, Iran to the east, Jordan to the southwest, and Kuwait and Saudi Arabia to the south. The modern capital of Iraq is Baghdad. This is a region of profound historical and political significance as the site of ancient civilizations of great creativity and invention, and the focus of modern political and military conflict.

Historical Context

The "Fertile Crescent" between the Tigris and Euphrates rivers in the center of Iraq is known as "The Cradle of Civilization." Mesopotamia, "the land between the two rivers," was the site of major innovations including the first instances of surplus farming about 8,500 years ago and the development of a group of city-states. It is where some of the first wheeled vehicles, sailboats, the pottery wheel, and cuneiform (one of the earliest writing systems) were created. Iraq has been the site of a series of successful civilizations dating to the sixth millennium BCE.

For example, the self-governing city-states of Sumeria in southern Mesopotamia flourished for thousands of years. One of these cities, Ur, is the birthplace of Abram, later known as Abraham, the father of three major world faiths (Catherwood 2006). In 2300 BCE, Sargon became the ruler of the city-state of Kush; he transformed the warring city-states of Mesopotamia into an empire spanning 900 miles and wrote one of the first sets of laws. The Code of Hammurabi, the sixth Babylonian king (1792–1750 BCE), is one of the oldest deciphered writings of significant length in the world, consists of 282 laws, and includes one of the earliest examples of the legal presumption of innocence. Babylon was capital of 10 Mesopotamian dynasties. It was once the most populated of the ancient world and achieved its peak again under King Nebuchadnezzar II (605–563 BCE), United Nations Educational, Scientific and Cultural Organization (UNESCO 2012). At various points in its history, Iraq was the center of Akkadian, Sumerian, Assyrian, Babylonian-Chaldean, and Abbasid empires and was also part of the Achaemenid, Hellenistic, Parthian, Sassanid, Roman, Rashidun, Umayyad, Mongol, Safavid, Afsharid, and Ottoman empires.

Enheduanna and the Place of Women in Sumeria

In ancient Sumeria, patriarchy prevailed between both the rich and the poor. Wives were expected to be obedient to their husbands and under no condition could they seek to divorce their husbands. A husband, on the other hand, could divorce his wife simply by paying a fine. If a husband died, the widow came under the control of her former husband's father or brother or her grown son. Women's rights varied dramatically according to their social status. Royal women might have considerable political and economic power. A Sumerian woman of lower status had no recourse or protection under the law. Female power was generally based solely upon her influence within her family.

The Mesopotamian women who displayed autonomous authority were usually royalty or the wives or daughters of men who had power and status. Enheduanna, for example, the first known female poet in history and according to the Oxford University Electronic Text Corpus of Sumerian Literature, "the first known writer in human history," was the daughter of King Sargon of Akkad and high priestess of Moon-God temple, Ur. Ca. 2300 BC. She was one of the rare Sumerian women permitted to train as a scribe. The Sumerians were polytheistic and worshipped many gods and goddesses. Each city had a special god who was believed to protect them from harm. The following is an excerpt of a poem she wrote in honor of the goddess, In-nin-sha-gurra (Women in World History Curriculum[1]):

[1] Ancient tablets, ancient graves: Accessing women's lives in Mesopotamia. Retrieved from http://www.womeninworldhistory.com.

> The great-hearted mistress, the impetuous lady, proud among the Anuna gods and pre-eminent in all lands, the great daughter of Suen, exalted among the Great Princes (a name of the Igigi gods), the magnificent lady who gathers up the divine powers of heaven and earth and rivals great An, is mightiest among the great gods—she makes their verdicts final. The Anuna gods crawl before her August word whose course she does not let An know; he dares not proceed against her command. She…changes her own action, and no one knows how it will occur. She makes perfect the great divine powers, she holds a shepherd's crooks, and she is their magnificent pre-eminent one. She is a huge shackle clamping down upon the gods of the Land. Her great awesomeness covers the great mountain and levels the roads.

After the death of her father, the new ruler of Ur removed Enheduanna from her position as high priestess. She expressed her outrage as follows (Women in World History Curriculum):

> Me who once sat triumphant, he has driven out of the sanctuary. Like a swallow he made me fly from the window. My life is consumed. He stripped me of the crown appropriate for the high priesthood. He gave me dagger and sword—'it becomes you,' he said to me.

Women of high status in Mesopotamia could learn to read and write, and some became priestesses and administrators. However, they were not treated as the equals of men, and the position of women varied between city-states and over time. Most women rarely were empowered to act individually outside of their personal households. Hammack (2007, p. 3) states: "The cultures of the Ancient Mesopotamian societies of Sumer, Babylon, and Assyria formalized the subordination of women in the ancient world. The religions and laws developed by these civilizations prevented females from asserting control over their reproductive function in society. The social institutions developed in these cultures reduced the social power available to women."

Modern Political History of Iraq

In 1920, the League of Nations divided the Ottoman Empire and created the modern boundaries of Iraq, placing Iraq under the authority of the United Kingdom as the British Mandate of Mesopotamia. In 1921, a monarchy was established, and in 1931, the Kingdom of Iraq became independent of Great Britain. The Republic of Iraq was created in 1958 with the overthrow of the monarchy of Iraq. Saddam Hussein came to power in 1979. The Iraq–Iran War took place from 1980 to 1988. In 1990, the first Gulf War (1990–1991) began with the Iraqi invasion of Kuwait. In 2003, an invasion led by American and British forces removed Hussein from power and Iraq experienced a military occupation by a multinational coalition. An insurgency emerged after the invasion. In June 2004, sovereignty was transferred to the Iraqi Interim Government. 2006 and 2007 were peak years of violence in the war (New York Times 2012). The United States was the last member of the coalition to cease combat operations in Iraq in August 2010. After the formal withdrawal, the US military retained two bases in Iraq and about 4,000 troops. In 2007, there were 505 bases and more than 170,000 troops. More than one million US service members served in Iraq.

The Iraqi invasion of 2003 took place following a near-total financial and trade embargo imposed by the United Nations Security Council that began on August 6, 1990, after Iraq's invasion of Kuwait and remained largely in force until May 2003. Estimates of excess civilian deaths during the sanctions vary widely; one estimate indicates more than 100,000 excess deaths among under five-year-old Iraqis from August 1990 to March 1998.[2] The United Nations (UN) estimated that between 500,000 and 1.2 million Iraqi children died during the sanction years 1990–2003 (CARA 2010).

Many tens of thousands of Iraqi civilians were killed during the Iraqi invasion and occupation. The Iraq Body Count project, a media-based analysis likely to be an undercount, reports over 162,000 civilian and combatant deaths from March 2003 to January 2012,[3]

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[2] Campaign against sanctions on Iraq (CASI). Morbidity and mortality among Iraqi children. Retrieved from http://www.casi.org.uk/info/garfield/dr-garfield.html.

[3] Iraq Body Count. Retrieved from http://iraqbodycount.org.

combining Iraq Body Count project (IBC) civilian data with official Iraqi and US combatant death figures and data from the Iraq War Logs released by WikiLeaks with 79 % being civilians.

The effects of exposure to war, armed conflict and civil disorder on Iraqi youth and children, and their needs for services and therapeutic/educational interventions have been addressed in a number of research studies (Al-Obaidi 2010, 2011; Al-Obaidi et al. 2009a, b, 2010a, b, 2012; Al-Obaidi and Budosan 2011; Al-Obaidi and Jeffrey 2009; Al-Obaidi and Attalah 2009; Al-Obaidi and Ali 2009; Al-Obaidi and Scarth 2008; Al-Obaidi and Piachaud 2007). Alwood et al. 2002) had previously studied the effects of the trauma experiences of children aged 6–16 years during the siege in Sarajevo and had found that 41 % had clinically significant PTSD symptoms. The effects of violence and deprivations during war and occupation may overwhelm the coping skills of children and adolescents. Kos and Zemljak (2007) concluded that even in so difficult wartime circumstances such as experienced in 2003 in Iraq, it is "possible to run psychosocial programs—if reliable partners are involved" (p. 150). Mathews and Ritsema (2004) addressed the reproductive health needs of conflict-affected young people, indicating that "young people affected by conflict face additional barriers as they often lack sufficient education, health care, protection, livelihood opportunities, recreational activities, friendship and family support" (p. 19). Bonanno and Mancini (2008) note the heterogeneous factors that promote resilience to potentially traumatic events "may be maladaptive in other contexts while some factors are more broadly adaptive" (p. 369).

In 2008, it was reported that between 2,000 and 3,000 people were leaving Iraq each day and at least 1.5 million Iraqi refugees had moved to neighboring countries with an additional 1.5 million people being displaced within Iraq (Cambanis 2008). Kira et al. (2006, 2007) have described the health and mental status of Iraqi refugees.

Iraq: 2008 and Beyond

Demographic information as of October 2008 was compiled in a report, "Iraq in Figures" by the Republic of Iraq Ministry of Planning and Development Cooperation Central Organization for Statistics and Information Technology. Iraq covers an area of 435,244 km^2. About 7.04 % of its land is arable with another 35,250 km^2 (in 2003) of irrigated land. Natural hazards faced in Iraq include dust storms, sandstorms, and floods. The population of Iraq (2008 estimate) was 31,895,637 with over 43 % under the age of 15. A little more than 54 % of the population is in the age-group of 15–64 years (male, 8,612,257/female, 8,636, 961). Only 2.8 % of the population were 65 years and over. The median Iraqi age (2008 estimate) was 20.2 years. The infant mortality rate (MICS3 2006) was 35 per 1,000. The total fertility rate (MICS3 2006) was 4.3 per 1,000. It was estimated (Employment and Unemployment survey 2006) that 78 % of the population was able to read and write (male, 86 %, Iraq Living Conditions Survey, 2004 estimate; female, 70.1 %.). There was universal suffrage for those 18 years and older.

Iraq's economy was dominated by the oil sector, which had traditionally provided about 95 % of foreign exchange earnings. The estimated GDP in 2007 for Iraq was $85.71 billion. Iraq had six airports with paved runways.

The World Food Program report concerning Iraq Comprehensive Food Security and Vulnerability Analysis (CFSVA) (United Nations World Food Program 2008) described an estimated 3.1 % of Iraqi households (930,000 people) as "food insecure," living with hunger and fearing starvation. In 2005, the figure had been 15.4 %. Without the monthly food rations given to 90 % of the population by the Public Distribution System, the World Food Program found that a further 6.4 million people would be vulnerable to food insecurity.

In 2010, the BBC reported World Bank findings that overall 23 % of Iraq's population lives below the poverty line (spending $2.20 per

person per day) (http://www.bbc.co.uk/news/world-middle-east-11095920). According to the Brookings Saban Center for Middle East Policy (2012), as of 2011, the available supply of electricity averaged about 56 % of demand. Impaired electricity supplies hampered the pumping of water to Iraqi households and restrict economic development. The number of unemployed people below the age of 34 consisted of more than one million people, and three-quarters of whom were male. Only 18 % of women were employed (www.bbc.co.uk/news/world-middle-east-11095920).

Voices of Iraqi Women

Oxfam International (2009) produced the document, "Rising to the Humanitarian Challenge in Iraq," reporting that one-third of the Iraqi population was in need of humanitarian assistance and that "essential services were in ruins." Oxfam International released a follow-up report, "In Her Own Words: Iraqi Women Talk About their Greatest Concerns and Challenges," on International Women's Day 2009 (March 8, 2009) "to highlight the daily hardships women are facing as a result of years of conflict, and to prompt positive action from their government and the international community." Oxfam and the Al-Amal Association, their Iraqi partner organization, conducted a survey of 1,700 respondents in Baghdad, Basra, Kirkuk, Najaf, and Nineveh in the summer of 2008 to collect information about the state of the civilian population's day-to-day lives, particularly as events impacted upon women. The largest group interviewed were those widowed by the Iraq war who were (as a consequence of the war) the head of their households. The report states (2009):

> At the time, there was a striking absence in the public sphere of a collective female voice from the cities, towns and villages of Iraq about the specific challenges women and their families face on a daily basis. In fact, there was very little comprehensive, detailed information available about the daily challenges of the Iraqi civilian population as a whole and their struggle to make ends meet—largely due to rampant insecurity. So a team of Oxfam-supported surveyors last year fanned out across the country, knocked on doors, and unlocked hundreds of women's voices that, until that point, had found nobody to listen (p. 2).

The report did not claim that the information gathered represented the situation facing all Iraqis, or even all women in Iraq nor were the survey results reported according to age or maternity of the respondents. However, the survey results represent an effort to focus on women's experiences in Iraq post-2003 and it is likely that adolescent Iraq mothers may also have been exposed to the conditions outlined in the report. A large proportion of women interviewed reported that although the overall security situation in Iraq improved beginning in mid-2007, their access to basic services had become more difficult, they had become more impoverished over the past six years, and their own personal safety was still in question. Survey results included (pp. 2–3):

- Nearly 60 % of women said that safety and security continued to be their number one concern despite improvements in overall security in Iraq
- As compared with 2007 and 2006, more than 40 % of respondents said their security situation worsened last year and slightly more than 22 % said it had remained static compared to both years
- Some 55 % had been a victim of violence since 2003: 22 % of women had been victims of domestic violence; more than 30 % had family members who died violently
- Some 45 % of women said their income was worse in 2008 compared with 2007 and 2006, while roughly 30 % said it had not changed in that same time period
- 33 % had received no humanitarian assistance since 2003
- 76 % of widows said they did not receive a pension from the government
- Nearly 25 % of women had no daily access to drinking water and half of those who did have daily access to water said it was not potable; 69 % said access to water was worse or the same as it was in 2006 and 2007

- One-third of respondents had electricity 3 h or less per day; two-thirds had 6 h or less; 80 % said access to electricity was more difficult or the same as in 2007; 82 % said the same in comparison with 2006 and 84 % compared to 2003
- Nearly half of women said access to quality health care was more difficult in 2008 compared with 2006 and 2007
- 40 % of women with children reported that their sons and daughters were not attending school.

Concerning access to education, survey findings indicated that many women and children have been prevented from continuing their education since 2003. Nearly half of the women reported that they have children who were still not attending school. The report states (p. 12): "A large percentage of women and girls are prohibited by their families from pursuing an education for cultural and economic reasons." Barriers to health care were also reported (p. 13):

- Of the 25 % of women who had not sought medical care since 2005, 45 % had not done so because they could not afford to, medical services were located far away, or it was unsafe
- 20 % of women who visited an emergency room went as a result of a violent incident as compared to only 11 % who went to give birth
- The largest percentage groups felt access to health care last year was more difficult than in both 2006 (40.4 %) and 2007 (41.8 %).

Religious, Cultural, and Traditional Influences: Iraqi Social Views and Customs

Over 75 % of Iraqis are Arabs, and 20 % are Kurds who are bilingual in Arabic and Kurdish. The remaining are minority ethnic groups, including Turkomans, Assyrians, Armenians, and some who are of Iranian origin. Arabic is the official language. Ninety-seven percent of Iraqis are Muslim, of whom 60 % are Shiite. Three percent are Christians. About 400 of the 150,000 Jews who once lived in Iraq continue to live there (Lamb 1995; cited in Nydell 2002).

Many marriages are family-arranged. However, in almost all Arab countries and depending upon how traditional or modern the family is, the prospective bride and bridegroom are provided with the opportunity to meet, become acquainted, and accept or reject a proposal of marriage (Nydell 2002). In traditional communities, the preferred pattern of marriage is to a first or second cousin. On average, about a third of all marriages are between cousins or someone in the same group and marrying within the family is the principal means of reinforcing kinship solidarity (Nydell 2002). Financial security, social status, and children are significant goals. A Muslim man may divorce his wife if he wishes although arbitrariness or haste about this decision is frowned upon. A woman may have more difficulty initiating divorce court proceedings, but successful grounds may include childlessness, desertion, or non-support (Nydell 2002).

Iraqi rights and obligations focus on the extended family and lineage. The primary focus of loyalty is the family. Deeply ingrained values of family loyalty are manifested in personal and public life. With urbanization, Iraqi society has displayed a greater tendency toward nuclear family social organization. Family solidarity, however, continues to be stressed (Country studies, U.S. Library of Congress).

In a report prepared for review by the United Nations Agency for International Development by The QED Group, LLC, regarding an assessment of gender integration conducted between March and April 2010, the following description of "Key Gender Issues in Iraq" was offered:

> Significant gender disparities are present in Iraq's economy, education and health sectors. While improvements in security have resulted in increased employment for women, the female labor force participation rate continues to be one of the lowest in the region. Similarly, adult literacy rates are particularly low for women and the dropout rate for both boys and girls is high and increasing. Job segregation is prevalent and women's entrance into male-dominated professions, including business and political leadership,

> is forbidden in certain communities. Women's access to justice and legal protection is also limited. Many women are unaware of their legal rights and are bound by cultural requirements to seek mediation through family and other traditional methods rather than through the (often gender blind) courts. Sexual and gender-based violence is a growing threat for women and girls and honor killings, rape, kidnapping and domestic violence are on the rise. More than half of Iraq's human capital is undervalued and underutilized and this gender gap has serious implications for the emergence of a viable and sustainable economy and for progress towards a secure and lasting democracy (p. 6).

This report also noted religious and cultural factors affecting female access to education, gender attitudes, and early marriage.

> A study in 2008 found that 76.2 % of respondents said that girls in their family were not allowed to attend school (Women for Women, 2008, 24). Early marriage is one factor that can prevent girls from continuing their education beyond primary school. Though the legal age of marriage is 18 years of age for women and men; young people can legally be married at age 15 with judicial permission. School-aged brides are often forced to leave school by their older husbands and their families after marriage. Traditional attitudes that emphasize the subordination of women and girls and their seclusion within the home also devalue the need to educate girls along with boys. In some cases, imams have issued *fatwas* against educating girls (NGO leader interview, Erbil, 2010). While many parents in Iraq value education for both boys and girls, interviews with stakeholders in the education sector revealed that in other cases educating girls is simply viewed as unnecessary or even "wasteful" (p. 42).

Noting that the Arab Human Development Report (2005) asserted that, "This year's report presents a compelling argument as to why realizing the full potential of Arab women is an indispensable prerequisite for development in all Arab states." The 2010 UNICEF report, "Girls Education in Iraq," stated that for every 100 boys enrolled in primary schools in Iraq, there are about 89 girls enrolled (p. 4). Approximately 75 % of girls who start school drop out during or at the end of primary school and do not go on to intermediate education. A small survey of 80 Iraqi girls is reported in this study and while not a statistically valid sample; it identified the following features why some Iraqi families do not support girls attending school. These reasons included, "concerns about safety, family poverty, a reluctance to allow adolescent girls to attend school, the distance from home to school, early marriage and the need to help at home" (p. 5).

The Inter-Agency Information and Analysis Unit (IAU) is an interagency unit in United Nations Assistance Mission for Iraq (UNAMI) created in January 2008 to "improve the impact of the humanitarian and development response in Iraq through the strategic use of information." IAU participating UN agencies and NGOs include UNAMI, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), UNICEF, World Food Program (WFP), FAO, World Health Organization (WHO), United Nations High Commission for Refugees (UNHCR), International Organization of Migration (IOM) Mercy Corps, International Medical Corps, and IMMAP. In a report entitled, "Access to Quality Health Care in Iraq: A Gender and Life-Cycle Perspective" (July/August 2008), it was noted (p. 26):

Some cultural and social barriers also impede women's health and well-being. Early marriage is on the increase, particularly in rural areas, jeopardizing the reproductive and mental health of young girls who may not be physically, mentally, or emotionally prepared to give birth. Social and religious beliefs sometimes prohibit the use of family planning and restrict women's ability to choose the spacing and number of children in their families. Moreover, the preference for larger families compounds risks for women when comprehensive maternal health services are not available.

It was also noted, "Traditional notions of women's roles and preferential treatment of male members of the family may also act as a barrier to women's and girls' health" (p. 26). Some Iraqi women are unable to obtain health care without the approval of a male relative. Higginbottom et al. (2006) suggests "an unambiguous focus on the reduction of pregnancy is not a credible message when teenage pregnancy is a social norm for a particular ethnic or cultural group. For young parents of Muslim faith in

particular, teenage parenting within marriage is not necessarily considered a 'problem' or seen as a distinctive event."

The preferred gender of gynecologists may be influenced by cultural practices. For example, it was reported that in Baghdad in 2007, male gynecologists were targeted for violence or assassination by Islamic extremists (http://mens-newsdaily.com/2007/iraq-male-gynecologists-attacked-by-extremists) for "invading the privacy of Muslim women." McLean et al. (2010) reported in a study in Al Ain, United Arab Emirates, that for gynecological and abdominal problems, female patients would generally refuse the medical services of male medical students and more than 50 % of subjects would not allow a male medical student to examine their face. Lafta (2006) reported that most female Iraqi subjects, aged 17–70 years, preferred a female gynecologist and obstetrician. It was noted that this was associated with social tradition and religious beliefs and the preference for female practitioners declined with rising educational levels.

Ameh et al. (2011) noted challenges facing healthcare providers of emergency obstetric care in Iraq. Challenges included difficulties traveling to work due to frequent checkpoints and insecurity, high level of insecurity for patients referred or admitted to hospitals, inadequate staffing due mainly to external migration, and premature deaths as a result of the war. There was also a lack of drugs, supplies and equipment (including blood for transfusion), falling standards of training, and regulation. The authors concluded that most women and their families do not currently have access to comprehensive emergency obstetric care.

Risks of Early Pregnancy

In Iraq, as in nearby Arab countries such as Egypt, teen pregnancy is not uncommon and occurs frequently in the context of early marriage. Becoming pregnant, which is a means of proving one's womanhood and pregnancy soon after early marriage, is highly valued in the social order. Female chastity prior to marriage is highly valued (Cherry et al. 2009). Maternal health considerations may not be a priority in the implementation of these cultural preferences.

Miller and Lester (2003, cited in WHO Technical Consultation on married adolescents, December 9–12, 2003) conducted a literature search to assess young first-time mothers' special needs in relation to maternal health. They found, in spite of limitations to the data, that first births are riskier than second and third births for women of any age and identified specific adverse outcomes associated with primiparity (e.g., pre-eclampsia/eclampsia, obstructed labor and malaria). Miller and Lester (2003) concluded that the role of age specifically is less clear except in the case of the mothers younger than age 16 who may not be physically ready for childbearing. While the relationship between young age and maternal mortality and morbidity is confounded by age and parity interactions, the relationship between young age and negative outcomes appears clearer, namely that babies born to young mothers (particularly those age 15 and under) are at increased risk of neonatal and infant death.

Characteristics of Women's Respondents to the Iraq Family Health Survey (2006/2007)

The results of the Iraq Family Health Survey (IFHS 2006/2007) were disseminated by the Iraq and Kurdistan Ministries of Health in collaboration with the World Health Organization (WHO)/Iraq. Key demographic and health status indicators related to women's and family health were generated from a survey of 9,345 households in almost 1,000 villages and neighborhoods in Iraq and 14,675 women of reproductive age from all governorates in Iraq to provide information for health and development policy-makers and program managers. Previous surveys on the circumstances of women and children had included the Iraq Child and Maternal Mortality Survey (ICMMS 1999), the Iraq Living Conditions Survey (ILCS 2004), and the Multiple

Indicators Cluster Survey (MICS III 2006). The IFHS was the first national survey in Iraq to present data concerning on adult mortality, including the causes of deaths, and to investigate domestic violence in Iraq. Among its findings was an estimate of the violence-related death toll of Iraqis, 104,000–223,000 during the period of March 2003 to June 2006.

In total, 14,675 women were successfully interviewed in IFHS. Almost 60 % of those surveyed were currently married. Teenage girls constituted 22.2 % of the respondents with 57.7 % of the females interviewed aged between 15 and 29, indicative of the youthful age structure of the population sample. Of those between 15 and 49 years of age, 17.3 % had no education. Overall, 65.7 % of women aged between 15 and 49 in the survey were literate. A high percentage of interviewed women (86.7 %) were not currently working.

As age increases, the proportion of women who are married, widowed, or divorced/separated also rises in the sample. In the 15–19 age-group, there were 18.8 % of women who were already married. Education is closely related to marital status with the proportion of single women increasing as the educational level rises. Concerning the percentages of females who were married by specific ages, 9.4 % were married by age 15, 26.8 % were married by age 18, and 55.6 % were married by the age of 25. The percentage of ever-married women who were married by age 18 decreased over the different age cohorts. For the 45–49 age-group, 39.3 % were married by age 18, while in the 20–24 age-group, the percentage that were married by age 18 had fallen to 24.9 %. The percentage married at the different ages was also highly related to educational level with higher educated women having a later age at first marriage.

Birthrate

Among ever-married women, 92 % had been pregnant at some point in their lives. The proportion of women who had been pregnant increased with age. Among young women aged 15–19 years, 72.7 % had been pregnant. This proportion increased rapidly in older age-groups (until in the 45–49 age-group). Among the women at the end of their reproductive years, 98.4 % had been pregnant.

In the younger cohorts, the difference between gravidity and parity is large. Of the young women (aged 15–19), 52.5 % of young women had had a live birth. This was markedly lower than the number who had ever been pregnant (72.7 %). This may indicate a high level of pregnancy loss among young women. Overall, out of every 100 pregnancies, 86.9 ended in a live birth. A relatively low percentage of divorced or separated women had ever been pregnant (70.1 %) or had ever had a live birth (64.7 %) compared to the average of all women. Consequently, nulliparity among these women is very high (29.9 %). Considering the high fertility norms in Iraqi society, this finding may mean that a high level of divorce or separation is precipitated by infertility.

By the end of their reproductive years, that is, those in the age-group 45–49, Iraqi women had attained a parity of 6.38. Perhaps in part because younger women had not yet completed their childbearing, parity decreased within the descending age-group. The mean number of children ever born was higher in rural areas than in urban; rural mothers had on average 4.04 children, while those in urban areas had 3.39 children on average. The mean number of children born was greater in Kurdistan, 4.17 children on average compared to the south/central area (3.54 children).

The mean number of children born to women with no education (5.24 children) was markedly higher than among women with a primary education (3.44 children). Education strongly influenced fertility. Women with higher education had the lowest mean number of children. The mean number of stillborn children increased with age cohort, reflecting increased parity, which is associated with poorer birth outcomes. It is also the case that this may indicate a declining level of fetal loss in younger age-groups.

Women in the survey had 11,063 pregnancies in the five years prior before the survey. Per 100 pregnancies, 9.7 had ended before the sixth month, while out of the pregnancies which reached a viable term (i.e., 6-month gestation or more), 0.8 out of every 100 were stillbirths. Overall, the number of pregnancies, which did not result in a live birth, was 10.9 out of every 100. Pregnancy loss was higher for the youngest and oldest mothers. Per 100 pregnancies, 17.7 pregnancies ended in fetal death in the 15–19 age-group. Regarding pregnancy loss in older mothers (45–49 age-group), 25.1 per 100 ended in fetal death. This difference was mainly due to differences in the rate of loss before 6-month gestation and not due to differences in stillbirth rates. Pregnancy loss increased as the educational level rose. Women with no education lost 9.2 per 100 pregnancies, while women with a secondary or higher education lost 14.5 per 100 pregnancies.

Medical Issues

Concerning the utilization of health care, 64.1 % of women delivered in hospitals in comparison with the 34.3 % who delivered at home. Hospital deliveries were more common in urban (70 %) as contrasted with rural areas (55.1 %). Home deliveries were more common among women with no education (46.8 %) in comparison with hospital deliveries by women with secondary and higher level of education (76.6 %). Hospital deliveries were much more common in the younger age-group 15–19 with 79 %, while among women aged 45–49, home deliveries were more common.

Women in the survey were asked whether they had ever heard of an illness called AIDS, other infections transmitted through sexual contact, and specifically syphilis or gonorrhea. Overall, 57.4 % of the women indicated that they had heard about AIDS. Those in the youngest age-group knew the least about AIDS with only 50.4 % having heard of AIDS. The percentage familiar with AIDS increased to about 60 % for the age-group 20–39 and then decreased again for the oldest age-groups. Women who lived in urban areas were twice as likely to have heard about AIDS, and 96 % of those who had attended higher education had heard of AIDS. Of the women with no education, 21.8 % indicated that they had heard about AIDS.

Only 17.7 % of the women indicated that they had heard about syphilis or gonorrhea. Women in the youngest age-group were least likely to know about these diseases than older, particularly those women living in Kurdistan with only 4.7 % having heard of either disease. Survey respondents were asked to list the symptoms of a sexually transmitted disease (STI) for both men and women. Less than 50 % of women could list any STI symptoms for males or females. The youngest group and women with little education knew the fewest symptoms. This is a troubling finding given that STIs constitute a major public health problem, potentially leading to pelvic inflammatory disease, infertility, and ectopic pregnancy. Hemoglobin levels were assessed in the women respondents; 34.9 % of those aged 15–19 displayed anemia. In those who were currently pregnant, there was a higher prevalence of anemia among the age-group of 15–19 and 25–29 with 40.7 and 42.9 %, respectively. The total prevalence of anemia in currently pregnant women is 37.9 %.

Data concerning adult mortality were collected. The overall adult male mortality rates for the last 15 years had more than doubled from 1.23 to 2.7 per 1,000 males, while the corresponding figures for females had slightly increased by 30 %. Maternal mortality indices for the last 15 years were also assessed. There were 42 maternal deaths reported during this period. The maternal mortality rate was 0.12 per 1,000 women per year. The estimated general fertility rate was 0.137 per women. The maternal mortality ratio was 84 per 100,000 live births. Maternal mortality ratio during the last five years was estimated to be 47 per 100,000 live births, which is similar to most countries located closely to Iraq. For the same time period, one in every 15 adult female deaths could be attributed to maternal death.

Psychosocial Issues

In the study, Iraq Family Health Survey (IFHS 2006/2007) data about domestic violence were collected although it was noted that "a culture of silence" surrounds this topic in Iraq. Moreover, the researchers noted the risk of harm to women by perpetrators who were present at the time of the interview. Particular care was reportedly devoted to decreasing the risk of further violence by obtaining privacy, while the interviews were conducted. It is reported that they were able to obtain privacy in 95.6 % of the interviews. Controlling behaviors were reported by 83.1 % of the married women. Younger women were the most likely to be restricted on most of the measures of control. For example, 74.5 % of the young women aged 15–24 reported having to ask permission to seek health care as compared to 60.3 % of those aged 40–49. In all, 33.4 % of the women reported at least one form of emotional violence. The youngest age-group reported the lowest levels of emotional violence with 29.2 % of 15–24-year-olds reporting at least one act of emotional violence. The oldest group displayed the highest percentage of women reporting some emotional violence at 36.8 %. Overall, 21.2 % of women reported experiencing physical violence. There were few differences by age or residence, but there were marked differences between Kurdistan and the south/center area. In the south/center area, 22.7 % of women reported at least one form of physical abuse in contrast to a report of 10.9 % of those from Kurdistan.

The researchers randomly selected one adult, aged 18 or over, male or female, to complete a 20-item self-report mental health assessment regarding specific health events in the prior 30 days. Over half had felt nervous, tense, or worried in the previous 30 days, and a large percentage of the respondents also indicated that they were easily tired, often had headaches, and felt tired all the time. It is noteworthy that 3.5 % of respondents stated that they had thought of suicide, while 7.8 % had felt that they were worthless at some point in the previous 30 days. Female respondents endorsed more symptoms than males did. Some 17.8 % of men said that they were easily frightened in contrast to 37 % of females. More, older respondents endorsed mental health symptoms. Overall, 35.5 % of the respondents endorsed symptoms to a level of significant psychological distress with a gender difference of 40.4 % of females as compared to 30.4 % of the males. The older the respondents, the more symptoms they endorsed.

Catastrophic health expenditures, payments equal or exceeding 10 % of a household's capacity to pay, were common in all regions of Iraq. Almost one quarter of the households in the survey faced financial hardship due to health payments, and poor households may choose not to seek care rather than become impoverished. Poorer households were more likely to pay for outpatient rather than inpatient care.

Legal Issues

Marriage before the age of 15 is illegal, and marriage between the ages of 15 and 18 requires special authorization from a judge and cosigned by the father or legal guardian (WHO/Iraq Central Organization for Statistics and Information Technology (COSIT)/Kurdistan Region Statistics Office (KRSO)/Ministry of Health Iraq Family Health Survey, 2006–2007). In spite of legal barriers to early marriage, 10 % of young women aged between 12 and 30 still believe that it is best for a girl to marry before she reaches the age of 18. Forced marriages are illegal (Iraq Personal Status Code 1959, Number 188, Article 9). However, a third of young women believe that a girl must marry her relative if it is her guardian's wish (United Nations Population Fund (UNFPA)/COSIT/KRSO/Ministry of Youth and Sport Iraq National Youth Survey, 2009; IAU, November, 2010).

In the Ministry of Planning Central Statistical Organization (CSO) study (March 2012, p. 57) of women's health, 4.9 % of the women surveyed reported being married before the age of 15, and 21.7 % reported being married before

the age of 18. Among men, 20 % who were surveyed expressed the belief that male privilege extends to the right of forcing a female child to marry before reaching the minimum legal age of 18. It was reported (p. 15) in this study that the percentage of ever-married women, aged 15–19, who had begun their reproductive lives, was 14.3 %. Almost 70 % of the women surveyed felt that they had not reached their desired educational level.

In Iraq, 24 % of all women 10 years old and above are illiterate. This is a rate of illiteracy that is twice as high as the rate for men (24 % compared with 11 %). The difference in illiteracy rates between women and men is as high among younger people as among older people (IAU and OCHA 2008).

Iraqi family laws include the following[4]:

The minimum marriage age is 18 for men and women; judicial permission for underage marriages may be granted at 15 years if fitness, physical capacity, and guardian's consent (unless the guardian's objection is considered unreasonable) are established.

Polygamy is only permitted by judicial permission, obtainable on two conditions; the husband must show some lawful benefit and financial ability to support more than one wife. Permission is not to be granted if the judge fears unequal treatment of co-wives. The ILPS provides penalties of imprisonment and/or fines for non-compliance.

Talaq (divorce) must be confirmed by the *Shari'a* Court's judgment or registered with the court during the "*idda* period." *Talaq* by a man who is intoxicated, insane, feeble-minded, under coercion, enraged (*madhush*), or seriously ill or in death sickness is ineffective, as is *talaq* that is not immediate or is conditional or in the form of an oath. All *talaqs* are deemed single and revocable except the third of three.

Public Policy

The document, "Maternal, Child and Reproductive Health Strategy in Iraq, 2005–2008,"[5] was developed by Iraqi health planners, healthcare providers (physicians, nurses, midwives, pharmacists), and decision-makers from the Iraqi Ministry of Health, Ministry of Higher Education, NGOs, and international organizations. A seven-day workshop, June 2–7, 2004, on "Maternal Child Health and Reproductive Health strategy" was organized by WHO in collaboration with Iraq Ministry of Health (MOH)/UNICEF/UNFPA. The needs and challenges of adolescent mothers were not addressed in this document as a specific focus. Quality care generally for adolescents aged 10–19 was identified as a specific component of the MCH/RH strategy.

In order to better understand the status of women and children's health and education, nutrition, and social protection, UNICEF developed the Multiple Indicator Cluster Survey (MICS) in 1995. The purpose of the MICS is to produce "a wide range of scientifically built and tested indicators to provide a realistic and detailed picture of the situation of women and children in many countries across the world." The Iraq Multiple Indicator Cluster Survey 2011 Preliminary Report (April 2012) provides information from the fourth round of Iraq surveys, 1996 (6,000 households surveyed), 2000 (13,340 households), and 2006 (18,144 households). In the fourth round (the MICS-4), 36,580 households were surveyed and information was obtained for all districts in all governorates. The Iraqi Central Statistical Organization (CSO), the Kurdistan Region Statistics Office (KRSO), and the Ministry of Health and UNICEF conducted the four rounds of the MICS.

The MICS-4 stated:

[4] Muslims for Secular Democracy, A survey of family (personal) laws and population control policies in Muslim-majority countries. Retrieved from http://www.mfsd.org/msdannex.htm.

[5] World Health Organization, United Nations Children Emergency Fund, United Nations Fund for Population Activities, Iraqi Ministry of Health, and Iraqi Ministry of Higher Education. Maternal, Child and Reproductive Health Strategy in Iraq, 2005–2008.

> Child marriage is a violation of human rights, compromising the development of girls often resulting in early pregnancy and social isolation, and the concomitant decline in their education level, which leads to less profitable occupations that reflect the gendered nature of poverty. It is known that women who are married at early ages are more likely to drop out of school, give birth to more children and are more exposed to domestic violence and the risk of maternal mortality (p. 28).

Findings from the MICS-4 show that one in every five girls and young women (19 %) aged 15–19 is currently married with little variation between urban (18 %) and rural areas (19 %). The educational level of the mother profoundly influences early marriage, reaching 26 % among women whose mothers had no education compared to 10 % among women whose mothers had secondary or higher education. Early marriage is less influenced by household wealth. Among women from the richest households, 17 % versus 19 % of women of the poorest households had married early.

Among girls aged 15–49, 6 % had married before the age of 15 years; 24 % of young women aged 20–49 years had married before the age of 18. The prevalence of early marriage has declined over time: 30 % of women aged 45–49 years were married before their eighteenth birthday, while this percentage has dropped to 23 % for young women aged 20–24 years.

Of the 12,268 women surveyed, 37.3 % indicated that they had heard about female genital mutilation. In the age-group 15–19, 7.7 % reported that they were exposed to female genital mutilation as opposed to 15.1 % (3,913) women in the age-group of 45–49. Of those aged 15–19, 86.1 % felt that female genital mutilation should be discontinued, while among the age-group of 45–49, 79.2 % felt that the practice should be discontinued.

Prevention: Educational Programs, Sex Education, Birth Control

In a recent survey, most Iraqi girls between the ages of 10–14 years reported that they need more information about different aspects concerning their health, reproductive health, and other life skills. Over 87 % reported that they need more knowledge in other areas including their religious rights and duties (71.1 %) (The Iraqi Ministry of Planning Central Statistical Organization (CSO) (March 2012), p. 37). UNICEF (2011) has raised awareness of the pivotal place of adolescence and the "imperative of investing in adolescence" in order to accelerate the fight against poverty, socioeconomic disparities, and gender discrimination. UNICEF dedicated the 2011 edition of its flagship "The State of the World's Children" report to adolescents and adolescence. The UNICEF report states:

> Inequities often become starkly manifested during adolescence: children who are poor or marginalized are less likely to make the transition to secondary education and more like to experience abuses such as child marriage, early sex, violence and domestic labor—especially if they happen to be girls. Denying adolescents their rights to quality education, health care, protection and participation perpetuates the vicious cycle of poverty and exclusion that robs them of the chance to develop their capacities to the fullest (p. 1).

Rashad et al. (2005) define the disadvantages of early marriage for Arab teenagers:

> Early marriage is generally associated with early childbearing and high fertility, both of which pose health risks for women and their children. Married adolescents are less likely to know about contraceptive methods and STD. Very young mothers are also at greater risk than older mothers of dying from causes related to pregnancy and childbirth. And, the younger the bride is, the more significant the age gap with her husband tends to be—which exacerbates her disadvantage in negotiating with her husband on matters such as her own healthcare needs.

Child Welfare Provisions: National and Private Financial Support

For Iraqi children, decades of armed conflict, political upheaval, and occupation have significantly decreased resources for comprehensive early childhood care and education. Factors affecting children's readiness for education, that

is, birth weight, lack of breast-feeding, stunting, iron and iodine deficiencies, lack of stimulation, biased gender socialization, and exposure to violence, have impacted negatively upon development and health. In 2011, UNESCO noted that less than 10 % of Iraqi children (4–5) have access to any form of preprimary education; during 2005–2010, 85 % of Iraq children (1–8 years) were exposed to violence; less than 40 % of all Iraqi children are fully immunized; and only 25 % of children (2010) were breast-fed exclusively for the first six months.

On May 15, 2012, the Child Welfare Commission and the Ministry of Education sponsored a National Seminar on Early Childhood Care and Education (ECCE). The Ministries of Education, Higher Education and Scientific Research, Labor and Social Affairs, Environment, Human Rights, and Justice as well as representatives of the UN agencies, and NGOs in Iraq attended the seminar. UNESCO Director-General Inna Bokova stated, "Early childhood programs are an important means of guaranteeing the rights of young children. Strong foundations for children are also strong foundations for building more equitable societies." Recommendations proposed during the National Seminar on ECCE (UNESCO 2012) included:

- Supporting ECCE involved a high-level committee within the Government of Iraq in partnership with UNESCO, UNICEF and other agencies and local/international NGOs to lead the advancement of ECCE in Iraq
- Develop a comprehensive and holistic ECCE strategy in Iraq in coordination with existing national development plans
- Map and strengthen existing ECCE services and improve the quality and reach of these services
- Explore alternative delivery mechanisms for ECCE services in Iraq including home and community-based programming
- Mobilize different resources including government and non-government communities and families, focusing particularly on the mother, and the media to advance ECCE in Iraq.

A Country-Specific Perspective on the Future of Adolescent Pregnancy

Although there are similarities in the cultural and religious practices in the 22 Arab countries, Zogby has emphasized in his polling of people in Arab countries that the Arab world is not monolithic (Zogby 2010, p. 60). He writes:

> The Arab World that emerges from our surveys is hardly a place populated by monochromatic stick figures. Rather, it is a highly nuanced region rich in detail, pointing to a simple truth that the real Arab world is more complicated than the neat caricature frequently presented by commentators, politicians, and even some academics. Cairo is not Riyadh is not Beirut is not Marrakesh. The residents of each of these cities are aware of—and proud of—the unique attributes of their countries and are deeply committed to the values of their faiths.

A number of reports by the Iraqi government and the United Nations concerning specific circumstances related to child and maternal health have been issued. The Iraqi Ministry of Planning Central Statistical Organization (CSO) (March 2012) produced a report, "Iraq Woman Integrated Social and Health Survey (I-WISH)." A finding reported in this study was a trend in increased approval for adopting more women's rights. Young Iraqis in particular support the integration of women into society. In particular, there is strong support for gender equality in education, work, the choice of a husband, and women's freedom to choose the number of children they give birth to. There was little indication, however, that attitudes are changing regarding women's traditional household and community role primarily as homemakers or toward early marriages. Both younger and older women support early marriages with approval rates of 42.4 and 45.1 %, respectively. However, 11.4 % of the adolescent females reported that early marriage is a challenge to achieve their ambitions.

In June 2012, a report was issued from the Iraq National Population Commission (INPC), "Iraq Population Situation Analysis—PSA

2012, The Second National Report on the State of Iraq Population in the Context of the International Conference on Population and Development (ICPD) and Millennium Development Goals (MDGs)." The Iraq Ministry of Planning (MoP) reportedly realized (p. 4) "the risk of ignoring the relationship between population and development, and the importance of having a population policy that support population welfare in accordance with the internationally endorsed conventions and treaties…" It was argued that Iraq needs to create a national population policy to meet the challenges of current population dynamics and "the changing socio-economic environment" (p. 6). It was noted that the proportion of spending on the health sector "seems to be modest when compared with spending on education or military spending" (p. 9). Individual and community factors affecting the fertility rate were acknowledged.

It was noted:

> …in Iraq and other Arab countries there is an important role for religious institutions which encourage[s] early marriage and support the stereotyping of the traditional role of women in the society. These factors are deep rooted in Iraq and other Arab societies. These factors become more dominant in the cases of lack of security and political instability. Therefore, this analysis emphasizes the importance of awareness of indicators of child-bearing and control as variables associated with fertility and mortality levels to get to understand the true benefit when formulating population policies, health and social policies (p. 10).

On July 11, 2012, the Special Representative of the UN Secretary-General (SRSG) for Iraq, Martin Kolber, met with women representing Iraqi civil society organizations. He addressed issues related to the implementation of UN Security Council Resolution 1325 (2000) on Women, Peace and Security in Iraq.

According to the UN Assistance Mission for Iraq,

> "Resolution 1325 is a watershed resolution that calls for the active participation of women in all levels of decision making in conflict prevention, conflict resolution, peace processes, peace building and governance. It calls for the promotion of women's rights and gender equality." Kolber observed, "In particular in political decision making, women remain severely underrepresented—despite the fact that they make up more than half the population of Iraq. They should play a far bigger role." It was noted that the UN in Iraq "supports the Government of Iraq, women's NGOs and other key stakeholders in strengthening gender equality and women's empowerment."

Research

The Ministry of Planning and Development Cooperation and UNICEF released the preliminary report of the Multiple Indicator Cluster Survey 4 on May 20, 2012. This report contains initial findings of the most comprehensive survey on children in Iraq conducted since 2006. Progress has reportedly been made in the areas of birth registration, immunization coverage, increased institutional delivery, gender parity in primary school, and child labor. It was noted, however, that increased attention is needed in order to reduce the mortality rates of children less than 5 years of age, especially newborns, and to address chronic under nutrition (UN Security Council, July 2012).

Policy

The Government of Iraq in consultation with the World Health Organization (WHO) has developed the national maternal child health and reproductive health strategy for 2012–2016. The UN Population Fund is supporting the Ministry of Youth and Sport and Iraqi young people in jointly developing the first national youth strategy for Iraq. The UN, in consultation with thousands of young people from the 18 governorates, asserted that the strategy must meet the challenges faced by Iraqi youth, their rights and role in society, and their expectations of a future in Iraq (UN Security Council, July 2012).

Conclusion

Critical issues faced by contemporary Iraqi girls and women are for the most part safety and security. They define themselves within their families and society for the most part in the context of traditional patriarchal values. Daily life is challenging in Iraq with continuing significant difficulties even obtaining basic services including electricity and clean water, let alone gaining access to quality health care and education. Religious and cultural practices regarding the place of consanguinity and the role of the family in arranged marriages are evolving in relation to current circumstances. The meaning and nature of teen motherhood in Iraq is likely to evolve in relation to these contemporary realities. While human rights groups decry the impact of early marriage in limiting female access to education and self-determination, others note that early marriage may sometimes be an adaptive response to the risks and uncertainty presented by dangerous civil unrest and crushing exposure to harsh economic realities and social upheaval. Early marriage in any case often is linked to early pregnancy and its concomitant risks to maternal health and exposure of adolescent mothers to domestic violence. While female chastity at marriage is viewed as of paramount value, the worth of adolescent females following marriage is likely to continue to be closely tied to their fertility. The impact of the Internet and exposure to social conditions that provide other options for female self-determination is yet to be fully revealed or understood.

Young Iraqis will play a major role in resolving the cultural contradictions and challenges inherent in contemporary Iraq. Growing up in situations of chronic danger and ongoing traumatic stress associated with dangerous environments present ongoing developmental challenges (Garbarino et al. 1991). A young Iraqi premed major studying in an American university, an Iraqi refugee for five years, captured the complexities of evolving and conflicting gender roles and expectations in the young refugees.

Lost in a Land of Instability: A Personal Reflection

There are so many sad, heartbreaking stories of *disenfranchised grief* and *ambiguous loss* among the people and communities of Iraqi refugees, but only few of these stories are told. *Disenfranchised grief*, particularly in children who have no control of events and whose sense of loss is not recognized or understood by their parents or caregivers, will affect the children throughout their life. It is the effect of ambiguous loss, that is living with loss that cannot be validated and the uncertainty that life will ever return to what it was.

In order to understand what the Iraqi people are going through, we need to look at the history of the war, violence, oppression, forced migration and displacement, human rights abuses, and poverty for the past four decades. It is only normal to have negative consequences after what Iraqis have been through. Starting from the time the United States invaded Iraq in 2003, some four million (15 % of the total population) have fled their homes. Of these refugees, 50 % are children.

Almost half of the four million refugees sought refuge inside Iraq. The rest crossed the borders into neighboring countries. Many of these refugees are highly qualified professionals, which leaves many Iraqis who live in Iraq without access to quality education and basic health care. With many children out of school, parents unable to find jobs, as well as the memories of violence experienced in Iraq remain powerful. These experiences, physical and mental health problems, are increasing and of a great concern to the international community.

Reflecting on personal experience as an Iraqi refugee for the past five years, my family and I have undergone countless losses and many traumatic experiences. We have lost our home, our friends, some family members while trying to survive ourselves. I still remember the day I heard some shots a block away from where my friends and I were hanging out. One of my

friends ran over thinking it might be one of his family members, but he came back running shouting one of my friends' names and saying that "he's dead, they shot him." After what he said, I just could not comprehend anything! I was stuck in a paradox where I asked myself the question of should I go see him, or should I get back home before my mother thinks they shot me instead? On the way back home, I saw his mother rolling on the street. She was unable to walk to the scene of her son's death to see him for the last time. That day, that late afternoon, and that image of my friend's death have been seared into my memory. It will never leave my mind. How can I act like everything is normal after seeing violent death in your own neighborhood, happening to my own people?

We lived in Iraq until 2007. We moved to several neighboring countries before settling in Egypt. We were in Egypt for over two years before immigrating to the United States. The process of migrating to the United States took about three years. The time was needed to complete and submit the paperwork. This was burdensome for my family, but imagines others with worse cases that were being threatened or needed medical care.

Literature and research have demonstrated that the consequences of the war are more than just death and physical destruction. The 2003 war in Iraq caused a great deal of "individual trauma" described as the pain, shock, and helplessness that disaster survivors are likely to experience. My family and I experienced what we call the "collective trauma" as a result of the loss of the network of relationships that make up the general human milieu. And I believe it happened to us because we were wrenched out of our community, torn from the landscapes, and were forced to leave a place we called home and people we considered family.

My family and I are very thankful just to be alive. We have seen and witnessed death everyday. It is fairly normal for a neighborhood in Baghdad to have 2–3 killings a day, maybe even more. We might get used to it, but it does not mean we will not have future negative consequences. I remember my mother waking up in the middle of the night, a few days after we were forced to leave our neighborhood, to make sure that I was still alive! She had many nightmares with specific details about me dying in front of our house.

Dead bodies were everywhere. One time I heard bullets go off on our street, and I started running to make sure it was not one of my family members dying on the street. It was not anyone I knew, but I kept going back and forth looking at that dead body, making sure it was not my dad. It was not a normal scene for a 13-year-old boy.

As Iraqi refugees in the United States, we experience a great deal of disfranchised grief. Many of the people that we meet in America are happy for us to be here, and they think we are "saved" from our homeland. They do not recognize that we lost our home. My parents lost their jobs. We lost our school and friends and most importantly our homeland. Therefore, I believe that many Iraqi refugees are disfranchised from that grief. Disfranchised grief manifested itself in adolescent Iraqi girls and boys. While attending my school to obtain my college degree, I often get questions from professors, classmates, and some strangers concerning my background and country. They often follow up their questions with "oh thank god you are here now" or "well it's good to have you here" and "you don't have to worry about all that here," which is a nice gesture that makes us feel welcomed and safe in a new community, but I never had the chance to mourn and grief about my losses. I simply did not have the chance to feel upset about what I lost because I am considered to be in a "better" place.

The other problem is the lack of having an Iraqi community to support each other and maybe grieve and mourn together. I live in the state of New Jersey and the closest Iraqi family that I am in touch with lives 45 min away. We do not have cultural centers, and we lack programs that could bring people from the same culture together. Some of my friends who have limited proficiency in the English language are suffering from loneliness, depression, and lack of energy. All they do is stay home because they

are afraid of what is outside, it is too much of a cultural shock, and it is scary different. Therefore, I believe that we need some programs to help these young men and women adjust to the new culture and explore the many opportunities offered in the United States and more importantly help them get over and accept their losses and past traumatic experiences.

Iraqis are also experiencing ambiguous loss. Many people can argue that we are very lucky to escape the war zone and to be able to migrate to another country. Even so, we would love the chance to go back and help our brothers and sisters build the country again—and provide any possible help. But we cannot. Some of us may be killed if we return. Most of us so not have a place to go back to.

Our feelings and emotions are all mixed up. We simply have not had the chance to mourn and grief our losses. In many places, we do not have a strong community of Iraqi refugees supporting each other, and in other places, Iraqi refugees are too busy trying to figure out their futures while living in a foreign country. Many have lost the chance to feel upset about their losses and that might result into deeper social and psychological problems in the future.

One of the examples of how Iraqi youth are experiencing ambiguous loss is through their education. Many have completed their college degrees such as medicine and engineering, but they end up working at fast-food restaurants and minimum-wage jobs just to feed their families. They have the right to complain about their situation, but who is going to listen to them? Therefore, they do not have the chance to even be upset over the loss of their social and economic standing.

In addition to that, we continue to see people dying a violent death everyday back home. Yet, we can do almost nothing about it, while we "enjoy" the safety of the country of our residence. Therefore, I believe that many of us are experiencing survivor's guilt on a daily basis. I personally experience it almost everyday. When watching the news and seeing how so many back home are living in constant danger, while struggling with the knowledge that there is nothing I can do to make it better, is emotional torment. What can I do to make their lives better? Why am I here having all the benefits of being safe, while they suffer? Should I go back home? These are some of the questions that go through my mind every time I think of my home, Iraq.

To explain this experience of ambiguous loss and its impact, Pauline Boss (2006) offers what she refers to as the *cyclical model of recovery*. This model identifies emotional issues that can be addressed to re-establish emotional equilibrium and to rebuild resilience. The six primary emotional tasks that she describes that will overcome or at least manage ambiguous loss are as follows: (1) finding meaning, (2) tempering mastery, (3) reconstructing identity, (4) normalizing ambivalence, (5) revising attachment, and (6) discovering hope. In Iraq, these issues have a different universal meaning for children than they have for children and adolescents who do not or have not lived on the frontlines of a war.

Finding meaning has been a struggle. We always hear people making a meaning of their losses, but for us, it is simply not the same. It all happened so quickly that we did not even have time to make a meaning out of it. One day we are in Jordan, the next day we are all the way across the Atlantic in New Jersey. Instability was a silent weapon controlling our lives, and we could not do anything about it. Losing our homeland with our people forced us, mostly young people, to change our assumptions of the world. We grew up believing that you do "good" and you get "good" in return, but that has not been the case for Iraqi refugees struggling for years as the consequences of the many wars we have witnessed as a nation. Many have lost their faith in their religion and their rituals because they did not solve their problems. We could not find anything to hold on to in order to get us out of our miserable situation.

Tempering mastery occurred when we started to realize that not everything is fair and just; that there are luckier people than us. Many of my friends finished college and advanced degrees and are making less than a high school graduate. The reason for that is that we are not living in our county. We are foreigners. Our degrees do not

matter, and our education does not count! It might sound ridiculous, but it is sadly true! In addition to that, we started reconstructing our own identity. Do we want to be Iraqis anymore? Our nation seems to attract negative forces. It attracts poverty, homelessness, unemployment, racism, and many more social ills. That is why you see many Iraqi looking forward just to obtain a citizenship anywhere else. Our identities are vanishing, and we cannot do anything about it.

On the other hand, we need to normalize our ambivalence. We need to normalize our guilt and negative feelings, but not in harmful actions. I personally experience survival's guilt everyday, but we must recognize that and normalize it as much as possible. We need to open up about our feelings and recognizing what the problem is. Then, we need to start treating whatever community we are living in as our own family. We have to have an enormous support group filled with professionals that provide a "judgment-free" zone for people to share what they are going through given that knowledge that we will never be able to solve the problems back home.

We also need to shift our attachment. We need to start moving on with our losses and admit the fact that they are gone forever. For example, we can organize memorial ceremonies and farewell rituals to say good-bye to our loved ones. It might be hard to do, but it is one of the necessary and first steps toward our last goal, which is discovering hope. We need, even if it seems impossible, to discover hope again. Contribute to the community that we live in. Find reasons for you to keep you alive. Construct goals that are realistic and achievable. We need to start forgiving others and ourselves in order to live in peace.

There are many stories out there that need to be told. We need to start thinking about certain programs to help this traumatized new generation. We need to educate others and ourselves about what is happening thousands of miles away from us. I am doing some of my part by writing this, and now it is time to do your part.

There are many horrific stories of disenfranchised grief and ambiguous loss among the community of Iraqi refugees, but only few of them have told their story. Their journey describes four decades of trauma because of political, social, and economic instability. It is the story of 31 million people who faced and continue to struggle with wars, violence, oppressions, forced migration, displacement, and human rights abuses. Unemployment and poverty have devastated Iraqi society. It has burned the people with the human and economic cost of a manufactured health crisis. As a consequence of the 2003 war and the US-led invasion of Iraq, an estimated four million Iraqis, nearly 15 % of the total population, have fled their homes, of which 50 % are children. Approximately 1.9 million people have sought refuge inside Iraq, and 2.2 million have crossed the borders into neighboring countries. Among the refugees are many highly qualified professionals, which leave many Iraqis who remained without access to quality education and basic health care. Life for many in the Iraqi refugee and displaced population offers few or no legal rights and extreme economic hardship. With children out of school, and parents unable to find jobs in order to support families, as well as the memories of violence experienced in Iraq remaining elevated, physical and mental health problems will continue growing among people who remained in Iraq but also among refuges.

While the young writer of the above essay pursues his studies in the United States, his sister remains in Iraq where she is completing her last year of medical school and in many ways embodies the challenges and opportunities of young Iraqi women today. She too experienced the profound insecurity, instability, and dislocation described by her brother and missed a year of her studies while a refugee in Egypt. She returned to Iraq to continue medical school where she became interested in maternal and child health. Having visited American medical facilities while visiting her family during summer vacations, she feels the healthcare facilities in Iraq and medical services provided to women in Iraq are outdated. She feels a life mission to improve circumstances for women and children in Iraq.

In commemoration of the death of dozens of children from a car bombing on July 13, 2005, UNICEF reaffirmed its commitment to protect

and promote the rights of Iraq's 16 million children on the occasion of the 2011 *Day of the Iraqi Child*. Working closely with the Ministry of Labor and Social Affairs and the Child Welfare Commission, UNICEF indicated its support for the Government of Iraq to develop a Child Protection Policy and Child Law to better protect children in Iraq. Issues to be given specific attention include discrimination and gender-based violence, particularly early and forced marriage as well as the impact of violence against children in the context of armed conflict. It is hoped that the Government of Iraq will endeavor to build a national child protection system that will effectively address all child protection issues in the years ahead.

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Adolescent Pregnancy in Ireland (Eire): Medical, Psychosocial, and Public Health Responses

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Keywords
Ireland: abortion · Children as rights-holders · Coerced sexual debut · Contraception · Human rights watch · International abortion law · Maternal health · Reproductive health · Sexual education · STIs and HIV

Introduction

To understand teen pregnancy in Ireland, one needs to put into perspective a history of a British policy of genocide that has shaped Irish culture and family life over the millennia. Equally demoralizing to both life and culture among the Irish has been the Irish Catholic Church. The Irish Catholic Church has ruled Ireland for over a 1,000 years with devastating effects that increased fertility, restricted knowledge of reproductive health and services, and ignored extreme rates of maternal and child mortality. Considering only the human body count, the nation of Great Britain, and the Irish Catholic Church have visited on Ireland one of humanity's greatest and longest running tragedies.

In this chapter, we begin to put into context the role of women's reproductive rights, the Irish Catholic Church and its influence on sexual politics in Ireland; and how it has impacted female reproductive health in the twentieth and twenty-first centuries. Context is essential because contrary to the experience of other countries where the Roman Catholic Church dominates sexual reproductive and sexual health policy (i.e., countries in South America), in Ireland adolescent pregnancy rates have remained stable since the 1970s. To put Irish adolescent pregnancy in perspective, keep in mind that abortion continued to be illegal in both the Irish Republic and Northern Ireland. In 1970, the adolescent birth rate was 16.3 births per 1,000. In 2009, the adolescent birth rate was also 16.3 births per 1,000. In contrast, in the USA in 2009, the adolescent birth rate was 41.5 births per 1,000. In the UK of Great Britain and Northern Ireland, the adolescent birth rate was 25 births per 1,000. At the low end of the continuum, Sweden's adolescent birth rate at the same time was 5.9 births per 1,000. Switzerland's adolescent birth rate was 4.1 per 1,000 (United Nations Statistics Division 2011). This is a rate of adolescent pregnancy that is diametrically different from what would be expected in a traditional Catholic country like Ireland, especially keeping in mind that historically the Catholic Church has successfully promoted high

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rates of fertility among Catholic girls and women worldwide.

To begin to understand this extraordinary drop in Irish adolescent pregnancy, the larger social environment within which the girl's live and develop their sexuality will be reviewed. Additionally, the history that shaped the traditional view of Irish women and which continues to influence the view and role of women and girls in Irish society today will provide a foundation for a more in-depth understanding of Irish adolescent pregnancy.

The Modern State of Ireland

Ireland or *Eire* is an island in the northern Atlantic Ocean. It is located west of Great Britain and made up of two independent nations, the Republic of Ireland is a sovereign state (a member of the European Union) and Northern Ireland (is a member of the UK of Great Britain).

Ireland's climate is mild, and its geology is remarkably diverse for a small island. The extended coastline, large expanse of territorial waters, and its "saucer-like" topography with mountainous areas concentrated along the coast, rather than along a central spine, have contributed to Ireland's exceptional beauty. Much of Ireland can be seen from the top of the Hill of Tara, the ceremonial center of Ancient Ireland.

The Republic of Ireland governs 80 % of the island. Northern Ireland controls the remaining 20 %. The Republic of Ireland is divided into 26 counties. The capital is Dublin, located in Dublin County with a population in 2012 of 1,270,000. The total population of the Republic in mid-2012 was estimated to 6,380,000 (CSO 2012). Northern Ireland is divided into six counties. Its capital is Belfast. The metro area of Belfast in 2012 had a population of 579,726. The total population of Northern Ireland in 2012 was estimated to be 1,810,900 (NISRA 2012).

The Republic of Ireland joined the European Union in 1973. In 1980, a major study of poverty in the Republic found that just under a million people were living below the poverty line. There were pessimistic—even apocalyptic predictions—about the Irish economic prospects (Foster 2007). This began to slowly change in the 1980s. Economic prospects really began to show change between 1995 and 2007, when the average GDP growth rate was about 6 % a year. This was a period in which the Irish economy evolved into a more diverse and sophisticated player in the European Union. By the 1990s, Ireland was a modern industrial economy, which generated considerable national wealth that benefited everyone. Ireland's industrial complex manufactured sophisticated electronics and other goods that competed on the international market. In the 1990s, Ireland was often referred to as the "Celtic Tiger" because of its international economic power. On January 1, 2002, Ireland was among the original 12 EU nations that adopted the euro (Girvina 2011).

Then, in 2008 the European and American economy faltered. The collapse of international markets and banking devastated the Irish economy. This economic crisis brought on successive devaluations of property values and widespread home foreclosures. Average home prices fell almost 50 % after reaching their highest value in 2007 (Girvina 2011). The dream of a stable home life, which included living in one's own home, for far too many—especially the young—became a nightmare. This reversal of national fortunes was not lost on adolescents. For those coming of age, opportunity was suddenly snatched from their grip. How were they to make their mark in the world?

As the economy worsened, the government was faced with growing budget deficits; in 2009, the Irish government made the first in a series of Draconian budget cuts. Across the board cuts and cutting wages for public servants, however, was not enough. In 2010, the budget deficit reached 32 % of the GDP—an extremely large deficit, as a percentage of GDP. Austerity measures made to meet the deficit targets demanded by Ireland's EU–International Monetary Fund (IMF) bailout showed moderate growth in 2011. Nevertheless, the economic recovery was expected to be slow (CIA World Factbook 2011).

The impact of the international and national economic crisis on the rate of adolescent pregnancy in Ireland is unknown. Cuts in public financial support for health programs and programs focused on adolescent sexual and reproductive health would logically result in an increase in adolescent pregnancies, abortions, and births. Intuitively, the negative impact on adolescent pregnancy caused by the macroeconomic effect may depend on how long the economic crisis lasts. In the short-run, there may be little measurable negative effect. In the long run, however, if children and adolescents see fewer and fewer opportunities in their future logical decisions should be expected by adolescent females. There will be an increase in adolescent pregnancy, abortion, and childbirth. In terms of adolescent maternal and child health, if the budget cuts in Irish health programs that serve children and adolescents are not restored to meet the need, the impact will have devastating effects on adolescent maternal health and the health of their offspring.

Historical Background of Eire

Hibernia (the Roman Empire's name for Ireland and still occasionally used poetically), Eire (related the poet Erin), and in recent history Ireland, are the major names used over the millennium to identify the large island west of the British Isles. Arriving some 10,000 years ago, the first inhabitants, it is speculated, crossed a land bridge (formed by the ice age and lower ocean levels) from Scotland during the Mesolithic or Middle Stone Age period. During the Neolithic/New Stone Age period (5500–2500 BCE), a time of human discovery and settlement, the people of Ireland were herdsmen, farmers, and builders. One of the earliest settlements from this period was discovered in Lough Gur in County Limerick. An ancient tomb constructed by these Irish natives about 3,200 BCE was called Newgrange. This prehistoric monument is older than Stonehenge in England and older than the Great Pyramid of Giza in Egypt (Connolly 2000; Kearney 2007).

By 1200 BCE, immigrants had brought and were producing a greater variety of weapons and artifacts. A common dwelling across the countryside during this period was the "crannog," an artificial island constructed in the middle of a lake. The Celts began to arrive in Ireland around 600 BCE. Linguistically, they were related to the Indo-European culture (Connolly 2000; Kearney 2007).

Between 200 and 100 BCE, the Celts divided the Island into some 150 small dominions called *tuaths*. Local leaders controlled the *tuaths*. They, in turn, were subjects to a more powerful ruler who controlled a group of *tuaths*. These related tuaths were organized under five major provincial kings. Conflict and shifts in power and rulers characterized this period in Irish history (Connolly 2000; Kearney 2007).

Celtic culture in Ireland was based on a simple agrarian society. The cow was the unit of exchange. Society was stratified by class and controlled by the Brehon Laws. The *tuath* was the political body, and the *fine* (the extended family) was the basic social unit. This class system formed the basis of family life and the role of women that continued to exist even after the Gaels began to arrive in 100 BCE (Connolly 2000; Kearney 2007).

The next major development in the role of women and family occurred when Pope Celestine I sent Archbishop Palladius to Ireland in 431 AD. After his sudden death in 432 AD, Saint Patrick, an ordained bishop, arrived in Ireland and began converting the pagan Gaelic Kings to Christianity. By his death in 462 AD, the Catholic Church was firmly established and Ireland had evolved into a recognizable Roman style civilization (De Paor 1993). The family structure based on Catholic doctrine demoted the role of women to that as subservient to men and defined motherhood as womanhood. These changes set the stage for family relations over the next 1,600 plus years (McDonnell and Allison 2006).

Culture and Tradition

Over the centuries, Ireland became a homogenous society based on Catholic ideology. The Irish Catholic Church was the only moral authority in Ireland, and it precisely defined the institutions of family and community (MacManus 1921). The Church controlled the State's hospitals and schools and was the largest provider of welfare services. Although the interest of the state and the Irish Catholic Church were at times in conflict, for the most part, there was consensus particularly on the symbolic meaning of women's reproductive and sexual behavior. The church's power and influence was operationalized as ideological conservative social policies that banned abortion, contraception, divorce, and pornography, including the censorship of books, music, and films objectionable to the Irish Catholic Church (Foster 2007).

When the partition of Ireland was enacted in 1922, 93 % of the Free State of Ireland's population was Catholic, while 7.4 % were Protestant. The percent of Protestants had fallen to 3.7 % by the 1960s. Emigration was high among all the Irish populous during this period because of the lack of opportunity in Ireland; even so, the rate of Protestant emigration was disproportionately high during this period. The bitterness over the Great Famine of 1845–1849 toward Britain and Protestants in general played out in the burning of Protestant homes belonging to the old landed class who thought of themselves as British. While the struggle against British control continued thought out the eighteenth and nineteenth centuries, the Irish Catholic Church regained the authority such that by the 1920s, the Free State of Ireland was a Catholic Nationalist State (Kearney 2007).

Once the Free State of Ireland was established, the Irish Catholic Church reasserted its authority over the institutions of family and community banning divorce, prohibiting remarriage, and making it illegal to sell any form of artificial contraception. The power and control of the church over the social and sexual life of women in Ireland held strong until the 1970s when the feminist movement began to take hold in Ireland (Maguire 2001). The impact of the feminist movement and a pragmatic medical community resulted in the Health Act of 1979. Although the church wanted to continue the ban on contraception, they had to settle for a compromise. In effect, the compromise was a form of restricting contraception; it did not prohibit the sale of contraception. Contraception could be purchased from a registered pharmacist with a prescription from a doctor. However weakened the church may have been, it was still powerful enough in 1983 to introduce and pass a constitutional amendment prohibiting abortion. This phase in the reassertion of fundamental beliefs culminated in the fundamentalist Catholic social movement and the 8th Amendment (1983) to the Irish constitution on the "right to life of the unborn" (McDonnell and Allison 2006).

The Ann Lovett and Kerry Babies Scandals

In 1983 when the Irish people went to the polls to vote on a constitutional amendment to ban abortion in Ireland, it was no surprise that the referendum passed. What was surprising was that it passed by a smaller majority than its supporters had anticipated when less than 50 % of the electorate turned out to vote. The push for this referendum came about not in response to changes in the abortion law, or from the small organized group that wanted to legalize abortion, but from a small group of conservative politicians and fundamentalist Catholic leaders who feared that Irish law would soon be replaced by European law and that abortion legislation would be imposed on Ireland from without. The rationale for their argument was that the only way to preserve Ireland's distinctive moral foundation was to make abortion a constitutional law and as such ward-off exposure to "foreign" cultural, political, and moral influences (Fogarty 1984).

Although there were many who opposed the referendum, most people still regarded abortion

as immoral. Parenthetically, they also viewed the pro-life advocates and anti-abortionists as hypocritical given the church and state refusal to recognize unmarried mothers and their children as deserving of respect, dignity, and afforded the same benefits extended to married mothers and holding men equally responsible for the "illegitimacy" and perceived immorality of unwed motherhood. At the same time, thousands of Irish women were annually seeking abortions in Britain and Europe (Solomons 1992).

Despite the reality, the majority of people in Ireland continued to practice Catholicism even though they no longer accepted the church's *moral authority* where their own sexual and reproductive lives were concerned. This precarious relationship with the church was all but destroyed by two events in 1984; just months after the vote on the abortion referendum. The death of Ann Lovett and the "Kerry babies" scandal shattered the belief among people who rarely questioned the moral underpinnings of their conservative politicians and leaders in the Catholic Church. These two tragic events brought into focus the divide between the "old" and "new" Ireland in terms of women's reproductive health. The public airing in the Irish press of these occurrences brought tension and conflict between the perceived image of Catholic Ireland that prevailed at the national level and the realities of moral and sexual behaviors and attitudes at the local level.

In January 1984, Ann Lovett, a fifteen-year-old convent schoolgirl, gave birth outdoors, in a grotto dedicated to the Virgin Mary, in Granard, County Longford. According to postmortem reports, Lovett's baby was stillborn, having died of exposure and hemorrhage after spending over 4 h lying on the cold, damp ground, unprotected from the wind and driving rain. The baby's death shocked and saddened people in her community and throughout the country. Those close to her claimed ignorance of her pregnancy and insisted that every aid would have been extended had they known. An inquest revealed that many people did, in fact, know that Lovett was pregnant but believed it to be none of their business. Rumors circulated through the town that Lovett's pregnancy was the result of incest, although these rumors had never been confirmed. "Lovett's pregnancy and death confronted small-town Irish society with a host of issues that were not new in the 1980s; incest, teenage sexuality, and unwed motherhood". What was new in 1984 was the very public way that the community was forced, by one young girl's personal and painful death, to wrestle with how it defined right and wrong, inclusion and exclusion, punished transgressions from the norm, and negotiated the limits of a community's responsibility for its most vulnerable members (O'Reilly 1984).

Kerry Babies

Shortly after the Ann Lovett scandal broke, a woman named Joanne Hayes was investigated by the Gardai (police) when a baby, who had been beaten and stabbed, washed up on the shore of a small village in County Kerry. To find the abuser, the Garda went door to door in the village demanding women who had recently given birth to show them their babies to establish that the dead child was not theirs. As it turned out, Joanne Hayes became pregnant after an affair with a married man and successfully gave birth to a baby in April 1984 in a field adjacent to her family farm. The day after the birth, she went to a local hospital complaining of severe bleeding. A physical examination showed that she had indeed given birth within the last 48 h. Although blood tests proved that she was not the mother of the baby that had been killed and washed ashore in County Kerry, Joanne Hayes was still characterized as an "unmarried mother and adulterer" who should be prosecuted to the fullest extent of the law. The news coverage in the print media and the national and local broadcast of the details of the case led to a different national critique of contemporary Irish society; a society which on the one hand professed to embrace "prolife" principles, and on the other hand, allow newborns to die, and single women to give birth frightened, alone, and stigmatized (Maguire 2001).

Historically, these two tragic events contributed to the diminishing influence of the Church on public policy related to reproductive and contraceptive rights. This loss of Church influence was apparent in 1996 when the church leaders failed to stop the prohibition on divorce from being removed from the Irish constitution (McDonnell and Allison 2006). This is probably more of a testament to the church having lost its moral authority, than having lost its political clout.

These events took place in the 1990s against a backdrop that can only be described as a seismic shift in the social consciousness of the young people of Ireland. A social revolution that accelerated social change away from the Irish Catholic Church and toward a modern, pluralist, and secular society. This loss of control by the Irish Catholic Church, over the daily lives of individuals and families can in part be explained by the public's reaction to the child abuse scandals, anti-intellectualism, authoritarianism, a litany of church abuses down through the ages, and questions about the morality of those who represented the church. Just as important to the decline in the Church's authority, young people of Ireland lost their belief in the Church as a viable institution in a modern Irish society (Foster 2007). A symbol of the decline in the Irish Catholic Church occurred in 2011 when Ireland's government shuttered its embassy at the Vatican (Pentin 2011).

Overview of Adolescent Pregnancy

How does a history of Irish Catholic ideology and dominance affect adolescent pregnancy in the twenty-first century? In many ways, it has caused a paradoxical reaction. Instead of church doctrine continuing to influence high rates of fertility and resistance to the use of contraception, especially among the youth of Ireland, the rate of pregnancy and birth dropped significantly. By the 1970s, the adolescent birth rate in Ireland was 16.3 births per 1,000. Although fluctuating slightly over the years, the adolescent birth rate was again 16.3 births per 1,000 in 2009. This is a rate that is slightly higher than the average for European countries. Yet, it is lower than that of Northern Ireland and the UK at 25 births per 1,000. With the economic change in the 1990s, in less than one generation, adolescent life was transformed from the traditional Irish Catholic existence to a more modern lifestyle common to adolescents in most Western European countries. The rate of change in Ireland was extraordinary (Canavan 2012).

Birth Rate

In 2006, there were 2,335 births to teenagers (15–19) in the Republic of Ireland. This was 16.3 births per 1,000 girls between 15 and 19. This was the lowest teen birth rate since 1995. The rate has not changed significantly since 1975. About 75 % of births to adolescents occur among females 18–19 years of age (1,815 of 2,427 births in 2005). Of the remainder, 42 births were to girls under the age of 15. Almost all were the teen's first child (90 % in 2001). The year 2010 marked a new 10-year low in the number and rate of births to teenagers in Ireland. Even so, about 33 % of births in 2006 were outside of marriage. For adolescent and young women giving birth to their first child, approximately 44 % of births were outside marriage. This figure decreased to 28.5 % for a second child and dropped to 20 % for a third child (CSO 2006).

Although high for the EU (fertility rate 1.5), Ireland's fertility rate at 1.88 is below replacement level. The average age for mothers in Ireland when they have their first child is 28 (30 years for married women and 25 years for unmarried women). In 2005, some 32 % births occurred outside marriage. In 1973, only 3.2 % of births were outside marriage. Based on the best data available, an estimated 136,000 women had experienced an unintended pregnancy (referred to as a crisis pregnancy in Ireland) in their lifetime. That is, 28 % of women and 23 % of men who experienced at least one unintended pregnancy. In 2010, 11 % of the population lives in one-parent families. This is an increase of

24.5 % since 1996. Almost 25 % of people experiencing persistent poverty in the Republic live in single-parent households (McBride et al. 2012).

Adoption, which was a major objective for children born to unmarried adolescents, has seen a dramatic change. In 1976, there were 1,005 babies adopted by non-family members. This number had dropped to 88 by 2004 (Adoption Board). Only about 0.5 % of births in 2002 that were born outside of marriage ended with the baby being placed for adoption. In 1976, 39.5 % of births outside marriage were put up for adoption (CPA 2007).

Adolescent pregnancy and motherhood in Ireland presents specific challenges to the state system of primary health care. Basic steps to meeting these challenges are the provision of health education and contraceptive services to prevent unplanned teenage pregnancy in the first place. Additionally, obstetric care needs to be available for teenagers who are at high risk of developing complications in pregnancy and childbirth. Finally, there is the concern over the perceived unresolved issue of care required to deal with the occasional longer-term adverse health consequences associated with adolescent pregnancy and childbirth. This is an issue where research is expected to inform health professionals and give direction for improving primary care for adolescents (Irvine et al. 1997).

Sexual Education

Since the 1990s, an abundance of research evidence from developed and developing countries have shown that gender norms and power disparities can affect the sexual attitudes, practices, and health of both boys and girls. Traditional attitudes about gender roles and disparities have been found to be associated with "earlier age of sexual debut, a higher number of partners, more frequent intercourse, lower rates of condom and contraceptive use, and higher rates of HIV infection" (Rogow and Haberland 2005).

As a post-Catholic, pluralistic republic, Ireland's culture is becoming increasingly more mainstream in their core beliefs, values, and behaviors and in its political discourse regarding women's reproductive health. This shift in cultural perspective is reflected in sexual education. For good reason some would say, the Irish Department of Education was late in exerting its authority over public sexual education. The Department had been struggling with the Catholic hierarchy over modernizing the school system in the Republic since 1963; modernizing has been difficult and measured (Clarke 2010). Nevertheless, in 1987, guidelines were issued to post-primary schools that directed schools to integrate sexual and relationship education into their curriculum. The Relationships and Sexuality Education (RSE) program was introduced in 1995. Since then, sexual education has progressively become more secular and pragmatic, moving toward a health orientation and away from the influence of religious teachings. Yet, children are not introduced to the biological basics until 10 or 11 years of age. By 2011, over 85 % of young adults between the ages 18 and 25 received sex education at some point in their lives as opposed to adults between the ages of 36 and 45 (57 %). Moreover, in the Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-2010) survey, over 60 % of those who received sexual education in the Republic reported that the content covered sex and sexual intercourse.

Providing sexual education in the public schools is important for two reasons. A standard curriculum can be developed and tested, and the impact can be measured. In Ireland, among those who receive sexual education, 50 % received their sexual education at school only, 32 % both at home and at school, 8 % at home only, and another 10 % receive their sexual education outside of the home or school environment. Knowing where an adolescent received their sexual education is important because in the Republic those who received their sexual education outside of the home and school environment were 1.5 times less likely to use

contraception the first time they had intercourse when compared with those who received sex education at home and/or at school. Finally, in the ICCP-2010 study, 71 % of young adults reported that their sexual education was helpful, while 60 % those aged 26 to 35 thought it was helpful. Adolescents who found their sexual education helpful were twice as likely to use contraception when having sex for the first time as their peers who did not find it helpful (McBride et al. 2012).

Sexual Debut

Equal to the miracle of life is the biological miracle of sexual development. During this period of development, there are reasons for joy and reasons for concern. Research since the 1990s has firmly established that an early age of sexual debut is associated with sexually transmitted infections (STIs), unplanned pregnancies, high rates of fertility, and other less positive economic and social outcomes (Rogow and Haberland 2005). Understanding the interplay of factors associated with early debut of sexual intercourse is important when trying to establish and maintain long-term sexual health.

Research shows that the average age of sexual debut Ireland is about 17 years, similar to the average age in the USA, and a year older than in the UK. The legal age of consent in Ireland is 17 for both boy and girls. Roughly one in three children of school age in Ireland have had penetrative sex. Of those, one in five was under the age of 16. The proportion of boys having sex before the age of 17 (28 %) has remained stable since 2003 (29 %), but the proportion of girls having sex before age 17 increased from 14 to 17 % between 2003 and 2010. Thus, the proportion of young women aged 18–25 who reported experiencing sexual intercourse for the first time before the age of 17 was 26 % in 2010, an increase from 21 % in 2003. For young men, 37 % reported experiencing sexual intercourse for the first time before the age of 17, a decrease from 39 % in 2003 (Drennan et al. 2009; McBride et al. 2012). Earlier sexual debut is also associated with alcohol and drug use, unprotected sex, and sexual exploitation.

Coerced Sexual Debut

While only one in 10 boys reported that they felt pressured to have full penetrative sex, approximately one in three girls reported that they had felt pressured to have full penetrative sex (Drennan et al. 2009). The Rape Crisis Network of Ireland has expressed concern that the sexual exploitation of teenagers by their peers is greater than is reported. They base this concern on teenagers who have sought help from their centers. These teens indicated that they were between the ages of 12 and 17 when the sexual abuse occurred. The centers also report that gay teens are struggling with added personal and social challenges related to sexual coercion (The Irish Times 2011). Research on mental health of LGBT people in Ireland in 2009 found that the most common age for becoming aware of sexual orientation was 12 (the average was 14), but the most common age for “coming out” was not until 17 (the average was 21). Even though demonstrating great resilience, this seven-year time frame from realization to “coming out” was strongly associated with mental health vulnerability and psychological distress. Some 80 % reported verbal insults, threats of physical violence, physical assaults, and sexual assaults because they were perceived to be LGBT (Mayock et al. 2009). These experiences and vulnerabilities have been reported in other studies of LGBT adolescents in other developed countries.

Contraception

A better understanding of contraception use and the lack of contraception use among adolescents can help improve intervention efforts to reduce the incident of unintended pregnancy, which can have a positive effect on adolescent sexual and

reproductive health. The most common reasons for not using contraception given by Irish adolescents were not being prepared for their first sexual encounter, thereby engaging in unplanned sex. Some 20 % of participants under the age of 25 said that alcohol and/or taking drugs had contributed to them having unprotected sex in the past (McGee et al. 2008).

The groups of adolescents identified as "at risk" for not using contraception during their first sexual intercourse, or boys who have dropped out of school, boys and girls from a lower "social class," and those adolescents who have sex for the first time before the age of 17. The good news is that over the years the percentage of adolescents using contraception when having sex for the first time has increased. Almost 90 % of those 18–25 surveyed used contraception during their first sexual experience. About 80 % of those 26–35 reported using contraception during their first sexual experience. Only 61 % of those 36–45 reported using contraception during their first sexual experience (McBride et al. 2012).

An increase of 20 % to a level of 90 % over 20 years in the use of contraception during first sexual intercourse of Irish youth is quite an accomplishment. In the USA, the use of contraceptives during the adolescent's first sexual intercourse has also increased from 56 % among women whose first sexual experience occurred before 1985, to 76 % among those who first had sex in 2000–2004, to 84 % among those whose first experienced sexual intercourse in 2005–2008 (Mosher and Jones 2010).

STIs and HIV

Another extremely important issue is adolescent knowledge of and testing for HIV and STI. Each new generation of adolescents must be educated about the transmission and consequences of HIV and STIs. Only sexual education can positively influence an adolescent's behavior and reduce the negative impact on health and fertility and ultimately influence an adolescent's decision to be screened for HIV or STIs.

HIV first appeared in Ireland, unlike the USA and other developed countries, as an ancillary problem associated with the opiate epidemic and IV drug use that swept across the Island in the mid-1980s. Although the spread was not isolated to any particular group, the gay community was the first to respond. Government reaction to the increasing number of HIV infections in the larger community was impeded, by the religious hierarchy, in the development of AIDS policy and services. The Irish Catholic Church was critical in determining the public perceptions of HIV/AIDS and the narrative about the men and women who were HIV infected. Two areas related to policy and services stand out. The influences on public health education programs, and in particular, the information about the risk and treatment of HIV/AIDS (often distorted or incomplete) provided to the public; and the Church's role in the development of services and other interventions for people at risk of becoming infected by HIV or who were living with HIV/AIDS (Smyth 1998).

First, the Catholic teachings that forbade any public discourse on sexuality delayed the distribution of accurate public health information. Second, the early and persistent HIV/AIDS educational message that emphasized abstinence and monogamy as the best protection against HIV infection (designed to be in line with Church doctrine) resulted in limited information and continued draconian restrictions on access to contraception. These early educational interventions essentially denied an unsuspecting public, one of the most effective means of protecting themselves from HIV infection. On an emotional level, the messages conveyed by the Church about HIV/AIDS gave rise to a fatalistic attitude about one's ability to prevent infection and reinforced a sense of guilt that prolonged at-risk behavior. As a result, the government's reaction to the HIV epidemic was perceived by many to be far too slow and driven by motives other than the prevention of the HIV/AIDS epidemic (Smyth 1998).

While the role of the Irish Catholic Church in delaying HIV/AIDS prevention efforts by the government has been documented, the strategies

are not unfamiliar in other countries where conservative religious organizations, including the Catholic Church, have fought the sexual education and HIV/AIDS prevention information and programs from using approaches that are effective and efficient in reducing the risk and preventing infection. The results of these efforts to steer morality in one direction or another have been devastating for a vast number of adolescents and young people around the world.

By 2010, approximately 36 % of the Irish adults had been tested for HIV (23 % of males and 42 % of females). For comparison, in the USA approximately 50 % have been tested (Kaiser Family Foundation 2005). In the total population of the Republic, less than 1 % have been diagnosed with HIV. In 2010, slightly fewer than 8 people per 100,000 were diagnosed with HIV. Irish males had an incident rate twice that of females (11.3 per 100,000 males and 4.2 per 100,000 females). The percentages were also low for STIs other than HIV (20 % of males and 32 % of females) (McBride et al. 2012).

Of the 330 new cases of HIV reported in Ireland in 2010, some 40 % of were among men who had sex with other men. Among these males, 30 % were between the ages of 15 and 29. Forty percent is lower than in the USA where more than half of new HIV cases (54,000 in 2009) occurred in gay and bisexual males (Crepaz et al. 2006). To better inform this identified at-risk group, a National HIV Prevention and Sexual Health Awareness Program was launched in Dublin on World AIDS Day in 2011 (RTÉ 2011).

At the same time, a new law took effect that will likely reduce volunteer testing. In September 2011, the Health Minister signed into law an amendment that made HIV an officially notifiable disease. Under law, doctors must report every case of HIV they diagnose to their local department of public health. The official reason for the new reporting law is to improve the accuracy of statistics on the number of HIV cases (RTÉ 2011). Historically, in others countries, similar laws have reduced voluntary testing.

Abortion

The majority of adolescent and young women from Ireland who seek an abortion go to clinics in the UK. Since 1980, thousands of adolescents and young women have travelled to the UK to terminate their pregnancies. More recently, in 1 year 4,149 adolescent and young women who received an abortion in the UK gave an address in the Republic of Ireland (McCormack 2012a). This was a decline from 6,673 adolescent and young women who gave an address in the Republic of Ireland in 2001. This number, however, is surely an undercount. As many as 1,000 young women may have obtained an abortion in other European countries such as the Netherlands and Belgium (Ring 2012). Adding to the number are an estimated 1,000 more Irish adolescents and young women who are obtaining an abortion elsewhere; this would constitute a 23 % decrease in abortions. The number and rate of abortions for adolescents 19 years of age and younger, giving Irish addresses in the UK when seeking an abortion, has also dropped some 38 % since 2001. This decline was a long-term trend that followed two decades of increases in abortion rates from 1980 to 2001 (CCP 2007). Of course, these numbers do not include illegal abortions performed in Ireland, or self-induced abortion using an abortifacient. This total also does not include the number of women who carry through with an unplanned and unwanted pregnancy.

The attitude about abortion has changed little among the Irish people since the constitutional amendment was passed in a national referendum in 1983, which made abortion illegal except "where the life of a woman is at risk" (Fogarty 1984). In 2010, almost 10 % continue to believe that abortion is not permissible under any circumstance. Yet, the vast majority of people in Ireland support the idea that a woman should have a choice to have an abortion if the pregnancy is a result of rape or incest or endangers her health or life. Over 85 % of men in Ireland endorse these circumstances as legitimate reasons for seeking an abortion (McBride et al. 2012).

A safe form of ending an unplanned pregnancy within the first 9 weeks is by using Misoprostol (RU 486). One of the well-known brand names is Mifeprex. In the 2010 survey mentioned above, only one in eight adults had ever heard of medications that could induce an abortion. To the question of legality, 75 % believed the practice was legal, 6 % thought it was legal, and the remainder did not know. Among the 13 % who knew about this type of medication, only 3 % reported that they or their partner had used it (McBride et al. 2012).

For a small group of conservative politicians and fundamentalist Catholic leaders, the struggle over legalizing abortion is the fight to prevent Irish law from being replaced by European law that would legalize abortion in Ireland. The rationale has been to preserve Ireland's moral foundation by making abortion a constitutional law and preventing exposure to "foreign" cultural, political, and moral influences (Fogarty 1984). The Irish law on abortion, however, goes against several international human rights treaties which they have agreed to abide by. As such, in 2000 the United Nations Human Rights Committee expressed concern over Irish women being forced to carry to term unwanted pregnancies and the lack of legal abortions allow under Irish law. The Committee on the Elimination of Discrimination against Women in 2005 also expressed its concern over the health of the Irish women because of Ireland's restrictive abortion laws. And, again in 2008, the United Nations Human Rights Committee made the determination that Ireland had made no progress on the issue of abortion and the rights of women to control their own reproductive health.

Rather than being a choice of lifestyle (i.e., a personal decision made on a moral or religious principal), abortion in cases of rape or incest, or a pregnancy that endangers a woman's health or life is a matter of International law that Ireland has agreed to follow. Under this provision, a woman can expect to be provided with accurate information about abortion services under circumstances where a woman's health is being compromised by her pregnancy.

In a 2010 report from Human Rights Watch, they delineated the abortion situation in Ireland as a violation of a woman's human rights. The report cited the Irish government for actively working to restrict access to abortion; a violation of a women's right to liberty and security. The law is backed-up by penalty of potential imprisonment for life for obtaining an abortion. This is a threat to a woman's right to liberty and security when seeking to exercise her right to health information and services. In the case of Ireland, the charge is that the Irish government allows blatantly misleading and false information about safe and legal abortion services that are available in Ireland. Additionally, the government has sought to restrict a woman's ability to exercise her full range of human rights by trying to stop women from going to England and Europe to obtain an abortion. These are government policies that disproportionately impact adolescents and young women with limited resources. In this report, the representatives of the Human Rights Watch reported that they were unable to document a single case where an abortion had been legally performed in Ireland. In sum, the Irish government stands accused by the Human Rights Watch report of being erratic, divisive and "contributing directly to violations of women's human rights, including those to health, information, privacy, freedom from cruel, inhumane and degrading treatment, quality of life, equal protection under the law, and nondiscrimination" in part attributable to the criminalization of abortion (Human Rights Watch 2010).

International Law and Abortion

Since the mid-1990s, a significant and growing body of international law recognizes the right of a woman to obtain a safe and legal abortion. There are over 122 cases that address the abortion issue in 93 countries. The cases are based on medical principals and scientific evidence that abortion-related services are essential to the health and well-being of women. As a justice

issue, females of all ages have a right to educational/information, medical, and social services that can sustain and improve their sexual and reproductive health, which includes safe and legal abortion (see, Concluding Observations of the Committee on Economic, Social and Cultural Rights, e.g., Chile 26/11/2004, U.N. Doc. E/C.12/1/Add.105, paras. 26, 53; Malta, 14/12/2004, U.N. Doc. E/C.12/1/Add.101, paras. 23, 41; Nepal U.N. Doc. E/C.12/1/Add.66, paras. 33, 55; concluding observations of the Human Rights Committee in, e.g., Poland, CCPR/CO/82/POL, December 2, 2004, para. 8; Monaco, CCPR/C/MCO/CO/2, December 12, 2008 para. 10; Nicaragua, CCPR/C/NIC/CO/3, December 12, 2008, para. 13; concluding comments of the Committee on the Elimination of Discrimination against Women in, e.g., Nicaragua, CEDAW/C/NIC/CO/6, February 2, 2007, paras. 17–18; Colombia, CEDAW/C/COL/CO/6, February 2, 2007, paras. 22–23; Peru, CEDAW/C/PER/CO/6, February 2, 2007, para. 25; conclusions and recommendations of the Committee against Torture: Peru, CAT/C/PER/CO/4, July 25, 2006, para 23; Nicaragua, CAT/C/NIC/CO/1, June 10, 2009, para. 16.). The laws on which the international decisions are based come from UN treaties and covenants that prohibit discrimination (i.e., in matters of civil, political, economic, social, and cultural rights). In the court cases, the UN organizations that monitor the implementation of the treaties have often cited the calls on relationship between restrictive abortion laws, a higher incidence of clandestine abortions, and other threats to woman's life, health, and well-being. These bodies continue to recommend that punitive legal provisions and restrictive abortion laws to legalize abortion, "…in particular when a pregnancy is a life or health threat or is the result of rape or incest" (Human Rights Watch 2010). As a signature on these international treaties, Ireland is required to comply with International Law.

Yet in 2012, Ireland is still considered to have the most restrictive abortion laws in the European Union. As a result, if the Republic of Ireland is to be in compliance with the treaties it has ratified, specifically relating to abortion as a discrimination issue, a number of major changes will need to be made at all levels of government. Some of the most obvious changes are as follows:

- First and foremost, the Irish government must decriminalize all abortion for females living in Ireland.
- The law, Regulation of Information (Services Outside the State for the Termination of Pregnancies) Act of 1995 must be repealed.
- Ireland needs to develop national guarantees that ensure access to legal abortion according to international standards.
- Legislation will need to be enacted to ensure that information provided to women is "truthful and objective" and "fully informs women of all courses of action."
- Section 2.6 of the Irish Medical Guide to Ethical Conduct and Behaviour-2004 must be amended to require doctors who decline to perform abortions on the grounds of conscientious objection to: (1) provide emergency medical care and (2) make timely and good faith referrals to a practitioner who will perform an abortion.
- Establish public policy that guarantees public funding for a woman seeking an abortion to seek a second medical opinion if denied access to abortion from her first provider.
- Establish clear policy guidelines on the right of individual healthcare workers who decline to provide abortions on the grounds of conscientious objection, including standards that make clear that all women have a right to receive full and accurate information about their health options as well as emergency health care.
- Establish public policy that guarantees that all publicly funded health institutions will have staff that will perform abortions.

A Legal Remedy

In April 2012, the European Court of Human Rights heard an unprecedented number of cases relating to abortion in the EU. Most of these cases came from traditionally Catholic countries

such as Ireland, Italy, and Poland. The legal dispute in Italy addressed a law that violates Article 8 of the European Convention on Human Rights. The court found the law that banned any pre-implantation genetic diagnosis of embryos to be incoherent and unlawful. In Poland, women sued because of the difficulties she experienced in obtaining an abortion for her pregnant daughter. In Ireland, the court case was brought by a woman who did not go public and was identified only as "Ms. C," in court reports and documents. Ms. C suffered from a rare form of cancer. As such, her pregnancy put her life at risk if she continued the pregnancy. In spite of the risk to her life, she was unable to find a physician in Ireland who would do an abortion. She had to travel outside Ireland to obtain an abortion. Subsequently, she took her case to the Human Rights Court, and they found the state of Ireland in violation of its own Constitution on the matter of abortion. Responding to the ruling in 2012 Kathleen Lynch, Minister of State at the Department of Health, pointed out that the government might have no choice in the matter. Because of Ireland's membership obligations to the European Union, it will have to comply with the Court's ruling (Ryan 2012).

There are other pressures that are forcing change, one is the knowledge that the Irish laws are not reducing abortions but is harming adolescents and young women and their families by placing an undue burden and cost on women with the fewest resources. Another reality is the availability of abortion pills online. In 2012, pills to terminate a pregnancy could be purchased online without a prescription for around $300 (US). In an effort to mitigate this trend, the Irish Medicines Board issued a safety warning about abortion pills. Undoubtedly, the greatest shift in attitude forcing change of the Irish abortion law is the decline in religiosity. In a WIN-Gallup global survey on faith and atheism, interviewers asked Irish participants: "Irrespective of whether you attend a place of worship or not, would you say that you are a religious person, not a religious person or a convinced atheist?" Of participants, only 47 % of those questioned responded that they thought of themselves as religious. In 2005, some 70 % said that they thought of themselves as religious. This was almost a 50 % drop among people that considered themselves as religious (McCormack 2012b).

Children as Rights-Holders

Of enormous importance to adolescents and issues related to adolescent pregnancy is the legal recognition that children have inalienable rights that the state cannot take away or legislate against. The goal for Ireland is a philosophical and political environment where a child-rights-based approach will be the basis for developing national policies and practices that involve Irish children. In this effort, the international treaties signed by Ireland play an important role. To date, Ireland has signed conventions and treaties with both the European Union and the United Nations. These treaties necessitate that Irish law, policy, and practice must change with respect to children's rights. Of these, none are more important than the United Nations Convention on the Rights of the Child. The Republic of Ireland ratified the Convention on September 12, 1992. It was signed without reservation on October 21, 1992. By signing the compact, the government agreed to change its laws and policies to better protect the rights of children. The government also agreed that they would cooperate with the United Nations Committee on the Rights of the Child (CRC), who would monitor and report on the Irish government's progress in protecting the rights of children. This Convention is also the only international human rights treaty that expressly gives non-governmental organizations a role in monitoring its implementation (under Article 45a). Since its adoption in 1989 (the idea of the rights of children was first introduced in 1929), the United Nations Convention on the Rights of the Child has been ratified by more than 140 countries, more than any other human rights instrument. The notable exception is the USA, which has not ratified the Convention on the Rights of the Child.

Other major international treaties signed by the Republic that protect the rights of children include:

1. the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflicts in November 2002;
2. the International Convention on the Elimination of All Forms of Racial Discrimination in December 2000; and
3. the International Convention against Torture in April 2002.

The fundamental principle on which the Convention functions is that children (individuals below the age of 18) are born with the same inalienable rights and freedom of all human beings. Nations that ratify this UN Convention are required to comply with international law. Compliance is monitored by the UN CRC, which is composed of members from countries around the world. Once a year, the UN CRC submits a report to the Third Committee of the United Nations General Assembly. After hearing the statement from the CRC Chair, the Assembly adopts a Resolution on the Rights of the Child. The reports and the committee's written views and concerns on each country are available on the CRC's Web site (http://www2.ohchr.org/english/bodies/crc/).

In the report in 2006, called Consideration of Reports submitted by States Parties Under Article 44 of the Convention on the Rights of the Child—Concluding Observations: Ireland, committee members observe that changes had been made to the Irish Constitution over the years, but that other changes were still needed. When the CRC committee expressed concern that the wording of the Irish Constitution did not allow the State to intervene in cases of child abuse other than in exceptionally severe cases, the Constitution was amended to be more explicit about the rights of children in cases of abuse (O'Brien 2006).

Based on the report to the United Nations, the CRC committee recommended that the principle of the best interests of the child be made a primary consideration in all legislation relevant to children and that "this principle is applied in all political, judicial and administrative decisions, as well as projects, programs and services that have an impact on children." Other recommendations made by the committee will strengthen families and greatly benefit adolescent sexual and reproductive health.

Recommendations to Strengthen Families

- Ensure that the principle of the best interests of the child is always a primary consideration when making decisions involving children under any legal or administrative procedures.
- Clearly prohibit all forms of corporal punishment the Committee's General Comment No. 8 on the right of the child to protection from corporal punishment and other cruel or degrading forms of punishment.
- Develop a comprehensive child abuse prevention program that adequately responses to abuse, neglect, and domestic violence, facilitating local, national, and regional coordination, and conducting sensitization, awareness-raising and educational activities.
- Extend the social work services needed by at-risk families and children to a 7 day, 24-hour service.
- Ensure and provide follow-up and aftercare to young persons who age-out and leave care centers.
- Enact universal child benefit payments as an additional and targeted allowance to assist families that experience the highest levels of poverty.

Recommendations to Improve Health Services

- Ensure that quality health care services are available for all children.
- Develop a comprehensive child abuse prevention program that adequately responds to abuse, neglect, and domestic violence, facilitating local, national, and regional coordination, and conducting sensitization, awareness-raising and educational activities.

- Clearly prohibit all forms of corporal punishment the Committee's General Comment No. 8 on the right of the child to protection from corporal punishment and other cruel or degrading forms of punishment.

Recommendations to Improve the Mental Health of Children and Adolescents

- Continue efforts to enhance children's mental health programs designed for children under 18 years of age.
- Undertake awareness-raising and sensitization measures to prevent children with mental health issues from being stigmatized and dissuaded from early intervention programs.
- Strengthen programming efforts to manage the alcohol and drug consumption by children and adolescents by developing and implementing a comprehensive strategy of awareness-raising, widely publicizing available educational information, and advertising that targets children and issues involving drug use and misuse.

Recommendations to Improve Education

- Strengthen the legal and policy framework for the right to an education.
- Provide accurate and objective sexual and reproductive health educational information and health services to all children and adolescents in line with their age and maturity.
- Create an educational environment where the requirements of special needs children are taken into consideration and where technical and material support for children with special needs is provided.
- Put in place measures to combat the phenomenon of bullying and deal with its consequences in a responsible and child-sensitive manner.

Recommendations for Administrative and Judicial Services for Adolescents

- Develop an ongoing review process to monitor the quality of support services across different governmental departments and determine unmet needs.
- Ensure children have the right to express their views in all matters affecting them and to have those views given due weight in families, schools and other educational institutions, the health sector, and communities;
- Ensure that children have the opportunity to be heard in any judicial and administrative proceedings affecting them and that due weight be given to those views in accordance with the age and maturity of the child, including the use of independent representations (*guardian ad litem*) provided for under the Child Care Act of 1991, in particular cases where children are separated from their parents.
- Reinstate to age 14 the provisions regarding the age of criminal responsibility for serious crimes as established in the Children Act 2001.
- Collect information and undertake research on child prostitution, pornography, and other forms of sexual exploitation and sexual abuse of children with a view to developing prevention and intervention programs.
- Complete a comprehensive needs assessment on children and adolescents belonging to the *Traveller* community to provide a basis for policies, strategies, and concrete programs and services that will improve the well-being of these children.

Concluding Observations

Adolescents in 2012 Ireland continued to live and struggle in an environment where they are still at risk of being deceived by false and misleading information provided by public and private sexual and reproductive health providers. These policies

are implicitly and explicitly designed to force an adolescent to carry through with her pregnancy. Irish health care workers are not legally required to provide "truthful and objective" information that will fully inform an adolescent of all her medical options. Physicians have no mandatory ethical obligation requiring them to provide a timely referral to a practitioner or institution that will perform a legal abortion. Moreover, there is abundant evidence that adolescents who have a legal right to an abortion in Ireland may still be unable to find a publicly funded health institution where she can obtain an abortion.

Despite these obstacles and barriers to adequate and quality sexual and reproductive health services, adolescents in Ireland continued to develop personal responsibility for their sexual behavior and far more than would be expected given the cultural, social, and political circumstances. While the Irish Catholic conservatives resist change in the social attitude toward sex and sexual relations, the children and adolescents of Ireland have modeled their attitudes and behaviors after the broader European community. This was unmistakably the case when the Irish economy was booming, a time when adolescent girls realized that opportunity and a modern lifestyle was available to those who delayed pregnancy.

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Adolescent Heath, Public Health Responses, and Sex Education Program in Japan

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Keywords

Abortion • Adolescent motherhood • Birth control • Birthrate • Child development • Family supports • Health related to sex • HIV/AIDS • Sex education • Human papillomavirus

Introduction

With the aim of reducing the abortion rate among teenagers and the prevalence of sexually transmitted diseases, the Ministry of Health, Labor, and Welfare in Japan is promoting initiatives such as dissemination of correct information under "Healthy Parents and Children 21." This is a national campaign to improve maternal and child health in the early twenty-first century. Since 1996, consultation systems have been improved for adolescents who have become pregnant, with test places at medical institutions and health care centers that provide medical, mental, and social consultation on a one-to-one basis.

Sex education in schools is specified in the curriculum guidelines released by the Ministry of Education, Culture, Sports, Science, and Technology. These guidelines aim to ensure that students accurately understand sex-related health issues and appropriate behavior. Specifically, sex education is supposed to be undertaken holistically throughout school education, being included in physical education, health and physical education, special activities, and ethics, while taking into account the developmental stages of adolescents and focusing on mutual understanding among the school community as well as parents.

Thus, there is no subject labeled as "sex education," which means that the actual educational content and implementation rate vary among schools. Because sex education has not yet found its rightful position in Japanese schools, not all adolescents have the opportunity to receive sufficient sex education.

In addition, there is a significant limitation because the curriculum guidelines state that *sexual intercourse and contraception* should not

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be covered by education in elementary schools and junior high schools. From around June 2002, confusion has become more prevalent, especially in elementary schools and junior high schools, with some news reports being published about so-called extreme or excessive sex education and an incident in which Tokyo teachers were punished (so-called sex education bashing). Accordingly, sex education is increasingly seen as a difficult issue and many teachers are hesitant to carry it out.

Historical Context

The dominance of men over women is still ingrained in Japanese society. The wishes of women are belittled, especially in rural areas where conservative values dictate that a woman should be a dutiful wife and devoted mother, and there is a high abortion rate due to unintended pregnancy in such areas (Saotome 2011).

Until shortly after World War II, it was the norm that "women should be virgins until marriage," while men were allowed free sexual license both before and after marriage. This was known as the "sexual double standard."

Since around 1990, various social phenomena related to younger people, including bullying, truancy, suicide, domestic violence, withdrawal, and compensated dating, have often attracted attention in Japan. Japanese society achieved material wealth and economic prosperity through postwar development, but social fundamentals such as connections between people at home, at school, and in the community have been increasingly eroded. An increase in sexual activity, as well as a reduction in the age of participants, was also noted in the 1990s. Underlying such changes is the weakening of Japanese society.

On the other hand, the structure of sexual relationships between men and women has shown little change, with men playing an active and women playing a passive role. In fact, there is an apparent trend for an increase of such asymmetrical relationships.

Recently, dating violence has become a problem. While domestic violence involves all violence by a dominant person against their intimate partner as a method of control, dating violence especially takes place among adolescents. It seems that young people, because of their developmental stage and other characteristics, fall into a situation where they cannot bear to part with their partner. It is estimated that this problem affects 20–40 % of high school students. In many cases, the victims are not even aware that they have been affected by dating violence, which not only causes physical harm but also increases the abortion rate and the prevalence of sexually transmitted diseases.

Religious Influences

The religious situation in Japan is quite complicated. Although most Japanese would claim to be Buddhists, the definition is largely statistical and for convention. This means they do not devote themselves to Buddhism as a religion to rely on. Instead, they merely employ the family temple and its priests for performance of funeral rites, and they simply follow their traditional family or community practices. It is normal for persons who embrace Shintoism to also believe in Buddhism, so they can visit a temple or a shrine, or even attend a Christian church. The religious beliefs of Japanese people are well represented by the synthesis of Shintoism with Buddhism, or by fusion of Buddhism and Christianity, which may seem quite strange. Thus, the religious life of Japanese people is not based on a monotheistic faith. Although there is no literature available about the relationship between the sexual behavior of adolescents and religion in Japan, it has been suggested that persons who believe in one religion and whose life is based on faith and religious activities tend to suffer from mental conflict between their religious activities and romance.

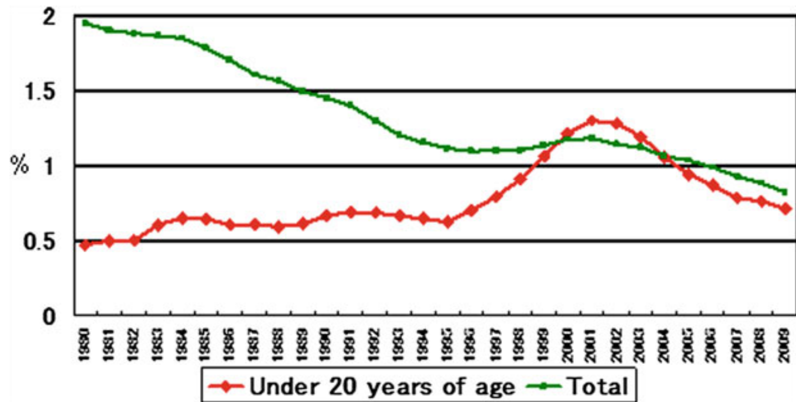

Fig. 1 Rate of induced abortion (1980–2009) (Mothers' and Childrens' Health and Welfare Association 2010)

Cultural and Traditional Influences: Social Views and Customs

A relatively new cultural influence is the mobile phone and text messaging, which have increasingly become a part of life for young people. Informatization has spread through Japanese society, while being associated with meeting people of the opposite sex and interest in sexual love by adolescents. These trends of informatization may help to explain why a larger number of young people are engaged in sexual activity.

The Japanese Association for Sex Education recently conducted a survey about sexual activity that compared a group of people who preferred e-mail with a group who preferred text messaging. As a result, the texting group had an active circle of friends and tended to show an increase of sexual activity, while the e-mail group were introverted and tended to have less sexual activity (Japanese Association for Sex Education 2007). This suggests that polarization in the use of social media has a certain relationship with polarization of sexual activity.

Since the 1980s, the decline of the birthrate has been a subject of discussion in Japan and has created a trend that neither the parents nor society blame a couple who marries due to pregnancy. The average age of marring for the first time was 27.2 years for men and 24.4 years for women in 1960, while it has increased to 30.4 years for men and 28.6 years for women in 2009. During the intervening period, the idea of not having sexual intercourse before marriage has gradually lost popularity and the first experience of sexual intercourse has been separated from marriage or pregnancy (Hashimato 2011). Consequently, the number of marriages related to pregnancy (shotgun marriages) has increased, reaching 82.9 % among teenagers and 63.3 % among persons in their early twenties in 2004 (Takada 2011).

Overview of Adolescent Pregnancy

Teenage Abortion Rate

Mothers' and Children's Health and Welfare Association (2010) reported that induced abortions for girls younger than 20 years of age have more than doubled to 46,511 (1.30 %) in 2001 from the total of 19,048 (0.47 %) in 1980. Abortions for girls younger than 20 years of age, however, have decreased to 21,535 (0.73 %) in 2009 from the total in the year 2001. Various factors could account for such a decrease, but these have not yet been identified (see Fig. 1). Kitamura and associates (2004) reported that the decrease of abortion was related to an increase in the number of prescriptions for oral contraceptive (OC), which were approved in 1999 in Japan. On the other hand, the Ministry of Health, Labour and Welfare (2006) have reported that females younger than 20 years tend to have abortions at a later stage of pregnancy compared with other age groups. Their higher rate of

abortion in the middle trimester could be related to a lack of adequate knowledge about pregnancy, abortion, and contraception, and it may also take them longer to seek medical advice because they feel unable to ask for assistance from their parents or teachers.

Birthrate

Mothers' and Childrens' Health and Welfare Association reported that the birth total member (the birthrate) for female from 15 to 49 years of age have decreased to 1,070,035 (4.03 %) in 2009 from 1,576,889 (5.18 %) in 1980. However, the birth total member (the birthrate) for girls younger than 20 years of age have increased to 14,620 (0.50 %) in 2009 from 14,576 (0.36 %) in 1980. Furthermore, the total of the birth for girls younger than 15 years have increased to 67 in 2009 from the total of 14 in 1980.

Medical Issues

One of the problems with teenage pregnancy is that the percentage of neonates with a birth weight under 2,500 g is as high as 10.1 % for girls 15–19 years old and increases to 17.9 % for those under 14 years old, while the rate for all females from 15 to 49 years old was 9.6 % in 2009 (Mothers' and Children's Health and Welfare Association 2010). In addition, the perinatal mortality rate (the fetal death rate after 22 weeks of gestation plus the neonatal mortality rate within 1 week of birth) for mothers aged 15–19 years was as high as 0.54 %, while that of all mothers aged 15–49 years was 0.42 % in 2009 (Mothers' and Children's Health and Welfare Association 2010).

Social Issues: Poverty, Family Supports and Family Structure

Sadatuki (2009) reported that the majority of teenage mothers had both financial and social problems and that they tended to be late in seeking medical attention. One reason could be the lack of appropriate advice because they tend to be unmarried and out of touch with their family or partner. Delay in seeking medical attention can lead to lack of knowledge and information about delivery because of fewer opportunities to receive health advice during prenatal checks and/or maternal classes. A woman who presents for the first time after the 22nd week of gestation will have no choice but to deliver a baby. Most pregnant teenagers have little awareness of the responsibilities of motherhood because they are neither financially independent nor mentally mature. In most cases, the partner is also young, and so their unstable relationship in addition to financial insecurity of the partner has a great influence on the situation after the teenager gives birth. Under such circumstances, the majority of teenagers have to depend on social welfare because they are estranged from their families, whose support would means a lot to them. Teenage pregnancy and childbearing are a trigger of domestic violence and a risk factor for infant and child abuse (Gender Equality Bureau of the Cabinet Office 2007). Accordingly, it is hoped that hospitals and local health centers will work closely together to provide support to teenagers during pregnancy and the postpartum period.

Legal Issues

The Constitution of Japan has the paramount position among Japanese laws, and Article 25 covers the right to life and the obligation to improve and preserve the living environment of the people. Based on these fundamental laws, the administrative laws are also related to the Civil Code and the Penal Code, under which come the Medical Practitioners Act, the Maternal and Child Health Act, and the Maternal Protection Act. In order to actually administer these acts, the relevant government ministry or agency stipulates enforcement laws for practical implementation with the particular system set up by each local government. The Maternal Protection Act is intended to protect the lives and

well-being of mothers by stipulating provisions about operations for sterilization and induced abortion. Medical doctors who are designated by the Medical Association, which is a public interest incorporated association, may conduct an abortion if either of the conditions (1) or (2) shown below are satisfied, with the consent of the woman and her spouse: (1) for physical or economic reasons, it could be a significant health hazard to the mother to continue the pregnancy or deliver a baby; or (2) the pregnancy is a result of sexual intercourse under circumstances where the woman was not able to resist or refuse because of assault or threat. The limit for a viable fetus was set as less than 24 weeks in 1976, and then revised to less than 22 weeks from 1990 (Ministry of Health, Labour and Welfare 2009).

The Act on the Prevention, etc. of Child Abuse defines improvement of cooperation among the health, medical, and welfare services for households that especially require support during pregnancy, birth, or child rearing as a responsibility of the state and local governments. Further, under the Child Welfare Act, persons who have encountered a child likely to suffer from abuse are obliged to inform the welfare offices or child consultation centers that are established by prefectures or cities, towns, and villages. The municipal governments are responsible for following up such children by visits, etc., as well as introducing appropriate support services for financial problems and foster care. In particular, in cases where support is deemed necessary, the Formal Regional Network for Child Maltreatment is consulted about the case in order to provide the necessary support in cooperation with medical institutions, including Departments of Obstetrics and Pediatrics (Ministry of Health, Labour and Welfare, Support for children and childrearing 2011a).

The Cost of Adolescent Pregnancy

In Japan, pregnancy and birth are not covered by the national health insurance scheme because pregnancy is not regarded as a disease. Regardless of age, all pregnant women are responsible for the cost of their prenatal examinations and checkups, and so most pregnant teenagers, who are not financially independent, need to have such expenses paid by their parents or partner. All pregnant women are expected to undergo checks every 4 weeks until week 23 of gestation, every 2 weeks from weeks 24 to 35, and then every week from week 36 to birth, which is a total of over ten examinations during pregnancy—although there are differences between individuals. The cost of a single check is between 5,000 and 10,000 yen ($50–$100 US dollars), so the total cost can be over 100,000 yen. The cost of hospitalization and delivery is also not covered by the health insurance scheme because delivery is not defined as a disease, and this ranges from 300,000 to 400,000 yen on average, depending on the hospital (Ministry of Health, Labour and Welfare, Lump Sum Birth Allowance Policy 2011b).

Public Policy

Prevention: Educational Programs, Sex Education, and Birth Control

The opportunities to learn about sexuality are limited during teacher training courses in Japan, although there are some exceptions. This results in a large number of teachers who have insufficient knowledge about sex education (Saito et al. 2009). Tanomura (2006) reported that university-level teacher training courses in Japan provide education about sexual psychology, physiology, sexual health, and medical care as special courses, but few instructors who have specialized in sex education are available to provide education on this topic to university students. Therefore, many students receive little sex education when they are at university before becoming teachers, and thus have to acquire sex education skills and implement programs without assistance. Accordingly, sex education is still confused and at the trial-and-error stage in Japan (Tanomura 2006). In 1999, the Japanese

Ministry of Education, Culture, Sports, Science and Technology recommended "Cooperation between Schools and Pertinent Organizations/ Community" in "The Concept and Approach of Sex education in Schools." Since then, junior high schools have often asked medical professionals to provide lectures for their students. It has, however, been pointed out that some medical professionals provide education without sufficient understanding of the circumstances of adolescents or are unable to cooperate with the school. In addition, the educational effect of one-off lecturer without evaluation is unknown (Iwamuro 2006). Furthermore, Hasuo (2009) has stated that sex education should not be managed by a gynecologist alone and should not only be provided to junior high and high school students. Instead, sex education should involve parents at home, teaching staff at schools, and nurses, midwifes, health nurses, gynecologists, and urologists from the medical field.

Public Awareness Initiatives

As the birthrate has been falling in Japan, teenage marriage, as well as teenage pregnancy and delivery regardless of marital status, has come to be accepted as long as the girl has graduated from high school. It is also socially acceptable for a college student to take temporary leave to give birth and then return to lectures afterward while receiving support. On the other hand, it is considered that students under 18 (including primary school, junior high school, and high school students) should prioritize schoolwork, and therefore, marriage, pregnancy, and childrearing in this age group are hardly accepted by society. Under such circumstances, marriage or delivery under 18 years old is rare. If a student from primary school, junior high school, or high school becomes pregnant, she often has no choice but to terminate the pregnancy because of lack of a system that allows study and raising a child at the same time, as well as lack of public support (Adachi 2009). Sasaki et al. (2009) conducted the studies that were carried out from 1999 to 2008 in Japan in relation to support for teenage pregnancy. Their results show that it is necessary to establish relationships that take into consideration the characteristics of pregnant teenagers, as well as, providing support that involves their family and the husband or partner, and support that is given in cooperation with regional and educational organizations. They also suggested that it could contribute to prevention of pregnancy at a young age if sex education was provided with the objective of improving self-determination by young women so that they would be able to choose appropriate sexual behavior and activities on their own initiative.

Programming: Maternal Care and Child Care

In accordance with the provisions of the Maternal and Child Health Act, municipal governments provide mothers and children with health services that include advice for pregnant women, home guidance for pregnant women, parenting classes, visiting newborn babies, health checks for infants, and child care consultation and classes. Additionally, based on the provisions of the Child Welfare Act, the government provides childrearing support in order to promote the prevention of child abuse under the Act on the Prevention, etc. of Child Abuse. (1) As a general rule, the regional childrearing support service will provide support for 3 days a week for at least 3 h each time. (2) As a service for all households with infants, a person who has completed the relevant training program visits households with infants under 4 months of age in order to provide information about raising children, as well advice and assistance based on the physical and mental state of the parent and the infant's environment. (3) As a service to support childrearing, a person who has expertise and experience in this field visits the households with children requiring support to provide

consultation and guidance about childrearing. (4) As a short-term childrearing support service, for parents who have temporary difficulty in bringing up a child at home, the municipal government can provide financial support to house such children in public facilities such as infant homes or child welfare facilities. For women who require protection from domestic violence, a special dormitory for mothers and children is available (with no limits on visiting by family members, but restriction of the partner), as well as a mother and child support facility (with limitations on visiting by family members and restriction of the partner) for cases of possible abuse by family members. Improvement of other childrearing services including nonprofit organizations (NPO) is also being addressed on a regional basis. In particular, the number of deaths from abuse of infants of under 1 year old is greater than at other ages, which may be related to various factors such as unplanned pregnancy, postpartum depression, and financial problems. In order to reduce such deaths, support needs to be provided continuously from pregnancy through the childrearing period (Ministry of Health, Labour and Welfare, Support for children and childrearing 2011a).

Child Welfare Provisions: National and Private Financial Support

In order to improve health care and reduce the financial burden for pregnant women, municipal governments share the cost of pregnancy checks, examinations, and health guidance, although implementation is up to each city, town, or village, depending on its financial status.

Women who are enrolled, or whose partner is enrolled, in the national health insurance scheme can receive 420,000 yen under the Lump Sum Birth Allowance Policy (Ministry of Health, Labour, and Welfare, Lump Sum Birth Allowance Policy 2011).

Perspective on the Future of Adolescent Pregnancy in Japan

"Healthy Parents and Children 21" is a nationwide campaign that is intended to chart the directions, indices, and targets in relation to health care for mothers and children in the twenty-first century. This campaign involves a collaborative effort between the relevant organizations and groups during the decade from 2001 to 2011. As measures to improve well-being of adolescents and further their health education, this campaign has been addressing reduction of the abortion rate and the prevalence of sexually transmitted diseases among teenagers. When the interim evaluation was performed in 2006, it was reported that no significant changes were identified and further analysis would be required because the results differed between regions and there was no improvement in the prevalence of sexually transmitted diseases despite a small decrease in the number of teenage abortions. It was stated that efforts under the program would be continued and that its efficacy would be evaluated again (Ministry of Health, Labour and Welfare 2006).

Japanese Research

The Rate of Adolescent with Sexual Experience

Based on the results of a 2005 survey by the Japanese Association for Sex Education (2007), there is a sharp increase in the rate of teenage Japanese males and females with sexual experience, which was 3.6 and 4.2 %, respectively. In 2005, among male and female junior high school students (aged 13–15 years of age), it was 3.6 and 4.2 %, respectively. Among male and female high school students (aged 16–18 years), it was 26.6 and 30.0 %, respectively, and among college students (aged

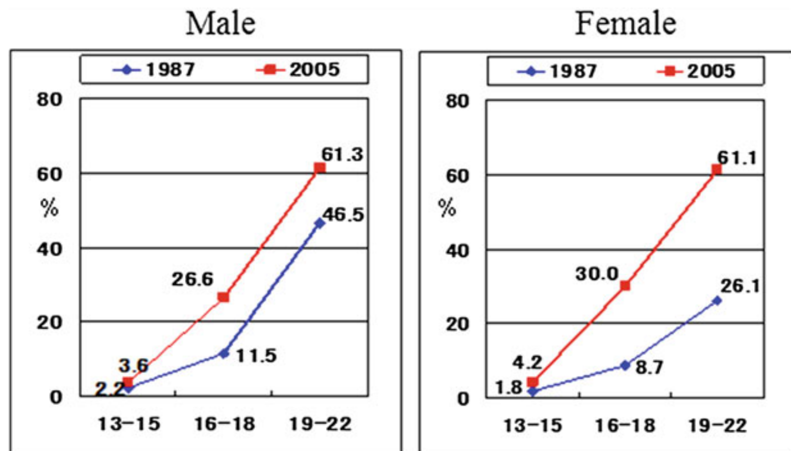

Fig. 2 The number of teenagers who had participated in sexual intercourse (Japanese Association for Sex Education 2007)

19–22 years), it was 61.3 and 61.1 %, respectively. In the study by the Japan Family Planning Association (2008), the average age of first intercourse is 19 years old (see Fig. 2).

Factors Influencing Sexual Behavior and Sexual Attitudes Among Adolescents

Based on the results of national and international studies conducted on adolescents, the elements influencing the sexual activity of adolescents include the social factors as well as individual factors.

Family Factor

In Japan, parents and school teachers feel uncomfortable about participating in investigations of adolescents' sexual behavior, resulting in a small number of studies on this issue. Parents and school teachers even showed negative feelings about discussing adolescents' sexual activity (Nagamatsu et al. 2007). Parental monitoring was statistically associated with delay of first intercourse in female students. While the same influences were present for male students, they also were influenced by parental disapproval of the adolescent's sexual behavior. Furthermore, more parental communication about acquired immunodeficiency syndrome (HIV/AIDS) was related to delaying an adolescent's first intercourse except for the relationship between father–female students (Nagamatsu et al. 2008). Other surveys conducted in Japan have shown that the low sexual activity of girls in late adolescence is greatly influenced by the good relationship between parents and the parent–adolescent relationship (Inoue 2005). However, there are some obstacles to implement such interventions at home. For instance, speaking with parents about sexual matters is extremely rare in Japan (Nagamatsu et al. 2007). Saito and associates (2009) have pointed out that Japanese parents and teachers did not receive appropriate sex education when they were adolescents and often do not possess accurate knowledge about AIDS. Furthermore, Takedomi et al. (2003) showed that parents did not adequately provide sex education, such as HIV/AIDS, sexual activity, and use of contraception at home. Yet, it is important for parents to comfortably talk to their children about HIV/AIDS, sexual activity, and contraception. Therefore, sex education should also be targeted to parents as well, so that they can communicate with their teens at home.

Individual Factor

Tokuhisa and Yamada (2009) concluded that increased knowledge about HIV infection reduced sexual behavior. These results suggested that interventions that increase such

knowledge might have salutary effects on adolescents' attitudes toward engaging in risky sexual behavior. Similarly, using Japanese high school students, Inoue and associates (2005) found that the sexual activity among girls in late adolescence is influenced by smoking/drinking behavior. Therefore, adolescents who have had risky experiences associated with smoking/drinking would tend to have a more liberal attitude toward sexual activity than those who have not had risky experiences.

Peer Factor and Dating Partner Factor

Another factor that influences adolescents' sexual attitudes may be presence of dating partners. There are a small number of studies on this issue. Among Japanese high school students, dating partners, friends with sexual experience both had significant influence on teens' sexual behavior (Inoue et al. 2005). Therefore, adolescents without dating partners and friends with sexual experience will tend to have more conservative attitudes toward sexual activity than those with liberal attitudes.

Future Policy and New Viewpoint on Sex Education

The objectives of sex education in Japan are to foster respect for life and a sense of self-worth. It is intended to cultivate a sympathetic attitude to the weak, provide an understanding of the biology of males and females and the process of growth, and promote behavior that improves "health related to sex and reproduction" throughout life while focusing on physical and mental health. To achieve these purposes, we need to determine which topics to present and how to teach children at different developmental stages during the period from kindergarten to high school. Sex education also requires the cooperation of parents, school teachers, school nurses, local people, and persons from the medical field (including doctors and nurses). At the 32nd seminar on sex education guidance, the Japan Medical Association set out themes for health care education of children and students according to developmental stage based on respect of the School Education Committee of the Japan Medical Association (2010) that covers "Sex education, when and how much?" In addition to male and female biology and physiological development, sexually transmitted diseases, pregnancy, abortion, and contraception, which have conventionally been considered as essential topics, "The relation between human papillomavirus (HPV) infection and cervical cancer" and "Introduction of HPV vaccine" have been added to sexually transmitted diseases as a new theme, which indicates the necessity of informing students and parents about prevention of cervical cancer. It was also mentioned that relationships with other people, methods of communication, and appropriate ways of selecting information are very important issues, in light of problems such as dating violence, cell phone dependency, compensated dating, homosexuality, gender identity disorders, and the influence of the media. It is necessary to provide more effective sex education through proper separation of roles between various specialists and good cooperation. As an educational scheme that we should try to evaluate, the new three-stage educational system needs to be introduced, in which "team teaching" is conducted simultaneously for all students and "individual coaching" is done with the agreement of the student and parents when the school teacher or school nurse deems it necessary (sometimes with attendance of the parents), as well as "step-up teaching" that is positioned between the former two methods and involves small groups, depending on the level of understanding and the requests of the student and with the agreement of the parents. When conducting such education, it is also important to broaden the opportunities for study through workshops and seminars where teachers and parents are able to obtain the required knowledge (Adachi 2009).

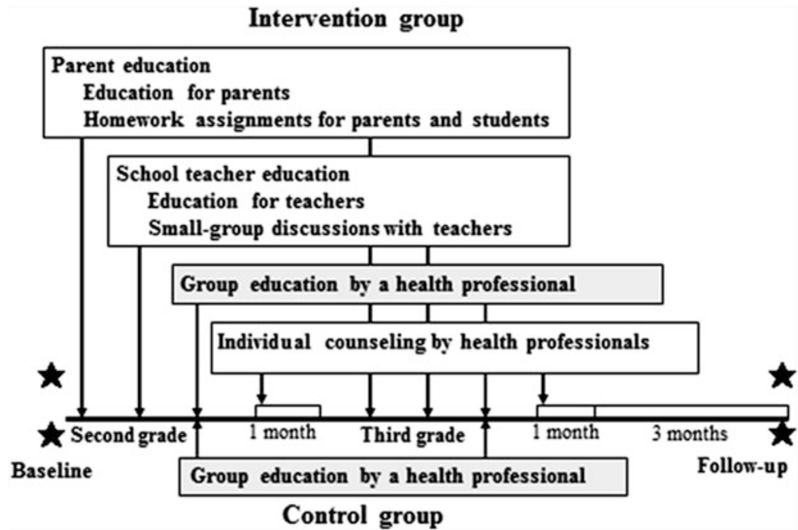

Fig. 3 Process of the intervention and then control (Nagamatsu et al. 2011)

Programming

Nagamatsu et al. and associates (2011) developed an extended program for students, parents, and school teachers, and then evaluated its effectiveness. The participants were 490 students, aged 13–14 years, attending four public junior high schools in Saga Prefecture, Japan. They were divided into two groups: a control and intervention group. All the students received group education by health professionals. In the control group, students received only two group education sessions given by health professionals. In the intervention group, there were three intervention components: parent education, teacher education, and student individual counseling by health professionals. Before and 3 months after the intervention, participants underwent evaluation of their frequency of communication about AIDS with parents or teachers, their knowledge of HIV/AIDS, and attitudes about sexual intercourse, self-esteem, and high-risk behavior. A total of 135 students (80 boys and 55 girls) from the intervention group and 236 students (115 boys and 121 girls) from the control group participated in the evaluation 3 months after the intervention.

The Program Procedure

The procedures for the schools receiving the intervention and the control schools are outlined in Fig. 3. Group education by health professionals was provided for students in both the intervention and control groups. The three intervention components were parent education, teacher education, and student individual counseling by health professionals.

Parent Education

The objective of parent education was to improve the self-esteem and self-protection of young people by helping their parents understand the changes affecting their children during puberty and how to cope with them.

1. Education for parents

   A midwife, a gynecologist, and two school nurses provided training for parents/guardians before assigning homework that involved both parents and students.

2. Homework assignments for parents and students

   Assignments were completed at home to improve communication between parents and

students. School nurses gave the students the homework assignments.

Teacher Education

The objective of teacher education was to provide teachers with knowledge about changes and prevention of potential risks during puberty, to understand methods of education for improving self-esteem and rejecting sexual activity, and to teach their students how to improve self-esteem and refuse sexual activity.

1. Education for teachers

   A midwife, a gynecologist, and two school nurses provided training for class teachers before small-group discussions.

2. Small-group discussions with teachers

   Class teachers conducted two small-group discussions after training. The objective was to improve communication skills related to refusal of sexual activity and negotiations with regard to sexual relations. The students also performed role-playing exercises. If examples of dangerous behavior arose during the exercises, the students were asked to think of ways to avoid such behavior and to fill out forms listing their ideas. Students wrote essays about their impressions after each small-group discussion.

Student Education

The objective of professional counseling was to provide knowledge about HIV/AIDS and sex to students, improve their self-esteem by answering questions and alleviating concerns, and to help the students develop a cautious attitude toward sexual activity.

1. Students group education

   A gynecologist or a midwife gave two types of group education to the students, who wrote essays about their impressions after each type of group education.

2. Students individual counseling

   Based on data from four sources—(1) the homework assignment, (2) the essay written after group education, (3) the small-group discussion forms, and (4) the essays written after the discussions—school nurses, midwives, and gynecologists selected students who had questions and worries about their education. These students were given individual counseling by a school nurse, midwife, or gynecologist after regular school hours.

The Program Evaluation

Adolescents in the intervention group showed more positive changes than those in the control group from baseline to follow-up. The intervention had a significant impact on the frequency of communication about AIDS with teachers ($p = 0.027$) and HIV/AIDS knowledge among females ($p = 0.023$), and intervention also had a significant impact on refusal of sexual activity by males ($p = 0.045$) (see Tables 1, 2).

This study suggested that adolescents showed more positive changes with an expanded intervention education program for students, parents, and school teachers. There were gender differences in the effects of intervention. It had a significant impact on the frequency of communication about AIDS with teachers, HIV/AIDS knowledge among females and a significant impact on refusal of sexual activity by males.

We consider that the differences between males and females might be related to communication and differing values about sex between male and female adolescents in Japan. It has been reported that the percentage of students who have had sex increases with age among Japanese junior high school and high school students, and young males who are sexually active and have strong sexual desires take a greater interest in sex and are more positive toward sexual behavior than young females who are passive with respect to sex (Japanese Association for Sex Education 2007). Female

Table 1 Comparison of intervention and control group between baseline and follow up among female students

	Pre-test *n* = 212 post-test *n* = 175		
	Regression	95 % C.I.	*p value*
Talking with parents	0.019	(−0.230–0.268)	0.882
Talking with teachers	0.343	(0.039–0.646)	0.027
Knowledge	0.934	(0.131–1.737)	0.023
Self-esteem	0.597	(−1.651–2.845)	0.602
	Multiple regression analysis		
Rejection of sexual activity	OR = 2.163	(0.550–8.512)	0.270
Confidence in rejecting	OR = 0.515	(0.163–1.629)	0.259
Alcohol use	OR = 1.291	(0.366–4.555)	0.692
Cigarette tobacco use	OR = 0	–	0.998
Sexual activity	OR = 0	–	0.997
	Logistic recession analysis		

Table 2 Comparison of intervention and control group between baseline and follow-up among male students

	Pre-test *n* = 212 post-test *n* = 195		
	Regression	95 % C.I.	*p value*
Talking with parents	0.001	(−0.192–0.194)	0.992
Talking with teachers	0.204	(−0.084–0.493)	0.164
Knowledge	0.480	(−0.348–1.308)	0.255
Self-esteem	1.678	(−0.466–3.822)	0.125
	Multiple regression analysis		
Rejection of sexual activity	OR = 2.910	(1.022–8.286)	0.045
Confidence in rejecting	OR = 0.603	(0.242–1.929)	0.471
Alcohol use	OR = 1.739	(0.570–5.300)	0.331
Cigarette tobacco use	OR = 1.290	(0.126–13.226)	0.998
Sexual activity	OR = 0	–	0.997
	Logistic recession analysis		

students who only had a slight interest in sex, a program that addressed their questions and concerns by increasing the opportunities for education from teachers was more effective for providing accurate knowledge than group education only. This study showed that females in intervention groups increased the frequency of communication about AIDS with teachers over 3 months than group education for students. On the other hand, male students were more likely to have a strong interest in sex, so that even group education led to improvement of knowledge. Among young females with a higher risk of pregnancy and sexual abuse, the percentage of students refusing sex was increased by group education in both the intervention and control groups. On the other hand, among the young males showing a decrease in rejection of sex with age, there was an increase in the percentage of students refusing sex that was probably due to intensified education provided by this program (including education for teachers, as well as individual counseling). These findings suggest that positive outcomes might be achieved by an expanded educational programming for students and teachers such as that described, and individual counseling that takes into consideration the sexual differences of Japanese adolescents.

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Adolescent Pregnancy in Mexico

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Keywords
Mexico: Adolescent pregnancy · Abortion · Contraception · Educational opportunity · Emergency contraceptives · Intrauterine device · Infant mortality · Maternal mortality · Millennium development goals · Sexual and reproductive education

Introduction

The story of adolescent pregnancy in Mexico is the overall reduction in fertility among girls and young women in Mexico from the 1960s through 2010. At the beginning of the twentieth century, the fertility rate in Mexico was six children per female. By 1960, the fertility rate was seven children per female. By 2010, the estimated fertility rate had dropped to 2.3 children per female and will reach replacement (2.1 children per woman) in the near future (National Population Council, Mexico 2011). This spectacular decline in fertility is even more remarkable when the context in which it occurred is considered.

The history of post-Columbian Mexico is in part the history of a burden imposed upon women and girls by Roman Catholic Church doctrine. As both, a formal and informal member of the Mexican-ruling Governments, over the years, the Church has sanctioned large families and forbid contraception and abortion. Using the threat of "excommunication" (based on Roman Catholic canon law that levies spiritual condemnation), it has been especially difficult for middle class and poor women to exercise control over their fertility. Yet, in the 1960s, after almost two decades of increasing fertility, the Mexican government began to reconsider its policies promoting large families. The adolescent birthrate was increasing exponentially. The cost in state resources and the human cost could not be tolerated. Turning to pragmatic solutions, family planning clinics, free birth control, and sexual education were the major interventions employed to deal with the high rate of fertility.

Over time, the fertility rate began to drop for all women both adolescent and young women. The policy changes in sexual and reproductive health services were credited with the reduction in family size. The program's centerpiece was comprehensive sex education for youngsters. Government-mandated textbooks frankly explained topics such as masturbation and homosexuality, noting that there is nothing wrong with either (Cause and effect 2006).

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The transition from a developing nation, with one of highest rates of fertility in the world to a country with a fertility rate like that of a developed nation, is the story of adolescent pregnancy in Mexico.

History Context

Mexico is a developing nation with a heritage rich in cultures, traditions, and history. A mix of Catholicism and native traditional beliefs continues to influence the Mexican people and their culture, although not as much among adolescents and young adults as in the past.

The people of Mexico and Central America had a historic past and many highly sophisticated civilizations such as the Olmec, Toltec, Teotihuacan, Zapotec, Maya, and Aztec. Mexico came under the control of Cortés in 1521. It remained a position of Spanish until 1821. The Mexican–American War (1846–1848) ended with the Treaty of Guadelupe Hidalgo. In this treaty, Mexico relinquished all lands north of the Rio Grande to the United States. Mexico City is the emotional heart of the people, the capital, and the largest city (Moreda 2000).

The Estados Unidos Mexicanos (United Mexican States) is a federal democratic republic comprised of 31 states and the Federal District of Mexico City. Mexico is the fifth largest country in the Americas covering almost two million square kilometers. Mexico's population in 2012 was approximately 115 million; projections are for the population to increase to 140 million by 2025. It has an annual growth rate of 1.09 % (18.87 births per 1,000 population), with 28 % of its population 14 years of age or younger (16,395,974 boys and 15,714,182 girls) (CIA 2012).

Mexico's GDP in 2011 was $1.683 trillion (US dollars) or $14,800 ((US dollars) per individual. The average annual inflation in 2011 was estimated to be 3.5 %. This is compared to over 18 % annual inflation during the 1990s. Mexico also has a modest nation debt estimated in 2011 as $204 billion (slightly over 12 % of GDP). In 1994, the national debt totaled 21 % of its GDP. National spending for health has changed little over the last since the mid-1990s, averaging approximately 3.17 %. In 2009, 13.8 % of GDP was spent on health. Educational spending accounted for another 4.8 % of GPD. The literacy rate for those who are aged 15 or older in 2005 was 86 %, with men having a slightly higher literacy rate (87 %) than women (85 %). Almost 78 % of Mexicans live in urban areas in 2012 (CIA 2012). This normal growth, added to large-scale migration from rural to urban areas, continues to strain Mexico's infrastructure and government services that are needed by adolescent girls and young women.

Like most developing countries, despite much progress, Mexico is a nation still sharply divided by income and education. While a growing middle class continues to emerge in the urban areas, there remains widespread poverty and sharp divisions between the wealthy educated elite and the poor.

In 2012, Mexico was the second largest economy in Latin America. This is still the case, even though it is recovering from a very severe recession causes by the global economic crisis. Its heavy reliance on oil exports and its reliance on trade with the United States linked its economic well-being to that of the US. When international trade collapsed, Mexico's GDP fell 6.1 %. From 2008 to 2010, the number of Mexicans living in poverty increased by 3.2 million as a result of the global economic crisis (CONEVAL 2010). By 2010, the economy was again showing signs of strength. The GDP grew 5.4 % in 2010 (World Bank 2012). Nevertheless, 46.2 % of all Mexicans (52 million people) continue to live in poverty. Most of these families live in urban areas (CONEVAL 2010). Of those living in poverty in 2010, 10.4 % (11.7 million people) were living in extreme poverty. In urban areas, the extreme poor were living on $978 pesos ($76 US dollars) a month. In urban areas, the extreme poor were living on less than $684 pesos ($53 US dollars) (CONEVAL 2010). To tackle poverty, the Mexican government requested the World Bank to provide support for 5.6 million low-income families, a total of 25 million people through the Financing for the Support to Oportunidades Project. In 2009,

Oportunidades increased the number of families receiving support by about 8 % (approximately 400,000 families) to a total of 5.6 million by June 2010. The majority of families live in urban areas. The added support included new cash benefit for families with very young children. The additional financial support became available in 2011 and will be available through 2013 (World Bank 2012).

Even after the economic downturn in 2012 in many areas of Mexico, there continues to be significant industrial activity. Industrialization with the promise of high pay is drawing the young from the depressed rural countryside to the urban areas. The wages and benefits from industry continue to support, although at a lower level, a consumer movement in Mexico.

During 2011, Mexico's economic growth was moderate and reached 3.9 %, and it is expected to stay at 3.3 % in 2012. External demand for Mexican manufactured goods is projected to persist, but it will normalize compared with its sharp postcrisis rebound (World Bank, 2012).

The industrial sites that produce Mexico's exports are similar to the *maquiladora* plants and factories that have been built along the border between Mexico and the United States. These factories typically owned by firms in the United States profit greatly from the labor of Mexican girls and young women that they hire. Today, there are more than 4,000 such plants employing almost one million workers in Mexico. Almost 80 % of these plants are located along the border. Since the 1970s, the majority of workers at these assembly plants have been girls and young women (Cherry et al. 2009).

While it is legal to hire adolescents when they turn 16, some children work legally with their parent's permission, or with permission obtained from local authorities at the age of 14, it is common for girls as young as 12 (with false documents) to be working for some of the largest multinational companies in Mexico. To obtain and keep their jobs at many plants, the adolescent girls and young women are required to submit to medical examinations and pregnancy tests to prove that they are not pregnant (Cherry et al. 2009).

Mexican Social Views and Customs

This prosperity has also created a major cultural conflict. Although, a traditional agrarian culture has characterized family life in Mexico for almost 500 years, these agrarian traditional roles for men and women do not fit with the pragmatism of commerce. Women are working outside the home more often; they are becoming better educated, and especially in urban areas adolescent girls are cosmopolitan and have aspirations familiar to girls in developed country worldwide. Most importantly, they view themselves as strong and will control their future (Cherry et al. 2009).

In modern Mexico, support for traditional family ideals (large families) can still be found in the rural areas, but even in the rural areas, traditional values have become more of a romantic idea, than a widespread practice. This is especially true because the traditional family ideals required the subjugation of girls and women. In the second decade of the twenty-first century, women see themselves as having value that far exceeds the value of their fertility. Women and adolescent girls have rejected a national tradition where they did not have basic civil rights. Since emancipation of Mexican women in the mid-1950s, the focus of their struggle has been on holding their husbands equally responsible for contraception and childcare, and the passing of laws that make their husband financially responsible for childcare and family support is for whatever reason the husband leaves the home or the marriage ends in divorce. In the recent pass, if a husband left their family, it would often leave his wife and family destitute. As a mother and wife, women often had few if any resources. As a group, these mothers and wives were poorly educated and were not employed outside of the home.

This is no longer the reality for the majority girls and young women in Mexico today. From a national perspective, the traditional ideals of the past, early marriage, childbirth, and large families do not fit with the demands of a growing and developing country. High birth rates, while prized in traditional agrarian cultures in Central and South America, are seen as deleterious to the environment and the economy of these developing countries.

Vignette

Being a Mexican female, from the moment I was born, is like being born with a sociological disease called "The female sociological curse," from the moment the doctor says "Is a girl!!!" people say "poor thing, she going to suffer," "women suffer more than man," and "I hope she marries a good man." After several years of being a Mexican female, I have found that the only antidote against "The female sociological curse" is education.

Females have to look beautiful, descent, hardworking, never think of sex, be submissive, accept our destiny, listen, and be quiet to man's directions. I was born in a house hold were my parents encouraged me to go to college; however, at the same time, they wanted me to be married before 20 and have children young because according to them "When you have children young, you get to enjoy your children more."

Gloria was my best friend when I was 17. Gloria's parents were so proud of her because she finished middle school and started high school. Gloria's parents would dream about her daughter being a lawyer, doctor, news reporter, teacher, etc. However, at home, the standards for Gloria were different than her male brothers; Gloria had to attend her brother's orders. Gloria had to cook, clean, prepare the bathroom for her brothers, take care of her little sisters, and help her mother with house chores.

Gloria started dating Manuel in high school, at the beginning Gloria was dating Manuel without her father consent, and later, Gloria's mom convinced her husband to allow Manuel date Gloria. After 6 months into the relation, Gloria and Manuel were invited to a party; Gloria and Manuel left early to have sex in Manuel's car. The next day, Gloria told me "I love Manuel with all my heart; we did it for the first time last night." Two months later of this sexual encounter Gloria started to wear loose clothes and she said to me with tears in her eyes "I think I am pregnant, my father is going to kill me." Gloria stopped attending school, and she isolated herself.

Gloria's mom found out that Gloria was pregnant after 6 months of pregnancy. The bomb exploded. Gloria's parents found out that their daughter was pregnant, when finally Gloria's mom confronted Gloria asking "Gloria, are you pregnant?" Gloria started to cry, and she could not deny the question saying "Yes, mom." Gloria's mom started to cry and her father was so mad that he started to scream and cussed at Gloria. During the pregnancy, Gloria's father did not talk to his daughter. Every weekend, Mr. Alberto will drink and say "Why my baby? Why my daughter?" and blaming his wife for Gloria's "mistake" (pregnancy).

Gloria's mom and family members denied to everybody that Gloria was pregnant. Gloria stayed at home 24/7 during her pregnancy, looking sad and confused. Gloria did not have a baby shower because her pregnancy was a shame for her family.

Finally, Gloria went into labor. Her father drove her to the Hospital, with a worried look on his face. At the Hospital, the Doctor told Mr. Alberto about preforming a C-section because Gloria was a teenager, and her body was not fully developed. The doctor told them that she could not have a normal birth, and the doctor did not want to put Gloria or her child in danger.

Gloria gave birth to a healthy baby boy who was named Alberto Jr. like her father as a sign of forgiveness; Gloria's father reconciled any differences with his daughter.

Gloria became a wife and mother at the age of 16. Gloria's parents are so proud of their grandson; Albert Jr. is the pride and joy of the family. Albert Jr. had a beautiful welcoming

fiesta with many gifts. All the women in the community congratulated Gloria and talked about her experiences of being a teenage mom and all the good things of being a teenage mother. When Gloria holds her child, you can see in her eyes mixed emotions of confusion and joy. Gloria did not finish high school. Currently, Gloria has three children and she still lives with Manuel.

Mexican Girls and Women in the Twenty-First Century

Increasing public knowledge about medical reproductive services, family planning services, and contraception played a major role in moving the public perception from the idea that sexual activity and procreation where synonymous. This shift in view to a more worldly perspective, especially for females meant that they did not have to risk pregnancy during intercourse. These changes in norms changed the role and expectations of Mexican girls and women during the last quarter of the twentieth century.

The social and economic conditions of women began to change in the mid-1970s. This was part of a larger transformation in Mexico. The influential and the moneyed held sway forced Mexico into a market economy. This was the first real effort to move away from government ownership of the means of production, or at least, controlling the means of production. Government own companies were sold to private enterprise. These changes in the Mexicans governmental economic philosophy and in the labor force were rewarded. In 1994, the North American Free Trade Agreement (NAFTA) was signed by the governments of Canada, Mexico, and the United States. NAFTA created a trilateral trade bloc in North America. The economic policies that were changed, increase wealth of the average Mexican family and brought great wealth to a few (Lederman et al. 2005).

The unintended consequence of transforming Mexico's economy to generate wealth was the need for an educated and healthy labor force. Simple enough in concept, when implemented in an ultra-conservative traditional society, which Mexico was before the 1970s, changing education and health services had a profound social impact.

Especially important for the predictive rate of adolescent pregnancy, girls began to have increased access to education and health services. Expectation was that they would become productive members of the labor force. Given this increased opportunity, young women became more able to become financially independent and exert more control over economic resources that had in the past been controlled by male family members or relatives. These opportunities, for Mexican girls and women, have resulted in an increasing autonomy and the ability to establish a more egalitarian relation with the men in their lives (Tuiran et al. 2002).

Variables indicative of the life of Mexican women that were measured between 1970 and 2005 (i.e., longevity, years of education, and years in the labor force) show dramatic changes. Life expectancy for females born in 1970 was 65 years of age. The average years of education were 4.2 years. And, women spent an average of 10 years in the labor force. The changes over the next 25 years were quite dramatic. By 2005, life expectancy for women had increased 14 years to the age of 79. The average years of education had increased to 10 years. Women on average were spending an average of over 25 years in the labor force (Tuiran et al. 2002).

Rising Expectations Among Girls

Expectations among girls in Mexico were shaped in the 1970s and 1980s by the knowledge that in the neighboring United States, girls lived a life much different than their own; a life with a future where women were respected and had valued. This was supported and reinforced by the expansion of mass media's sphere of influence. As the percentage of households with radios and television increased, new ideas, social concepts, technologies, lifestyles, and models of behavior evolved. Ideas related to sexuality, contraception, family structure, and the division

of labor gave way to a more modern, secular attitude toward fertility and the ideal family size. In 1970, only 30 % of all households had a television and 76 % had a radio. By 2000, as a result of increased household discretionary income, 85 % of households had a radio and television. By 2010, that percentage had increased to 93 % of households with a television (Tuiran et al. 2002).

Modern Medical Practice

As more girls and women were being seen and treated by medical professionals, the concepts of reproductive control and pre- and postpartum care reached more women, even in the rural areas of Mexico. The percentage of births attended by a medical doctor increased from 55 % between 1974 and 1976 to 66 % in 1985–1987 and to 82 % in 1994–1997. The percentage of births attended by medical doctors in urban communities was greater than that in rural areas; however, the number of births attended by medical doctors continues to increase both in rural and urban areas. Whereas, medical doctors attended 37.8 % of rural births in 1985–1987, that number had increased to 59 % by 1994–1997. In urban areas, it was 84 % in 1985–1987 and 91 % in 1994–1997 (Tuiran et al. 2002).

The principal explanation for the high rate of adolescent pregnancy in Mexico in the 1970s and 1980s was poverty. The more severe the poverty the adolescent girl lived in the higher the risk of an unintended pregnancy. Poverty has been shown, in every context, to increase the risk of adolescent pregnancy. Approximately 70 % of adolescent pregnancies are among girls from the most disadvantaged groups in Mexico. Girls living in rural areas are generally at high risk. Poverty has also been associated with poor outcome among children of adolescent mothers. Children of adolescent mothers may experience periods of poorer nutrition, being less likely to attend school, and show poorer motor skills than children of adult women (Moreda 2000).

Overview of Adolescent Pregnancy

In Mexico, the story of adolescent pregnancy and childbearing is the story of adolescent marriage or in union and childbearing. There were 21,700,000 adolescents between 10 and 19 years of age in 2010. They comprised 19 % of the population. Some 15 % of adolescent girls between 15 and 19 years of age married or were in a union (UNICEF 2011).

In 2010, data from the World Bank show that there were 65.84 pregnancies per thousand among Mexican adolescents between 15 and 19 years of age. This was a decline from 77.8 pregnancies per thousand in 1996. A rate of 65.84 is a low average for Central and South American countries. The range in Latin American runs from a high in Brazil of 89.36 per thousand adolescents to a low in Chile and Argentina of 60 and 57.7, respectively, per thousand. There are about 37 % more adolescent pregnancies in Brazil than that in Mexico (World Bank 2012).

Even so, a recent study (Arceo-Gomezy and Campos-Vazquezz 2012) showed that in the Mexican context while adolescent pregnancy continues to decline, adolescent childbearing continues to have a negative effect on the life outcome of the mother. During the period 1990–2010, the percent of adolescents living in rural areas (communities with fewer than 2,500 inhabitants) remained fairly stable at about 25 % of all Mexican adolescents.

The number of single adolescent girls remained stable over the 20-year study period at about 82 %, while the number of married and in union adolescents was between 16 and 17 %. What is important to note is that the percent of adolescent girls that were married decreased substantially over the same time period from 10.8 % in 1990 to 4.7 % in 2010. During this

same period of time, the percent of girls who were in union increased from 5.8 % in 1990 to 11.7 % in 2010. For the most part, childbearing has been stable since the 1990s.

The percent of females with at least one child born alive increased slightly from 12.3 % in 1990 to 13 % in 2010. About 2.5 % of these girls were single (not married or in union). Noticeably, the increase in childbearing rates has been in the urban areas not in the rural areas. In effect, girls in the rural areas are less likely to become an adolescent mother. Girls in the urban communities are slightly more likely to become teen moms. This has increased public expressions of dissatisfaction with the direction of the public health approach to adolescent sexual and reproductive sexual education and services.

Adolescent girls with less than a primary education (less than 8 years of schooling) have the highest childbearing rates in Mexico. Nonetheless, while childbearing among this group of less educated girls has been decreasing since 1990, the rate of childbearing is increasing among girls who complete 9–11 years of school (secondary school). As well during this period, nationally, education and school attendance continued to improve. Education doubled from 21 % among 55–64-year-olds to 42 % among 25–34-year-olds. Related to the improvement in educational opportunity, if a girl is attending school, the probability that she will give birth is greatly reduced.

Other characteristics reported were that girls who became pregnant came from more disadvantaged backgrounds (based on the years of schooling of the head of the household). They had lower school attendance and a history of work before becoming pregnant. They were also more sexually active than girls who did not become pregnant. Given these circumstances and the reality that social mobility in Mexico continues to be limited (Torche 2010); the outcome of adolescent childbearing tends to perpetuate intergeneration poverty.

Policies that can impact these outcomes are sexual education services and educational opportunity. Increased programs to provide sexual education and access to contraceptives through public health systems will reduce unintended adolescent pregnancy. Moreover, if a girl does become pregnant and decides to carry the child to term, providing teenagers with support in the form of childcare and educational scholarships would prevent the mother from dropping out of school.

Contraception

> "Stop crying and whining, you didn't complain when you were making the baby." *A nurse responded to a patient who was about to give birth.*

In Mexico, 71.6 % of females of reproductive age suffer from *medical violence*, thousands of histories of women who had invasive procedures in Public Hospitals without giving consent. In too many cases, procedures like the insertion of an intrauterine device (IUD) and tiding tubes are performed without consent. During these procedures, both adult women and girls are subjected to emotional violence, discrimination, and inhumane treatment. Many women cannot conceive for years because of damage from an IUD or cannot conceive due to negligent treatment (GIRE 2013a).

Mexico has a shortage of contraceptives. Moreover, the statistics clearly show a disparity in access to contraception among girls and women of Mexico. According to the nongovernmental organizations, 72.5 % of females have contraception coverage, native females 58.3 %, females from rural areas 63.7, and 60.5 % of females with low levels of education (INEGI 2013).

The World Health Organization has set the standard for a reasonable goal for the provision of contraception at 90 %, as a measure of established health options needed to decrease unintended pregnancies. The Women Health Coalition noted that the number of sexually active teenagers who were satisfied with available contraceptives has dropped, from 75 % in 2003 to 64 % in 2006. According to the Coalition, teenagers in 2006 had a higher rate of disapproval related to access of contraceptives than

rural adolescents and teenagers with marginal educations and natives (Paola and Ermani 2013). In many cases, local communities do not have the funds to buy contraceptives. Thus, health offices do not have the quantity of condoms needed in their community (Valadez 2012, Aug. 3).

When Vicente Fox won the presidency in 2000, the first conservative president in 71 years, his government stopped financing reproductive health programs, family planning, and promotion of public health regarding reproductive prevention. Instead the government promoted conservative ideologies. By 2006, Felipe Calderon was the second conservative president elected; his government continued promoting a religious ideology of contraception (Farias 2013).

In Mexico, emergency contraceptives are included in many official standards issued by the Health Department. Based on these standards, emergency contraceptives must be provided by federal, state, public, and private insurers. Emergency contraceptives have been included in the Mexican Official standards for family planning since January 21, 2004. Emergency contraception was included as a basic medication by the Health Department in July 11, 2005. Laws that address domestic and sexual violence include emergency contraceptives as a standard practice since 2009 (i.e., NOM-046-SSA2-2005). The standards for prevention and attention stipulate: "According to the Mexican official standard practice in a case of rape, the institutions that provide medical attention and services should apply the prevention standards, offering immediate attention with a maximum period of 120 h after the occurred event providing emergency contraception, and information about how to use the medication. The goal is that the woman makes an informed and free decision" (GIRE 2013b).

The unsatisfied demand for contraceptives is a public health problem; many teenagers who are married and living in free unions are at risk of getting pregnant because they do not have access to contraceptives, even though at the moment do not want children (Paola and Ermani 2013, June 26). In the 1970s, Mexico was a leader in family planning policies; however, today, Mexican politicians have taken a step back from supporting contraceptives. In addition, it is relevant to mention that the states with the highest dissatisfaction with contraceptive access are historically the same states that have the highest maternal mortality rates: Chiapas, Guerrero, Puebla, and Oaxaca. These states also have counties with the worst health conditions. On the other hand, Baja California Sur, Distrito Federal (Federal District), and Nayarit are states with a lower index of dissatisfaction. This is due to pro family planning standards and policies that are supported by the state government. It is interesting to mention that governors and politicians from states that support family planning policies are politicians in liberal parties or politicians who are now in a conservative party but began their career as a socialist or liberal party, which supported family planning ideologies (INEGI 2013).

Abortion

The most accepted views about abortion in Mexican society are based on religious beliefs, in particular Catholicism. As is common knowledge, Mexico was conquered by Spain. Less well known is that the people were conquered by the Catholic Church. The Catholic Church had and still has a strong influence on the life of people in Mexico. The Church is opposed to the abortion. The role of women is to procreate as many children as possible. The Church teaches that abortion interrupts God's plan for creation (CIMAC 2008).

In the eighteenth century, however, international events began to weaken the Church's hold on power in Mexico. The French Revolution and the French occupation of Mexico brought about changes in Mexican politics, which weakened the influence of the church. These changes in politics and the consolidation of National States also reduced the church's authority

Yet, little changed for Mexican women. Rather than be a dictate from the Church, the role of women was codified into law. A women's role

in Mexican society was redefined and written by church leaders and legal experts. A women role was to procreate as many children as possible because God wanted to strengthen the Nation with citizen-soldiers or citizen-workers.

In 1931, a change was made in the Federal Code stating, "Abortion is giving death to the product of the conception in any moment of gestation." Even so, in this same year, abortion was legalized, but only for women who had been raped. The atrocities during the Mexican Revolution (approximately between 1910 and 1920) were still fresh in the mind of the politicians. Many girls and women were raped during the revolution and would have conceived an unwanted child if the fetus had not been aborted (CIMAC 2008).

The change in Mexican society's view of a woman's role began in the 1970s. Liberal groups began calling for a change in the eighteenth century legislation. They wanted as end to policies that were promoting and enforcing pro-life policies. In 1979, the Coalition of Feminist Women (CMF) and the National Front of Fight for Women's Rights and Liberation (FNALIDM) demanded that congressman pass legalization related to a women's right to control her reproductive life. The result of this effort is embodied in the 4th Article of the Mexican Constitution. It reads, "Men and Women are equal before the law. The law will protect the organization and development of the family." And, "Every person has the right to decide in a free manner, the number and time to have children." It became effect on June 10, 2013 (Constitución Política de los Estados Unidos Mexicanos Titulo Primero articulo 4 2013). These constitutional changes were efforts to meet the demands of women to codify their demand for a legal right to be free from moral, philosophical, and religious law. These laws are unacceptable in a country where State and Church are separate, where the government is secular. Even though great progress was made, the feminist groups fail in their attempt to legalize abortion (GIRE 1980).

It took until 1998 before conservative attitudes were again seriously challenged. A group of authors, intellectuals, and scientist signed a letter called "Para un Cambio Indispensable" (For an indispensable change). The letter demanded that the Mexican penal code on abortion be change. At the time, legal abortion could only be approved for three reasons: (1) Eugenic, (2) the pregnancy put the mother at risk, and (3) economic reasons (GIRE 1998, July 25).

In the Federal District, Mexico legalized abortion on April 24th 2007; the procedure is allowed in the first 12 weeks of gestation. Since that date to March 31, 2013, 97,562 abortions were performed. By the end of 2010, the Group for Information and Chosen Reproduction counted 1,000 constitutional protections that limit any abortion practices (GIRE 2011). Eighteen states took a position against the legalization of abortion, Baja California, Tamaulipas, and Morelos had made modifications to the Constitution to repeal abortion. These modifications are called "The Constitutional Shield" (GIRE 2012, April 13). Yucatan, Mexico is the only state that allows abortion for economic reasons of extreme poverty, and if the mother already has three children (Jimenez 2009).

Maternal Mortality

> The Devil talking with God said, "I want the souls of all pregnant women when they died giving birth, Can I keep them?" God responded, "You can keep all the souls of pregnant women, only with one condition, you need to go to earth turn into a woman and get pregnant and only if you bear the pain of birth like any women, you can keep their souls when they die giving birth." The Devil came to earth with a mission, he turn into a woman, got pregnant and when he had the contractions and was giving birth, he could not handle the pain and left. My grandmother tells this story while knitting from her rocking chair, and she says, "This is the reason why pregnant women who died giving birth go directly to heaven."

In Mexico, in 2010, there were 50 maternal deaths per 100,000 live births (CIA 2012). A woman that lives in southeastern states of Mexico is five times more likely to die of obstetrician causes than women living in northern states of the Republic. Women with poor nutrition are three times more likely to die

during pregnancy than women with adequate nutrition. In Mexico, between 2004 and 2008, 33.39 % of women who died because of pregnancy-related causes lived in communities with less than 2,500 people, and in communities with more than 50 thousand people 67.28 % of women died, from pregnancy-related causes (OMM 2011a). This is important because according to the *Statistics in Mexico Alejandro Aguirre,* in 2001, concluded that being a poor teenager and a native with lower levels of education in Mexico equates to being at a higher risk of death during pregnancy and postpartum. A lower level of education increases a women risk of dying due to a pregnancy 4.6 times higher than women with a higher level of education. A native has 4.6 times the risk than a nonnative. Girls between 10 and 18 years of age have a 2–5 times higher risk of dying due to a pregnancy than females from 20 to 29 years of age, while females that live in communities with high marginalization have 2.4 times more risk of dying due to a pregnancy (Aguirre 2001).

The maternal mortality rate reflects the Mexican government's position on women's rights and it's attitude toward sexual and reproductive rights to service. The unacceptable high rate of maternal mortality persists because of the absence of health protection, the violation of a woman's civil rights, lack of attention to the disparities and needs, and the absence or poor access to health services. Women who are poor, native, and are of afro descendant, who live in rural communities suffer mostly from the inequality of health services (OMM 2011b).

According to the National Institute of Statistic and Geography, 13.8 % of all girls who die between 15 and 19 years of age died due to causes related to pregnancy; 63.4 % of young women who die between 20 and 34 years of age are victims of maternal mortality; and 22.8 % of women who die between 35 and 49 years of age died from complications during pregnancy (INEGI 2011).

Infant Mortality

> "Run to the market and bring me a candle! Before I forget, tomorrow is November 1st day of the Angels, and I need to light up a candle for my unborn son Ricardo right now he would it be 40 years old, it seems like yesterday when it happen, but my son is coming tomorrow to visit and I need to light up his path" Miss Mercedes was giving instructions to her granddaughter while talking with her best friend.

In Mexico, there were 16.77 infant deaths per 1,000 live births. Based on statistics from 224 countries worldwide, Mexico ranks 103rd in terms of the number of infant deaths (CIA 2012). The statistics from 1970 to 1974 show that Mexico had 64 infant deaths per 1000 live births. Later, in the year 2000, the number had declined to 31 deaths per 1,000 live births.

Similar to maternal mortality, the infant mortality rates from state to state. The states of Puebla, Mexico, Tlaxcala, Guerrero, and Chihuahua have the highest rates of infant deaths, at 16 deaths per 1,000 live births. While the lowest rate of infant deaths are found in Nuevo Leon, Coahuila de Zaragoza, and Sinaloa at nine deaths per 1,000 live births.

Guerrero, Puebla, and Tlaxcala have the highest rates of infant mortality. All these are in the south of Mexico City and share state borders. The people in these states also have the lowest levels of well-being. They have poor access to clean drinking water and the lowest levels of education in the country. On average, it is slightly above primary school level. The three main causes of infant mortality are infections originating during pregnancy, cardiac malformations, and respiratory infections (INEGI 2011).

Oaxaca, Chiapas, Veracruz, Yucatan, and Puebla are the states with the highest native communities, a total of 7.3 million people. These states are also located south and southeast from Mexico City. The people in these states have limited public health services and

educational opportunities. Yet, the native in these states have little access even to the limited health and social services that are available. In many native communities, there is little infrastructure such as roads that would give them access to health service centers, schools, and social service (UNICEF 2011).

Public Policy

Using a multidimensional approach to measure and predict behavioral and social problems provides valuable information that can help select the best interventions and approaches to reduce the social problem or the harm caused by the problem (CONEVAL 2010). When a social right approach is added to the formula, for example, a measure of poverty not only provides a means for reducing the burden of poverty but also is in alignment with the Mexican Constitution and the Law of Social Development. Moreover, it also helps to sort out a number of methodological issues. In particular, it can help solve the issues of weights and thresholds. Since all social rights are equally important, the weight is the same for all social dimensions. At the same time, Mexican regulations have selected various thresholds. For instance, the Constitution decrees that the minimum educational level in Mexico should be secondary school; thus, that is precisely the threshold used for the education dimension (CONEVAL 2010).

In terms of health and developmental thresholds, Mexico is a signatory to the "Millennium Development Goals" and continues to develop and support these goals (Travis et al. 2004). In many ways, this United Nations covenant set the standard in Mexico for health care and social services in the eight areas that define the goals.

In a decentralized health care system, like the health care system in Mexico, change involves multiple government and nongovernment agencies. In this political and economic health structure, making a change entails a process of developing guidelines, securing cooperation from the shareholders, and coordinated action. Given a decentralized health care system, these programs become the government's instruments for meeting the health challenges facing the Mexican people and meeting the eight World Health Organization's "Millennium Development Goals."

Programs to Reduce Adolescent Pregnancy in Mexico

Working from a social rights perspective and based on empirically identified disparities, adolescents became the focus of a number of initiative put together by the National Center of Gender Equality and Reproductive Health (CNEGSR) and the Administration of Public Education (SEP). The goal of the initiative, which began in 2007, was to improve the development and well-being of adolescents, increase access to medical care, and sexual and reproductive health services. The objects were to decrease unplanned pregnancies and reduce sexually transmitted diseases (STDs). The programs address gender relations, overcoming social inequalities, and the promotion of respect for human rights (Secretaria de Salud 2012). Some of these programs are listed below.

- Program "Build T" (Contruye T): The slogan is "Adolescents as leaders of their own life project." The Administration of Public Education (SEP) created this program in 2008. Twenty-six organizations and the United Nations Children Foundation (UNICEF) fund this program. The purpose of this program is to create learning communities for adolescents, which promote inclusion, equity, and democratic participation. It is designed to encourage young people to remain in school, to face and overcome adversity, and to encourage each young person to develop his or her skills and gifts, and build their "Project Life". The goal of the program is to ensure the rights to full development of each adolescent's potential educationally and to development a civic identity. The program serves young people between 15 and 18 years of age who are enrolled in secondary education programs (SEP 2012).

- Program Equal Start in Life (Arranque Parejo en la Vida APV): The objective of this program was to reduce the number of maternal and infant deaths by providing a package of social services and health care to all pregnant and parenting mothers. The services include: accessibility to social services, prenatal care, detection and treatment of HIV and syphilis in pregnant females to stop transmission in pregnant females, childbirth care, newborn care, emergency care, puerperium services, and related obstetric care. The program was started in 2002. Coverage of this program was extended to all states and federal entities and became mandatory in 2004. It has reduced maternal mortality by approximately 10 % (Block 2006).
- Program Strategies for a Health Pregnancy (Estrategia Embarazo Saludable): Created in May 2008, it is a component of the Popular Insurance (Seguro Popular). The Social Health Protection System (Popular Insurance Scheme) seeks to provide health service coverage, through voluntary and public insurers, for persons that otherwise would not have access to health services because of poverty. Since 2008, all pregnant girls and women who do not have health insurance are automatically enrolled in Seguro Popular to ensure medical attention during pregnancy, birth and after birth. The focus of the program is to provide free medical attention for pregnant women and their children. Members of families affiliated to the Social Health Protection System through Popular Insurance will have access to the medical, surgical, pharmaceutical, and hospital services that fully satisfy their health needs. The Popular Insurance Scheme currently provides coverage for 275 medical operations, described in the Universal Health Service Catalogue (Gonzalez and Aguilar 2009).
- Social Milk Supply Program (Leche Industrializada Conasupo Sociedad Anonima de Capital Variable): Started in 1944, this program is designed to help improve the nutritional quality of the diet of millions of Mexicans by providing disadvantaged families with high-quality fortified milk at a subsidized price. The fortified milk subsidy is offered to girls and boys from 6 months–12 years and to 15-year-old girls, women between 45 and 59 years of age, as well as pregnant and lactating mothers. A study in 2006 that evaluated the benefits of the fortified milk program reported that more than 1 and 1/2 million children between one and 4 years of age compared to children who did not consume the fortified milk were less iron deficient by almost a third; there was lower chronic malnutrition; the children grew 2.6 cm more than the control group, on average the children added 700 g more of muscle mass than children in the control group, and they were reported to have developed higher IQs. In 2012, almost 6 million children and adults receive fortified milk from this program (Liconsa 2012).
- The Comprehensive Care Program for Pregnant Women Infected with HIV (Programa de Atencion Integral a la Mujer Embarazada Infectada por el VIH): In Mexico, more than 85 % of cumulative AIDS cases among children under 15 years between 1983 and June 2008 were due to mother to child transmission. The Comprehensive Care Program Pregnant Women Infected with HIV program was created in 1998. The objectives of the program are to provide quality services to women with HIV in the following areas: management of the infection and decreasing the transmission from mother to newborn (Comisión Nacional de los Derechos Humanos 2012).
- Prevention and Response Program for Teenage Pregnancy (Programa de Prevencion y Atencion del Embarazo en Adolescentes PAIDEA). This program was created in 1997 with the objective of preventing unintended pregnancy during adolescence. The goal of this program is to prevent and manage the risks of social exclusion arising from pregnancy and unplanned childbearing in adolescence. The program provides gender and age sensitive services consistent with each adolescent’s individual needs, while promoting a

responsible attitude about sexuality and helping the adolescent develop skills needed for a full and productive life. The program was designed for adolescents who are interested in learning more about sexual and reproductive health. The target population is pregnant adolescents across the country (UNICEF 2010).

- The Health Care of Adolescents program (PASA) has been in operation since 2009. The PASA program is designed for adolescents from 10 through 19 years of age. The program's goals are to develop and improve adolescent health by promoting a healthy lifestyle among adolescents, promote the development of adolescent sensitive sexual and reproductive health services, and promote adolescent access to modern sexual and reproductive health services (CeNSIA 2012).

Conclusion

> "Men are not the problem, we women are the problem. We have to say no, respect ourselves, be pure until we get married and love ourselves. Yes, just remember love ourselves" A principles and ethics teacher was talking about sexuality. When a student asked, "And how can we learn to love ourselves?" The teacher did not respond.

The story of adolescent pregnancy in Mexico is the story of adolescent girls coming of age in a changed world. A world far different than the world even their parents live in. It is the story of girls who are far ahead of Mexico's political and social leaders. It is the story of girls who are not waiting for an invitation into society but girls who are making their own society. For the Roman Catholic Church in Mexico, benign public acceptance of adolescent pregnancy (in the form of providing sexual and reproductive services) is tantamount to a threat to their traditional authority over the reproductive life of parishioners and the Mexican people—and they are fighting back. It is a position that opposes providing sexual and reproductive services to adolescents and a position that will continue to harm poor and native girls, their child, and their families.

The major changes in sexual behavior among adolescent girls in Mexico are much the same as among adolescent girls in developing countries worldwide. The overall reduction in fertility among girls and young women in Mexico since the 1960 has been profound. At the beginning of the twentieth century, the fertility rate in Mexico was six children per female. In the 1960s, the fertility rate had increased to seven children per female. In 2010, the estimated fertility rate was 2.3 children per female and is estimated to reach replacement (2.1 children per woman) in the near future. This is a 70 % drop in fertility. This spectacular decline in Mexican fertility is even more remarkable when the context in which it occurred is considered.

In 2012, Mexico was the second largest economy in Latin America. Like most developing countries, however, and despite much progress, Mexico is a nation still sharply divided by income and education. While a growing middle class continues to emerge in the urban areas, there remains widespread poverty and sharp divisions between the wealthy educated elite, and the poor and native people. In 2010, data from the World Bank showed that there was a decline from 77.8 pregnancies per thousand in 1996 to 65.84 pregnancies per thousand among Mexican adolescents between 15 and 19 years of age, still far too high. This is a decline that will continue because it is driven by a change in the belief system among adolescent girls in Mexico. As more adolescent girls believe that a small family (1–3 children) is more desirable than a large family (3–7 children), the more adolescent pregnancy will decline. Additionally, as the number of adolescent girls who want to finish their secondary education increases, the more likely those adolescent girls will be to avoid unintended pregnancy. Finally, when these changed beliefs are supported by increased opportunity for girls and young women, the

adolescent fertility rate will come in line with the national rate of fertility.

So, how will adolescent pregnancy in Mexico be characterized in the future? Given the ever-widening and profound changes in the beliefs of adolescent girls about their role as women, for years to come, adolescent pregnancy will be characterized by its rapid and continual decline.

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Adolescent Pregnancy in the Netherlands

C. Picavet, W. van Berlo and S. Tonnon

Keywords
Abortion · Adolescent parents · Adolescent pregnancy · Contraceptive methods · First sexual intercourse · Reproductive health services · Teenage fathers · The pill · Sexuality education

Introduction

Teenage pregnancies are a public concern in most of the Western world. Adolescent mothers tend to be from disadvantaged backgrounds and raising children often interferes with their education and economic prospects (Kiernan 1997; Fergusson et al. 2007). It is also related to depression, insecure attachment styles, external locus of control, and low self-efficacy (Figueiredo et al. 2006). Furthermore, adolescent pregnancies are not without medical risk, for instance of early birth and perinatal mortality (Van Enk et al. 2000). Next to these negative consequences for teenage mothers, there may be a number of negative consequences for their children. There is evidence that these are likely to suffer numerous health and psychosocial disadvantages (Jaffee et al. 2001).

Vignette: Samantha

Samantha is a 17-year-old girl from Antillean origin. She lives in a large suburban area in the south of Amsterdam. Her parents divorced when Samantha was a little girl. Samantha has vague memories of huge rows between her father and mother, sometimes even accompanied with physical abuse. After the divorce, Samantha stayed with her mother. The two had a good relationship, but Samantha did not see her mother very often. The latter had to work long hours to provide for her family, and Samantha had to take care of her two younger brothers. Mother had several boyfriends, but none of them stayed very long.

Samantha had her first sexual experience at the age of 14. It was not out of lust or love that she had sex, but she felt ready for it, "all my friends had done it and I was curious." She did not like it very much, it even hurt, but she was proud to belong to the in-crowd now. She knew

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from the start how to protect herself against pregnancy, as she had learned that in school. However, sex education at school did not entail more than information about safe sex and contraception. She did not learn anything about relationships, how to stand up for herself and how to protect her boundaries.

Although she knew how to prevent pregnancy, she was careless with contraception. Somehow, she had the naive idea that it would not come to that. She had unprotected sex a few times, and all went well.

But of course, Samantha was not so lucky all the time. She became pregnant and a year ago she gave birth to a daughter, Destiny. The father was a 25-year-old man, Wesley, with whom Samantha had an affair. Although Wesley wanted her to have an abortion, she refused. Abortion is murder in Samantha's perspective. Moreover, she knew at a very young age that she wanted to have children. It felt wrong to take away a child that was already in the making. "And it is my own body, so I will decide."

Samantha and Wesley do not see each other any longer; the relationship was not very steady from the start, and he was not interested in the child. That is fine with her, for she does not want him around anyway. Samantha yearns for a place of her own, but she and her little girl live at her mother's place. Samantha feels that with Destiny, she finally has someone all to herself for the first time in her life. She never looked very far ahead in the future, and now she has Destiny to take care of. She does not know what to do with her life anyway.

In 2011, the pregnancy rate among Dutch adolescents between 15 and 19 years old was 13.8 out of every 1000 young women. Most of them (9.0) had an abortion and 4.8 gave birth to a child (Van der Linden & Garssen 2012; Health Care Inspectorate 2013). This rate is among the lowest in the World (Singh and Darroch 2000). Approximately 60 % of these pregnancies end in abortion and only one out of every 65 newly born children in the Netherlands was born to an adolescent mother (Garssen 2008). Of all European countries, only in Switzerland birthrates among adolescents are lower than in the Netherlands (see Fig. 1; WHO 2009). Nevertheless, teenage pregnancy is considered problematic, because negative effects on health and socioeconomic opportunities are considerable. Therefore, the Dutch government finances interventions to reduce pregnancy rates and support adolescent mothers and fathers.

The Dutch Context

Birthrates among adolescents are available from 1950 onward. The highest birthrates were recorded in the late 1960s and early 1970s. At that time, the birthrate among girls under 20 years old was 23 per 1,000. Most of these births occur among 18 and 19-year-olds (Fig. 2; Garssen 2004). In 2007, this was reduced to less than a quarter of that number. This decrease has drawn the attention of researchers and policy makers around the world. The Netherlands are often seen as a forerunner among Western countries with regard to reproductive health. Particularly an open sexual climate, easy accessibility of contraceptives, comprehensive sexuality education, and a nonjudgmental attitude toward young people's sexuality are believed to contribute to low rates of unintended pregnancies (Furstenberg 1998; Garssen 2004; Ketting and Visser 1994).

The open sexual climate has not always existed in the Netherlands. Until the introduction of the contraceptive pill in 1962, family planning was a morally questionable undertaking. Selling contraception was even illegal (Rensman 2006). Only a few decades later, the atmosphere had drastically changed. A pragmatic, rather than moral, approach to sex and sexuality education was believed to be required. Presently, intercourse

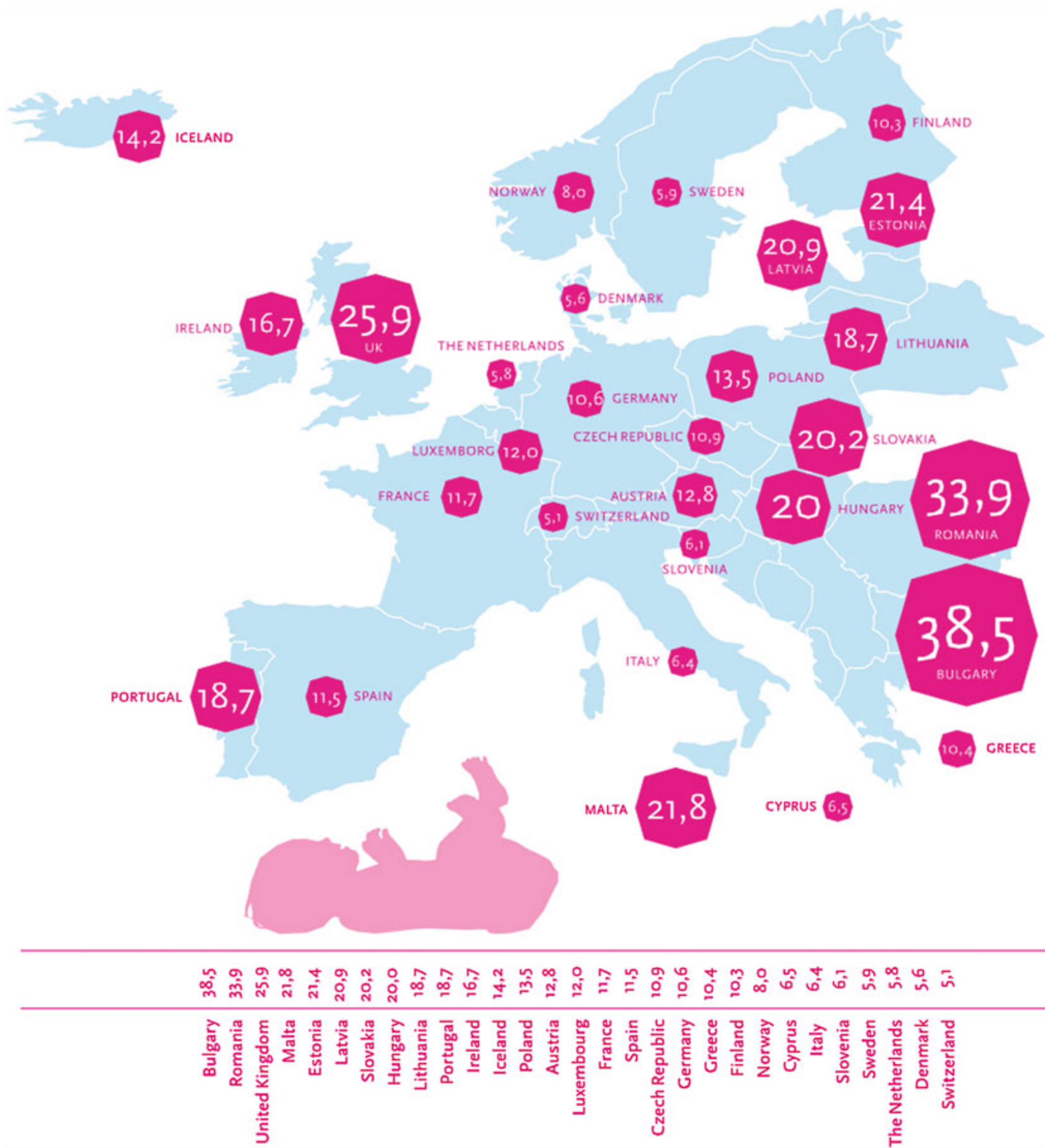
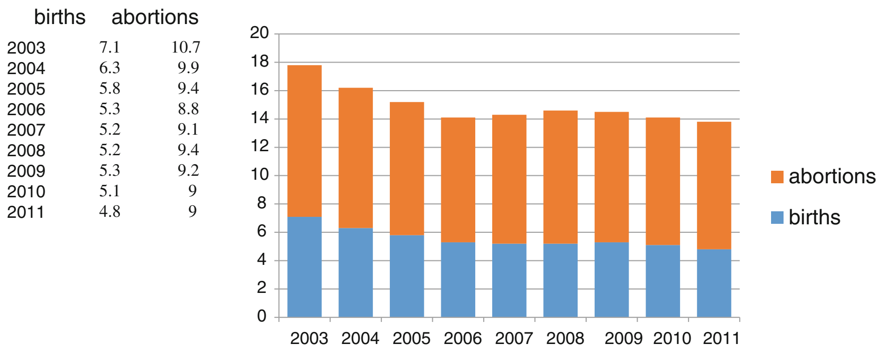


Fig. 1 Number of live births per 1,000 girls aged 15–19 in Europe, 2005

among adolescents is usually not rejected in the Netherlands, but mildly discouraged. Many Dutch parents teach their children that sex should be reserved for somebody special, not just a fling. Furthermore, adolescents are encouraged to be well prepared. They learn to have safe sex when and if they do have sex (Van Lunsen and Wijsen 2009). When parents accept the sexual relationships of their children and support their use of contraceptives, young people are more likely to use contraceptives (Kosunen and Laipapala 1996).

Schalet (2000) considers terms such as ‘permissive’ and ‘restrictive’ inadequate for describing attitudes toward adolescent sexuality in the Netherlands. She argues that Dutch parents tend to normalize adolescent sexuality, which means they describe it as something that does not and should not present many



	births	abortions
2003	7.1	10.7
2004	6.3	9.9
2005	5.8	9.4
2006	5.3	8.8
2007	5.2	9.1
2008	5.2	9.4
2009	5.3	9.2
2010	5.1	9
2011	4.8	9

Fig. 2 Live births in the Netherlands per 1,000 girls, by age, from 1950 to 2002

problems. In contrast, American parents tend to dramatize their children's sexuality, which is seen as a disruptive force in adolescence (Santelli et al. 2006). This is mirrored in Dutch and American college women's experiences. Whereas American women find their parents silent and uncomfortable, their Dutch counterparts see their parents as supportive and educators (Brugman et al. 2010).

Abortion and birth rates among teenagers have been steady during the past 10 years (see Fig. 1). However, the overall pregnancy rate is higher than in the second half of the 1990s. It was argued that both the quality and quantity of prevention programs in the Netherlands suffered from the relatively favorable situation in this country, because policy makers considered prevention campaigns unnecessary any longer (Wijsen and Rademakers 2003; Vogels et al. 2002). Little effort went to the prevention of unintended pregnancies, while attention was mainly focused on STI prevention. The temporary increases in adolescent pregnancies and abortions can be mainly attributed to Dutch native girls. Nevertheless, ethnic minority youths are still far more likely to get pregnant. Since a few years, pregnancy prevention—of teenage pregnancies in particular—has returned to the political agenda. Since that time, STI prevention, the prevention of sexual violence, and the prevention of teenage pregnancies have been further integrated within sexual health promotion programs.

Despite prevention efforts, some girls do get pregnant during their teens. These girls need care, whether they have an abortion or decide to keep the baby. With regard to decision making, pregnant girls can turn to their family doctors, midwives, or dedicated services. These services, especially the pro-choice organization FIOM and the pro-life organization Siriz, provide counseling and assistance. A national network of abortion clinics is available to carry out an abortion, if that is what the girl decides.

If the girl decides to keep the child, pregnancy care is necessary. When there are no medical problems, this is the responsibility of midwives and they are easily accessible. After the birth of their child, young parents may need support with regard to raising their child, social support from family or friends, or psychosocial support by social workers or therapists. They may also need a place to live and social security. Many of these services are provided by local communities. Therefore, policies can differ between different areas in the country.

Prevention of Adolescent Pregnancy

There are several strategies available for reducing the number of unintended pregnancies, particularly among adolescents. The most effective strategy is the promotion of reliable contraceptive methods (Darroch et al. 2001).

Table 1 Experience with sexual intercourse, by age (%)

Age	Boys	Girls
12	4	3
13	8	4
14	13	8
15	27	29
16	44	37
17	45	63[a]
18	70	77
19	70	80[a]
20	81	82
21	86	88
22	86	88
23	85	91
24	89	94
Total	55	57

[a] significantly higher than the other sex ($p < 0.05$)

The First Time

First sexual intercourse is an important experience for many young people. It usually takes place during adolescence, a tumultuous period for many people, in which physical changes, identity issues, and changing relationships go hand in hand. The most secure way to prevent pregnancy is abstinence. However, for many adolescents, this goal proves to be unattainable. Although the age of first intercourse differs between countries, all over the world a substantial proportion of adolescents have had intercourse before the age of 20 (Currie et al. 2008; Wellings et al. 2006). In the Netherlands, the median age for first intercourse is 17.1. This means that by the age of 17 half of all youths in the Netherlands have had sexual intercourse. By the age of 20, 78 % of Dutch teenagers have had intercourse (Table 1; De Graaf et al. 2005).

Whether sexual intercourse constitutes a pregnancy risk depends on the correct use of contraception. In a study of De Graaf et al. (2012) among 7,841 young people under the age of 25, only 9 % of girls and 13 % of boys said they did not use a contraceptive method when they had sex for the first time. However, the percentage varies among different subgroups. Girls from Turkish and Antillean backgrounds more often reported not having used contraception at first intercourse than those from other ethnic backgrounds, and religious girls more often did not use any contraception at first intercourse than those who did not adhere to a religious tradition. Finally, girls with a lower education were less likely than highly educated girls to have used contraception. Among boys, those with non-Western backgrounds, or for whom religion was important, were less likely to use contraception at first intercourse (De Graaf et al. 2012).

Most young people, however, protect themselves during first intercourse. Both condoms and oral contraception were used by a large group of the girls, respectively, 75 and 58 %. Boys mentioned oral contraception less often (50 %). Perhaps some of the boys did not know their partners were taking the pill. The use of oral contraception and dual methods increased with age of first intercourse. Both boys and girls who were older when they had their first intercourse were more likely to use these highly efficacious methods. On the other hand, the use of condoms decreased somewhat with age of first intercourse, probably because of the increased proportion of girls using oral contraception (De Graaf et al. 2012).

Contraception

Oral contraceptive pills (OCPs) are the most widely used contraceptive method in the Netherlands. “The pill” was introduced in the early 1960s and became well established in a very short period of time. Although OCPs felt like liberation for many women because they could have sex without fear of getting pregnant, there was opposition to contraception as well. It was said that contraceptive use could degrade moral standards, particularly of young people. In later years, feminist critique with regard to contraception became more prominent. Women were required to take hormones daily and suffer from side effects, while the benefit was only for the men. Intercourse was considered to be a sexual activity for men’s pleasure only. More recently,

Table 2 Use of contraceptive methods by women, by age (%)

Age N	15–19 (N=340)	20–29 -656	30–39 720	40–49 866	Total 2582
Oral contraception (OCPs)	30.1	39.5	26.1	17.9	27.3
Condom	3.5	6.6	7.6	5.7	6.2
Dual methods: OCPs and condom	10.6	7.8	2.2	0.9	4.3
Injectable	1.5	1.4	1.8	1.0	1.4
Patch (Evra)	0	0.3	0	0	0.1
Ring (NuvaRing)	0.6	1.7	1.1	0.2	0.9
Implant (Implanon)	0	0.5	0.6	0	0.3
Hormonal IUS (Mirena)	0.9	4.4	10.4	9.4	7.3
Cu IUD	0	1.1	1.4	1.0	1.0
Partner vasectomy	0	0.6	6.0	13.0	6.2
Sterilization	0	0	2.6	7.3	3.2
Different	0	2.0	1.8	1.4	1.5
Total: contraception	47.6	65.7	61.7	58.0	59.6
No sex with men	46.3	18.2	13.6	17.8	20.5
(Becoming) pregnant	0.6	10.3	13.2	2.0	7.0
Want to become pregnant	0.6	7.7	5.4	6.2	4.0
Different	5.0	4.4	6.1	16.0	8.8
Total: no contraception	52.4	34.3	38.3	42.0	40.4

another consequence of contraception became apparent. Because women increasingly delay the birth of their first child, as a consequence of which, fertility problems occur more often. However, the opposition to contraception did not stand in the way of wide-spread use and positive attitudes toward contraception (Rensman 2006).

In the Netherlands, contraceptives are easily available for men and women. A doctor's prescription is required for all methods except condoms and emergency contraceptive pills, but prescriptions can be easily obtained from the family doctor. Consultations with the family doctor are confidential. Therefore, it is possible for teenagers to use contraception without their parents knowing. No repeat prescriptions are needed, and there are no age limits. Table 2 (Picavet 2012) shows an overview of contraceptive use in the Netherlands by age. Most of the girls under 19 who do not use any method of contraception (40.9) do not have sexual intercourse. As is apparent, only OCPs and—to a lesser degree—condoms are used by young girls. In later age groups, the methods that are used become more varied. OCPs remain the most frequently used method, but women above 40 years of age are also frequently sterilized, or their partners have had a vasectomy (Picavet 2012).

Both OCPs and condoms are methods that require consistent and correct use. From research among adult women, it is known that not using OCPs or condoms correctly occurs frequently. Therefore, women using OCPs or condoms worry about pregnancy more often than users of other methods (Picavet 2011; Picavet et al. 2011). Nevertheless, the Netherlands have the highest percentage of 15-year-olds in Europe who used contraceptives the last time they had sex. In a comparative study among European sexually active teenagers, 97 % of the Dutch girls and 90 % of the Dutch boys reported the use of the pill, a condom, or both (Gabhainn et al. 2009). Contraceptive use during last intercourse does not necessarily reflect consistent use. Another study revealed that consistent contraceptive use with the (last) partner was reported by 78 % of the boys and 81 % of the girls under 25. Higher education and Dutch ethnic origin are related to more consistent

Table 3 Young people with sexual experience who (always or sometimes) used a form of contraception with their last partner (%)

	n	Boys			Girls		
		Always	Sometimes	Never/do not know	Always	Sometimes	Never/do not know
Age 12–14	127	61▼	18	21▲	71▼	6	23▲
Age 15–17	777	74▼	14	12▲	79	12	9▲
Age 18–20	1350	81▲	11	8	80	14	6
Age 21–24	1864	78	14	8	84▲	12	5▼

▼▲ = Significantly higher or lower than the other age groups (0.05 level of significance)

contraceptive use (De Graaf et al. 2012) (Table 3).

Sexuality Education

Contraceptive use can be promoted through sexuality education. There are to this day strong beliefs in several parts of the world that sexuality education increases sexual activity among youth at a younger age and that it is therefore better to advocate abstinence until marriage. However, as is cited above, all over the world a substantial proportion of adolescents have had intercourse before the age of 20. With regard to the fact that young people have sex anyway and they better be prepared, a pragmatic approach toward sexuality of young people and sex education is common in the Netherlands. This entails that sex education has a long tradition in this country.

Education concerning relationships and sex was first included in Dutch school curriculums over 40 years ago. The call for good sexuality education became prominent in the 1970s. In 1985, curricular targets were introduced for primary schools, which concerned healthy behavior and self-regulation, including sex and sexuality issues. Almost ten years later, in 1993, similar targets were set for secondary schools. Since 2006, sexuality and sexual health are no longer targeted explicitly. Schools are free to choose their own approach, methods, materials, and topics. Particularly religion-based schools have the possibility not to implement sexuality education.

Teachers use a variety of mostly comprehensive and liberal school-based sex education programs (Ferguson et al. 2008). The programs used are often evidence-based and regularly updated. The most well-known and widely used sexuality education program is Long Live Love, available for the second grade of secondary school. This program was systematically developed in 1994 and has been updated several times. The main topic is safe sex, protection against pregnancy, and STIs by promoting combined pill and condom use. This package has shown to be effective; positive results have been noted in the improvement of knowledge, attitude, intentions, and skills to use contraceptives effectively (Vanwesenbeeck et al. 2003).

The majority of young people (older than 12 years) in the Netherlands reports receiving sexuality education at school (94 % of girls and 92 % of boys). Next to schools, media such as television, magazines, and the internet appear to be important sources of information about sexuality. For example, the Dutch Web site www.sense.info contains information, and young people have the possibility to chat and ask questions about sex. Adolescents also talk with their parents, particularly about relationships. Contraception is a topic of discussion for girls and their parents, but not for boys and their parents (De Graaf et al. 2005).

The idea that sexuality education activates young people to have sex has proved to be unfounded. For example, several studies have suggested that young people in the Netherlands do not start to have sex at an earlier age than in other countries (Currie et al. 2008; Bozon and

Kontula 1998). Pragmatic sex education programs acknowledge and accept young people's sexuality. It provides information on how to prevent unwanted pregnancies, and STIs, or HIV. It educates on how to develop friendships and respectful relationships, and how to communicate about wishes and boundaries. The programs refer to the physical, emotional, and social development of young people in a positive way.

When Adolescents Get Pregnant

Quantitative data about adolescent pregnancies in the Netherlands are mainly about prevalence and abortion rate. In a number of qualitative studies that were performed in recent years, determinants of adolescent pregnancies were examined.

Background of Adolescent Pregnancy

Although the number of teenage pregnancies is low in the Netherlands, some girls do get pregnant despite widespread sex education programs. A distinction can be made between planned, unintended, and unwanted pregnancies. In a study among predominantly white Dutch girls, it was found that adolescent girls get pregnant because they want to have a baby, because they did not use contraceptives adequately, or incidentally, and because they just had bad luck due to the failing workings of the contraception method used (Van Berlo et al. 2005). Inadequate use of contraception was explained by the girls either because they had objections ('too many hormones') or because they were careless ('that will not happen to me,' or 'I didn't think about it'). On a deeper level, three patterns in the backgrounds of the girls were distinguished to explain pregnancy, especially with regard to planned and unintended pregnancies. The first was the lack of a focus or direction in life. This was for a large part determined by a problematic or chaotic upbringing with inconsequential parental authority. These girls did not do well in school, and the parents were not able to support their daughters in setting goals for their future. When pregnant, the baby became the goal in life, not only in a functional sense but also for some in an emotional sense. Some of the girls even considered the child as their rescuer. The warmth and stability they missed in their youth was compensated by a child of their own. One of the girls said:

> I wanted something for myself. I knew my mother would get mad. She would look differently at me; she didn't have any attention for me. Maybe a child would change things.

This desire for warmth and stability also played a role in the decision to keep the child, instead of choosing an abortion.

The second pattern is a lack of effective sex education, both in school and at home. At home, talking about sexuality was not an issue. Although most of the girls received sex education in school, the information they got was limited to the methods of contraception. The focus was on the prevention of STD's and HIV. Emotions, wishes and boundaries, social skills to communicate with their sex partner about contraceptives, and the consequences of having a baby at a young age were not discussed (Silva 2002). One of the girls put it as follows:

> The message was that you had to do it safely. Everybody knows that! The bottom line is that love makes you blind. They have to make clear that you should talk; they have to teach you how to discuss things. A lot of boys and girls do not dare, they are ashamed.

In addition, many girls were prejudiced or had misunderstandings about contraceptives ('too many hormones ….'). On the other hand, they were all convinced that they knew enough about sex. In general, sex education was not tailored to the specific situation of the girls. Sometimes they were too young when they got information, and in other cases they already had their first sexual contact when they received sex education:

> I only received information after I had lost my virginity.

> I understood, but I was only 13, so at that moment it was not relevant for me. And if you do need it, you have forgotten all about it.

The third pattern, which is partly associated with the previous, has to do with traditional attitudes about sex roles. Despite decades of feminism and sex education, a lot of girls still subordinate their own wishes and desires to that of their partner. They do not have sex out of pleasure or lust, but because their boyfriend wants to, because all their friends already did 'it,' or for some other reason beyond themselves. To cite a few of them:

> I was not in love, but I liked him. He didn't ask anything, he just did. Afterward I felt dirty.

> I liked it, and afterwards I was relieved it wasn't as painful as I thought it would be.

The risk of getting pregnant is higher among girls from immigrant backgrounds. The results of the above mentioned study were for a large part confirmed in a second study among girls whose parents originate from Surinam, the Dutch Antilles, Africa, and China (Wijsen and Van Lee 2006). The same patterns were found, such as an ambivalent wish for a child in combination with unclear perspectives concerning the future, and a lack of support regarding sexual development and sex education. However, there were also some complementary aspects, which make these girls more vulnerable. The first is that motherhood has a high status in the backgrounds of these girls, and childbearing is an important part of their female identity. The mothers of these girls were often pregnant in their teens too. In addition, in some cultures fatherhood is associated with machismo: A man gets respect by dominating women and procreating. The choice for using contraceptives or terminating an unintended pregnancy is less self-evident.

> My mum was also a young mother, but she was above 15 years old, 17 or 18. She said she wanted a grandchild before she is old.

> My boyfriend wanted a baby, but I didn't. But I changed my mind and we didn't use condoms any longer.

Secondly, living in two cultures with sometimes contradictory messages about sexuality makes sexual development more complicated, especially when sex education is not adequate. At home, sexuality is often taboo, while in the outside world these teenagers are confronted with an open-minded attitude toward sex and very explicit expressions of sexuality. Sex education is often not tailored to address these conflicting messages. In addition, some girls simply do not understand the Dutch language good enough to benefit from sex education or to get access to counseling. Finally, in some cultures there exist particular prejudices about contraceptives. For example, in Surinamese and Antillean culture, it is often believed that the pill can cause infertility (Lamur et al. 1990).

Teenage Fathers

There is generally little information about the partner of teenage mothers. It is estimated that about one out of seven teenage mothers also has a teenage partner and that about 3 % of the male partners are in their twenties (Van Agtmaal-Wobma and Latten 2008). The number of adolescent boys that registers as a teenage father is much smaller. In 2003, there were about 450 teenage boys registered as fathers. That is about one tenth of the number of registered teenage mothers. A survey among Dutch youth shows that 1.7 % of the 15–19-year-old boys and 1.4 % of the 20–25-year-old boys say they have been involved in a pregnancy (De Graaf et al. 2005).

Some adolescent mothers are still involved with the biological father of their child. Others, however, have no relationship with the biological father. Some fathers may not want to be involved, but others do. In those cases, it is the adolescent mother who decides about how much and what kind of involvement she allows. For many of these girls, the father does not play any role in the lives of either the mother or the child. Many of them feel upset about the lack of

involvement of the father. These boys do want to have sex, but they do not want to be bothered with the consequences. In other cases, there is some involvement of the father in the form of alimony payments or occasional visits. The role of the father is often part of a power struggle between the adolescent mother and her former boyfriend (Keinemans 2010).

> I am not the only one who gave life to this little person. He has to take responsibility for his actions. But it will happen the way I and my child want it. He has had his chance.

A small qualitative study among teenage dads investigated the perspective of the father. It showed that young parenthood had seldom been a topic of conversation between these boys and their parents. Young fathers have very vague ideas of what the implications of parenthood are. When there are teenage pregnancies in the family, the initial negative response soon turns more supportive. This contributes to ambivalent feelings toward young parenthood. For young fathers, being a teenage parent sometimes seems preferable to the possibility of remaining childless in the long run (Gesell and Van Dijk 2010).

> If you look at it, all my brothers and sisters got children when they were twenty. My mother was nineteen when she became pregnant with my sister. But then, that's considered normal.

For boys, a contributing factor seems that the use of the pill is identified with the prevention of pregnancy and considered strictly the girl's task; whereas the condom is considered the method of choice to prevent STIs and the boy's responsibility. This task division conveniently frees both partners from the difficult task to discuss contraception; a challenge many teenagers do not live up to. Specific factors that contribute to unwanted pregnancy among ethnic minority groups are ineffective support in their environment and a pro-natal cultural background (Gesell and Van Dijk 2010).

Decision About Abortion

If a teenage girl gets pregnant, she has to decide whether or not she wants to keep the baby. In 1984, pregnancy termination legislation was passed. Abortion has been legalized until 24 weeks of pregnancy. Abortion services are widely available, of high quality and financed by the Ministry of Health. Girls under 16 require permission from their parents before undergoing an abortion. If this is not possible, they can be supported by a professional, such as a medical doctor or a social worker. Girls over 16 are allowed to make the decision by themselves. There is an obligatory waiting period of five days before the procedure can be performed, to allow for a change of mind. No costs are involved for a woman undergoing the treatment if she has health insurance.

The choice for abortion is not made lightly. Widespread acceptance of contraception preceded the legalization of induced abortion in the Netherlands. In a struggle for the legalization of abortion that lasted a decade and a half, both proponents and adversaries of legalization stressed that effective contraception is essential. Even proponents of legalized abortions saw these as a last resort method. The Dutch have never felt at ease with abortion. It was defined as the right of the woman, but a right that—as far as possible–should never be exerted (Ketting and Visser 1994). This feeling persists until today.

Although this attitude contributes to more effective contraceptive use, it does not prevent girls who get pregnant from having an abortion. Almost two-thirds of the girls who get pregnant choose to have an abortion. This abortion ratio among adolescents is higher than in other countries. Together with the low pregnancy rate, the high abortion ratio is responsible for a very low rate of adolescents who give birth. From the number of teenagers who get pregnant annually,

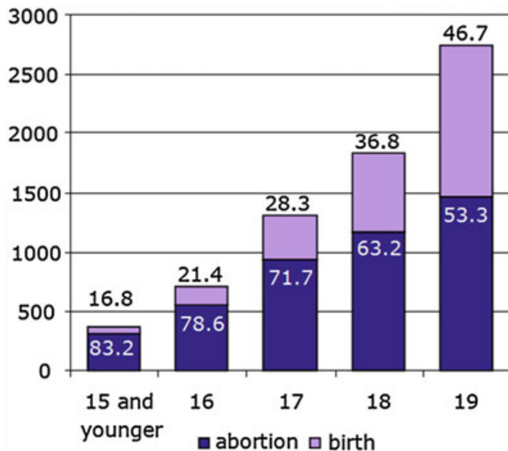


Fig. 3 Numbers and percentage (%) abortion and birth according to age, 2007

Table 4 Estimated abortion rate per 1.000 and abortion ratio (%) for girls aged 15–19 both based on origin, 2008

	Abortion rate	Abortion ratio (%)
Netherlands (native)	4.7	61.3
Surinam	33.0	71.9
Dutch Antilles	47.6	62.4
Turkey	5.9	71.4
Marocco	10.5	78.7

54 % is of Dutch native origin. Non-Western migrant young women get pregnant more often than Dutch women. Ethnic teens also run a greater risk of having an abortion than native Dutch adolescents. Teenage girls from the Dutch Antilles and Surinam run the highest risk: In 2008, 37.6 out of 1,000 Antillean girls and 33.0 out of 1,000 Surinamese adolescents had an abortion. The abortion rate of native Dutch teenagers is 4.7 per 1,000 (Table 4; Kruijer et al. 2009). About 20 % of all teenagers who have an abortion are younger than 17 years old. The older the girls, the more often they choose motherhood (Fig. 3).

For many pregnant adolescents the decision whether or not to keep the baby is relevant. Recently, Christian political parties have promoted adoption as an alternative to abortion, but it is rare that people choose this possibility. Only a minority immediately knows that they want to keep the baby. In many cases, the environment of these girls opts for abortion, at least until a clear decision is made to keep the baby. Particularly the mother of the girl, and sometimes the partner, can be relevant in the decision-making process (Keinemans 2010).

If it is not immediately clear what the pregnant adolescent wants, it appears that she can have several reasons for or against abortion. Some have strong moral objections to abortion. They think of abortion as murder, especially when the abortion has to be carried out in a later stage:

> Abortion would feel as murder, I can't do that. Especially when I saw him at the ultrasound. He was 10 cm already, with a head and little arms and legs. He waved.

Others think of motherhood as their destiny and think abortion would be tempering with that fate. Sometimes guilt plays a role: 'It is my own fault; I am going to take care of it.' Less moral arguments can refer to responsibility. This can both be a reason for having an abortion and a reason for keeping the baby. Many adolescents have more personal considerations as well. As we saw ambiguous feelings about having a child is related to early pregnancy. Therefore, the baby may be wanted and welcome. The mothers can also feel a connection with their unborn child at an early stage. They may also feel that abortion would be an unbearable emotional burden. On the other hand, they may also fear that having a child impedes their opportunities for personal development (Van Berlo et al. 2005; Keinemans 2010).

The decision making about abortion is generally considered the woman's right. Though support of the partner is valued and his opinion often heard, the choice is the mother's. Young fathers generally accept the dominant role of their partner in this process, while they themselves are in a vulnerable position. Fathers want to be part of the decision-making process, but there is a fine line between participation and real influence (Gesell and Van Dijk 2010).

> I think I may have had influence, but I didn't want it to be too much, because I didn't want, well, it's

> not necessary. It's her body. I mean, I am the father, but I'm not telling her, you have to do this. That wouldn't make me feel good.

Negative feelings were associated with being shut out from the decision-making process. On the other hand, taking too much influence could cause feelings of guilt, especially influence toward having an abortion, when the mother finally decides otherwise. Boys would appreciate it if their position received more consideration (Gesell and Van Dijk 2010).

> I would have liked if I had the opportunity to join in the decision, but it was very difficult at the time, because we did not have a relationship. That was tough, but that brought me to working on myself as well.

Professional Support for Adolescent Parents

Professional care and support are an issue that usually does not come up spontaneously during interviews with adolescent mothers. Apparently, this does not play a major role in their lives. Persons from their informal network, such as parents and partners, are considered more important when support is concerned. If this social network functions well, professional support may even be superfluous. However, professional support may be meaningful for young mothers who have a limited social network to depend upon (Keinemans 2010).

Even though professional support is seldom brought up by young mothers themselves, most of them are not averse to support and information. Many of them have actively searched for help. Especially on the internet it is appreciated as a means to seek and find information, as well as social support through network Web sites. Help that is needed includes psychosocial support and support in parenting, but especially practical information considering reintegration in education or employment and financial advice. Trust in professional support is related to prior experiences. Looking for help is seen by some young mothers as a sign of vulnerability. It implies they have a problem and they cannot solve themselves. Independence is valued greatly by these adolescents. If pregnant adolescents or young mothers do have contact with professionals, the support that is given does not always correspond to the girls' needs. For example, health care professionals may define the situation of the girl as more problematic than the girl herself. Subsequent advice may then be inappropriate for her (Keinemans 2010).

Many adolescent fathers in the study of Gesell and Van Dijk (2010) had some form of professional support. This usually had very practical aims, such as housing, debt services, and finishing their education. Some of them had received counseling as well, for example, relationship therapy. Nevertheless, most boys claimed they needed very little support at the time. They mostly were taken along with their partners or were involved with care providers for other reasons. Where counseling concerned contraception, the boys were generally not involved. The care provider addressed mainly the needs and possibilities of the mothers. Therefore, it is not surprising that many of the teenage fathers continued to have unsafe sex after the pregnancy. It is also questionable whether they would have been receptive to advice.

Concluding Remarks

As mentioned before, adolescent pregnancies are a public concern. The prevalence of teenage pregnancies is considered an important indicator of a population's sexual health. Therefore, from the perspective of policy makers, adolescent pregnancies are problematic, even though the number of pregnancies among adolescents is very low in the Netherlands. However, from the perspective of adolescent mothers themselves, their pregnancies sometimes are wanted and their children are welcomed. It is important to keep this in mind, in order to be able to reach out to adolescents and help them, either in preventing pregnancies or in supporting them when they have become pregnant.

Furthermore, continuing efforts to prevent unwanted adolescent pregnancies remain important. There are always new generations of young people in new need of education and services. Lifestyles, attitudes, and needs of new generations change. And, change means making constant adaptations and updates of materials and services necessary. A pragmatic, nonjudgmental approach to teenage sexuality contributes to safer sex and more responsible decision making.

In the Netherlands, special attention is needed for vulnerable groups. The lower educated population of Dutch origin and migrant groups are for instance more at risk of poor reproductive health and more in need of an adequate health care response. Challenges are also provided by changes in the demographic composition of the Dutch population. Effective prevention programs need to be tailored to specific needs, be culturally sensitive, and often need to be delivered through different channels. Among migrant groups, teenage pregnancy and young parenthood sometimes have different connotations due to cultural norms and values. The needs of migrant groups are not met as adequately as those of Dutch origin. For example, interventions do not reach enough young people of migrant backgrounds (Frouws and Hollander 2009). This may be responsible for the disparity between Dutch and migrant groups with regard to adolescent pregnancy.

Reproductive health services, such as the provision of easy access to contraception and safe and accessible abortion, will always be necessary. Not all unwanted pregnancies, however, can be prevented. Furthermore, professional support is needed for those adolescents who choose to keep their babies, but also for the ones who decide to have an abortion. All of these services can hardly be seen as an incentive to get pregnant at a young age. Otherwise adolescent pregnancies would be more common in the Netherlands. Accessible services add to an atmosphere that it is wise to prevent pregnancy, but that nobody is left to his or her own devices if a pregnancy occurs.

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Adolescent Pregnancy in Nicaragua: Trends, Policies, and Practices

Wendy Campbell and Amy Elizabeth Jenkins

Keywords
Nicaragua: abortion • Adolescent pregnancy • Adolescent sexual activity • Barriers to birth control • Child labor laws • HIV/AIDS • Human trafficking • Partner violence • Reproductive health • Sexual and reproductive health

Introduction

Nicaragua is resilient. In the last century alone, the country has been through 20 years of occupation under the US Marines, 40 years of dictatorship, 10 years of a civil war with over 22,000 citizens killed, and over 20 years of democratically elected presidents. In addition, the country has survived a massive earthquake, two major hurricanes, and numerous volcanic eruptions within the second half of the past century alone. With each challenge, the country has persevered and moved forward. This dedication and perseverance is evident regarding social issues as well. Advances that began with the Sandinista Revolution in terms of health care, education, and gender equality have continued to grow. Although the country suffers from poverty and the litany of issues that ensue, the people of Nicaragua are resilient, inquisitive, and passionate about social change. This dedication is evident in the genuine and forthcoming ways in which the country has embraced the challenge of prevention and intervention related to adolescent pregnancy.

Historical Background

From 1936–1979, Nicaragua was under the oppressive rule of the Somoza dictatorship. The divide between the rich and the poor was wide, illiteracy rates were high, and human rights violations were numerous. The Somoza family, however, had the crucial support of the United States, and the last of the series of dictators, Anastasio Somoza Debayle, was even trained at West Point (Somoza 1980). This family regime continued until 1972 when a major earthquake destroyed the capital city of Managua two days before Christmas, killing over 6,000 individuals. International aid flowed into the country, but nearly all of it was diverted by Somoza for his family and friends (Brancati 2007). This corruption signaled the end of the Nicaraguan people's tolerance of the authoritarian rule.

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The Nicaraguan people, under the leadership of the Sandinista National Liberalization Front (Frente Sandinista de Liberalización Nacional-FSLN), mobilized and overthrew Somoza on July 19, 1979. The Sandinistas inherited a country rife with poverty, illiteracy, and disease. Under the leadership of the *Junta of Five,* the Sandinistas worked to restore peace, justice, and human rights to Nicaragua. Illiteracy rates, for example, were reduced from 50 to 13 % in 2 years (Arnove 1981; Hanemann 2005). In 1984, through the first free elections in the history of the country, Daniel Ortega was elected president.

The Sandinista party, however, was a threat to the United States. The party's socialist practices, modeled after and supported by Cuba, led to friction and distrust with the United States during the Cold War era. The USA via ruthless and controversial means funded the Contra opposition, cut foreign aid to Nicaragua, and eventually instituted a full trade embargo. A violent civil war followed in which an estimated 30,000 Nicaraguans were killed. Weary of political unrest and war, the Nicaraguans elected a candidate favored by the US Violeta Chamorro, to the presidency in 1990, thus leading to a new era of more moderate government and improved relations with the United States.

The country maintained relative stability during the 1990s and continued to grow both socially and economically. In 1998, however, another natural disaster, Hurricane Mitch, slammed into the country, destroying 70 % of the country's infrastructure and killing 4,000 individuals. Nearly 10 years later, just as the country had begun to recover, a Category 5 Hurricane Felix hit, destroying 95 % of the infrastructure and 99 % of the crops in the Atlantic region. The economic damage was devastating and led to a spike in inflation and economic despair (NicaNet 2007; World Bank 2009). The subsequent worldwide financial crisis of 2009 has only further limited Nicaragua's economic recovery in terms of growth and development.

Nevertheless, Nicaragua remained resilient in terms of progress in social issues and public health. The Sandinista government expanded the education system into rural areas, established lay health care models, and focused attention on women's rights, which set Nicaragua on a different trajectory from other counties in Central American. Many of the traditional norms in terms of gender roles and family dynamics are not as prominent or adhered to. In this environment, women have taken advantage of opportunities to further their education and make informed decisions on their health care needs. The efforts in the 1980s to increase literacy rates, improve health, and mobilize rural communities continue to have an impact on Nicaragua, including the ways in which the country, as a whole, addresses issues related to sexual health, reproduction, and contraception.

Current Status

Nicaragua has a population of approximately 5.5 million individuals (United Nations [UN] 2011). Over 1 million individuals live in the capital city of Managua. Nicaragua is the second poorest country in the Western Hemisphere. Over 56 % of the population lives below the poverty line with an annual per capita income of $1228 (UN 2011). The country is predominantly rural and depends on agriculture, which makes up 20 % of the GDP, 40 % of the labor force, and 60 % of the country's exports (Arce 2009). Nearly 10 % of the eligible workforce population is unemployed (UN 2011). Of the entire population, 32 % lives at an income under $2 per day (Population Council 2011). Although fertility rates have declined, there is a division between the rates of the wealthiest 20 % of the population (1.8 children) and the poorest 20 % of the population (4.5 children) (Indacochea and Leahy 2009). Nicaragua currently ranks nineteenth in the world in terms of the gap between the wealthiest 10 % of the population and the poorest 10 % of the population with a 31.1 ratio (United Nations Development Programme [UNDP] 2010). Although these data present the realities of social inequality within the country, Nicaragua has a smaller gap between the rich and the poor than most other countries in Central

America with the exception of Belize and Costa Rica (Arriagada 2002; UNDP 2010).

Nicaragua is a predominantly Spanish-speaking country rooted in a mix of Catholic values and indigenous practices. Approximately 90 % of the population speaks Spanish, although in the two autonomous regions of the Atlantic coast, other languages including Creole English, Miskito, and Garifuna are prevalent (Grinevald 2007). An estimated 73 % of the population is identified as Roman Catholic, 15 % are evangelical Christians, and the remainder includes, among others, Jehovah's Witnesses, Moravian, Judaism, and Muslim (United Nations Statistics Division [UN Data] 2010). The percentage of people identified as Roman Catholic has steadily declined over the past 20 years, and this trend is estimated to continue in the future. There is a distinct difference between the Atlantic region and the rest of Nicaragua. In the two Atlantic regions, culture is rooted in communities such as Miskito, Garifuna, and Afro-Caribbean. The majority of the population in these regions speaks an indigenous language or Creole English and practices the Moravian faith (UN Data 2010). These differences between the east and west coast are significant when analyzing sexual health and reproduction practices and policies countrywide. The eclectic mix of cultures means that health care and human service workers must design pregnancy prevention programs that are region-specific.

Economic Development

The Central American Free Trade Agreement (CAFTA) and other similar policies have had an impact on modernization and economic growth in Nicaragua. Nicaragua has traditionally been a rural area, but current trend indicates that the urban sector is growing more rapidly than the rural sector. Part of this growth is, in part, due to Nicaragua's membership into CAFTA in 2005. Nicaragua is one of the many Central American countries that signed a free trade agreement with the United States during the past 10 years. This policy, similar to the North American Free Trade Agreement (NAFTA), removes restrictions on trade, making it easier for companies from the USA to relocate to Central America. CAFTA has not been an entirely positive step for Nicaragua. Although the policy has created jobs, the agreement has undermined agricultural growth. Nicaraguan farmers are unable to compete with subsidized agriculture from the United States and cannot compete with the market of corn, beans, rice, and dairy (Campbell et al. 2010).

The most current data from the United Nations (2011) indicate that over half (56 %) of the population lives in urban areas with Managua as the largest metropolitan center. The population growth of individuals in the urban sector was 1.8 % from 2005 to 2010 as compared to 0.7 % growth in the rural sector for the same time frame (UN 2011). One of the most telling indicators of modernization has been in cell phone use. From 2000 to 2008, the number of subscribers increased from 5.0 to 59.1 % of the population. The number of Internet users has also increased from 1.0 to 3.3% of the population. This is significant in terms of adolescent health because the number of youth accessing online communities has grown. Some of the major adolescent health programs, such as *ProFamilia* (the Nicaraguan branch of International Planned Parenthood), are now online in Websites and even in Facebook pages.

Children and Adolescents

Nicaragua is a young country. Specially, 35 % of the population is under the age of 14 and 20 % is between the ages of 15 and 24. The under-five mortality rate has decreased from 68 % in 1990 to 26 % in 2009 (United Nations Children's Fund [UNICEF] 2010). Adolescent ages 10–19 make up 23 % of the population. More adolescent girls than boys are enrolled in secondary school (UNICEF 2010). The life expectancy has increased from 57 in 1970 to 73 in 2009.

Girls are excelling at a higher rate than boys in terms of education and literacy rates. The literacy rate for persons aged 15–24 is 85 % for

men and 89 % for women (UNICEF 2010). Although the enrollment ratio in primary schools is higher for boys than girls, the attendance ratio is higher for females than males in both primary and secondary schools at 77/84 and 35/47, respectively (UNICEF 2010). Enrollment rates are also higher for women than men in higher education (Global Movement for Children 2010). Conversely, more boys than girls are part of the child labor population (UNICEF 2010).

Child Labor

Although child labor laws prohibit children under the age of 14 from being employed, 11 % of all children in Nicaragua are working in child labor (United States Department of Labor [DOL] 2010). Many of the children work in agriculture, harvesting cotton, tobacco, coffee, bananas, and rice. An estimated 4,000–5,000 children work in the streets of Managua as beggars, cleaning windows, or selling goods (United States Department of State [DOS] 2009). The International Labour Office has been working with Nicaragua on several initiatives to reduce child labor in garbage dumps, prostitution rings, and coffee plantations (International Labour Office [ILO] 2007). Education is free and mandated through sixth grade although it is generally not enforced (DOS 2009). Children from backgrounds of poverty are at a greater risk of not attending school and of being forced into child labor.

Human Trafficking and Prostitution

A growing number of Nicaragua children are involved with child prostitution. Many of these girls work along the port cities and the borders of Honduras and Costa Rica. Others stay along the Pan-American Highway, working as prostitutes for truck drivers traveling through Latin America. A survey was conducted by the Ministry of Family to investigate child prostitution in Nicaragua (DOS 2009). The results showed that many of the girls enter into prostitution to help their families pay for food, clothing, and shelter. Others engage in sexual practices to support drug habits. A growing number of children are trafficked and sold into sex slavery. The 2010 Trafficking in Persons Report discussed the issue of women and children being sold into slavery and forced into sex workers in Managua (DOS 2010). Recommendations are for stricter enforcement of human trafficking and more public awareness campaigns to increase prevention.

Health Care

The delivery of health care in Nicaragua, like in many parts of Latin America, is based on a three-tiered approach. For the wealthiest segment of the population, there is private, out-of-pocket medical care. Persons formally employed in the country receive services through the Social Security Institute (INSS). The INSS is funding through mandatory salary contributions on behalf of employees. INSS then contracts with private health firms to provide services to employees and their families in both public and private settings. Finally, the Ministry of Health (Ministerio de Salud-MINSA) provides free, public health care to the rest of the population including the unemployed and persons living in poverty (Angel-Urdinola et al. 2008; World Health Organization 2001).

With the assistance of the World Bank, Nicaragua has embarked on a healthcare reform initiative designed to improve efficient, effective, and sustainable delivery of services to poor and underserved communities. The Modernization and Expansion of Health Services included two phases (Indacochea and Leahy 2009; Regalia and Castro 2007). The first phase focused on improving the management of healthcare via a national organization (MINSA) and local care administered through decentralized, regional operations (Sistemas Locales de Atención Integral en Salud-SILAIS). This system allowed for more regional control and responsibility for health care services. The second phase of this reform has centered on ways to improve access

and delivery of health care to the poor and underserved through free and universal health care. Part of this phase included a cash-transfer incentive program for families in poverty, modeled after a similar program in Mexico (Regalia and Castro 2006). In reality, however, there has been difficulty in funding services at the local level. Consequently, free healthcare is more a goal than a reality.

The Nicaraguan administration, in conjunction with MINSA and SILAIS, is committed to the management and distribution of contraceptives nationwide. One of the responsibilities of MINSA and SILAIS is to monitor the supply and distribution of contraceptives and to provide community-based education on pregnancy prevention. MINSA provides an organized and detailed plan regarding contraceptives and family planning. The guidelines address the responsibilities of both men and women in family planning (MINSA 2008). One of the challenges for Nicaragua is in maintaining a consistent and adequate supply of contraceptives. There have been times when local health clinics have either been overstocked or have run out of certain methods of prevention. MINSA has been working to better coordinate supplies and maintain updated inventories, especially in poor, rural, and remote areas.

The government has been consistent in its willingness to address the issue of contraceptives and family planning. In 2003, the Contraceptive Security Committee (Comité de Disponibilidad Asegurada de Insumos Anticonceptivos-DAIA) was formed. It is a public/private partnership of organizations committed to family planning. Its focus was to better coordinate and streamline services (Betancourt 2007). The government partnered with USAID in a plan where they would assume 25 % of the cost of providing contraceptives in 2008, 60 % in 2009, and 100 % in 2010 (Deliver 2007). In 2008, the government allotted 40 % of the funding for condoms, IUDs, injections, and oral contraception. One of the strengths of this provision of contraceptives has also been one of the country's greatest challenges. The national campaign, nevertheless, was successful in increasing family planning with an emphasis on injections, IUDs, and condoms. Local health clinics were consistent in promoting these forms of protection, and women, especially, took advantage of this initiative. As a result, MINSA has had to contend with an increased demand for Depo-Provera, oversupply of condoms (men's reluctance and/or interest in condoms continues), and the reality that there is no manufacturing of contraceptives nationwide (Indacochea and Leahy 2009). With difficult economic times, the country now struggles with how to maintain a steady supply of contraceptives and how to keep the momentum for family planning alive.

There are several international partnerships committed to reproductive health in Nicaragua. The United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) have historically been the primary funders of contraceptives. USAID's donations, however, in the form of condoms, DepoProvera, and oral contraceptives, have been phased out over the years with the understanding that the Nicaraguan government will take over the financing of contraceptives (Deliver 2007). The current economic situation, however, has made financing difficult, and other international agencies through Finland, Spain, the European Union, the United Nations Children's Fund, UNFPA, and the World Bank have been instrumental in providing contraceptives (Indacochea and Leahy 2009). Private NGOs such as ProFamilia (the Nicaraguan branch of the International Planned Parenthood Federation), PanAmerican Social Marketing Organization, and NicaSalud have also been involved in the distribution of information and services related to family planning (Indacochea and Leahy 2009). Finally, Cuba and Venezuela have worked in solidarity with Nicaragua on health care issues. Cuba's assistance has been in the form of medical training and provisions in rural areas. Venezuela, through reduced costs of oil, mandates that the savings be applied by the Nicaraguan government to health care and medications.

Health and sanitation conditions have improved countrywide. In 2008, 98 % of the urban areas and 68 % of the rural areas had improved drinking water facilities (UNICEF 2010). Sanitation in both urban and rural areas has improved as well. In terms of prevention, most infants under the age of 1 year have been immunized against tuberculosis (98 %), DPT (98 %), polio (99 %), measles (99 %), hepatitis B (98 %), and tetanus (80 %). There is a decline, however, in medical treatment of children under 5 years of age for diarrhea (49 % receiving oral rehydration) and pneumonia (58 %) and limited provisions of anti-malarial drugs (UNICEF 2010).

Adolescents and Sexual Activity

It is not uncommon for adolescents in developing countries with high fertility rates to become pregnant and/or marry at an early age. There are over 14 million births to adolescents worldwide, and the majority of these births occur in impoverished nations (Bearinger et al. 2007; Westoff 2003). In Latin America, between 13–25 % of all adolescent girls are pregnant or mothers (Reynolds et al. 2006). Some of the reasons for high rates of adolescent pregnancies in developing nations include lack of information about birth control, unavailable and/or limited access to contraceptives, and cultural factors. Religion, especially in nations that are predominantly Roman Catholic, plays a role as well although the past decade has seen an increase in acceptance of birth control, regardless of religion. In Latin America, for example, the machismo culture reinforces manliness through the number of children and number of partners a man has (Sternberg 2000). A man's virility is often determined by the number of his partners and offspring. This culture puts pressure on boys to become sexually active at a young age.

Adolescent Pregnancy in Developing Countries

Worldwide, there are serious medical risks involved with having children at a young age. Teenage girls who become pregnant are at a 2–4 times greater risk of death than women who give birth over the age of 20 (Reynolds et al. 2006). Children born to these mothers are at a higher risk of being at low birth weights and/or infant mortality. Infants born to teenage mothers are 35 % more likely to die before the age of one and 26 % more likely to die before the age of five (Bicego and Ahmad 1996). Poverty, cultural factors promoting early marriages, distance to health care facilities, and inadequate healthcare all contribute to increased health risks for adolescent mothers and their children (McCarthy and Maine 1992).

One of the major preventative factors in terms of maternal and infant health is access and quality of health care services. Women in developing countries with good health services are more likely to suffer fewer complications in pregnancy, labor, and delivery (Bicego and Ahmad 1996; Reynolds et al. 2006). As well, babies born with higher birth weights are less likely to die in infancy. Mothers are less likely to contract parasitic malarial infections and other diseases that may harm both mother and child. Access to quality health care also insures better delivery services and, if needed, emergency care (Reynolds et al. 2006).

Another issue related to health care and adolescents is the willingness to seek medical attention. Adolescents under the age of 18 are less likely to obtain prenatal care than mothers between the ages of 18–34 (Reynolds et al. 2006). These mothers are also less likely to access quality delivery services, thus compounding risks for safe deliveries. The health risks continue after delivery as children born to mothers under the age of 20 were less likely to receive necessary immunizations, regardless of

availability of services (Reynolds et al. 2006). Poverty is strongly related with maternal and child health as well. Pregnant girls in high-poverty environments are less likely to access prenatal, delivery, and immunization services (Reynolds et al. 2006). Poverty is a predictor of teenage girls' low access of health services.

Adolescent Pregnancy in Nicaragua

The percentage of adolescent pregnancies in Nicaragua is the highest of all countries in Latin America. The average age of the onset of sexual intercourse is 17.8 years for girls (Meuwissen et al. 2006b, c). Among girls aged 15–19, 22 % are either married or in a partnership. Of women aged 20–24, 28 % had given birth before the age of 18 (UNICEF 2010). There are 119 births annually per 1,000 women aged 15–19 (Meuwissen et al. 2006a, d). Almost half of women under the age of 20 in Nicaragua give birth, and 25 % of all births in the country are to women under the age of 20 (Lion et al. 2009). While the fertility rates of women as a whole in Nicaragua have dropped 26 % from 1990 to 2005, the rates for women aged 15–19 have only dropped 11 % (Lion et al. 2009). The latest Demographic and Health Survey of Nicaragua also showed a slight increase in the number of teenage pregnancies from 17.9 % in 2001 to 19.6 % in 2008 (Instituto Nacional de Desarollo de Información [INDIE] 2006). Furthermore, more than half of all mothers aged 20–24 gave birth to their first child under the age of 20 (Rani et al. 2003). The rate of unplanned teenage pregnancy is also increasing (Instituto Centro-americano de Salud 2007).

Adolescent pregnancy and health care services follow the typical patterns in the developing world. Adolescent pregnancy in Nicaragua is inversely related to access of prenatal care. Women who gave birth under the age of 18 are less likely to take advantage of prenatal services than older women. These women are also less likely to take their children for rounds of immunizations (Reynolds et al. 2006). This reality points to the need for systematic education and program development that targets the maternal and child health of adolescents and their offspring.

Adolescent Pregnancy and Risk Factors

Adolescent pregnancy is correlated with low educational levels and high levels of poverty. Some of the risk factors associated with teenage pregnancy in Nicaragua are low self-esteem, high levels of poverty, and increased chance of dropping out of school (Samandari and Spencer 2010). With adolescent pregnancy comes an increased danger of being ostracized and banished from close family connections at the very time when those connections are most needed. While boys are encouraged to become sexually active at a young age and to fulfill some of the preconceived notions of "machismo," women have traditionally been expected to refrain from engaging in premarital sex (Pittman et al. 2010; Sternberg 2000). These expectations, however, do not come with accompanying discussions with adolescent girls about reproductive health. A common belief in families is that talking about sexuality will encourage adolescents to experiment, and therefore, it is better to not engage teenage girls in conversations about reproduction (Pittman et al. 2010).

Socioeconomic Status

Socioeconomic status plays a significant role in the likelihood that adolescent girls will become pregnant. Studies show that girls from educated, middle- and upper-class families were less likely to have engaged in sexual intercourse at a young age or given birth (Samandari and Speizer 2010). Furthermore, there is a high correlation between socioeconomic status, educational level, and living in an urban area with using contraceptives and being in a stable, consensual relationship (Samandari and Speizer 2010). Adolescents with higher educational levels and career aspirations are more likely to defer marriage and parenting until later on in life. In addition, girls living in

urban areas have more frequent and easier access to contraceptives. These adolescents are also more likely to use a modern method of contraception such as oral contraceptives, injections, and/or condoms rather than relying on natural methods (Samandari and Speizer 2010). Finally, girls from wealthier families in urban areas are more likely to delay marriage and/or consensual unions until after completion of higher education and career goals (Samandari and Speizer 2010). There is definitely a shift going on in Nicaraguan culture around gender roles and expectations.

Sexually Transmitted Illnesses and HIV

Sexually transmitted illnesses and HIV prevalent among adolescents are related to education and socioeconomic status as well. Much of the population is at risk of these diseases because of low use of contraceptives and other methods of birth control (Berglund et al. 1997). The majority of teenagers report having an understanding and awareness of contraceptives but are not informed on best practices and the strengths and limitations of each form of protection. Furthermore, men report feeling as if their machismo is compromised when using condoms and prefer that the woman use pills or other forms of contraceptives rather than condoms (Manji et al. 2007). These beliefs regarding condom usage put young men and women at a high risk for catching sexually transmitted infections and the HIV virus (Manji et al. 2007). Women are also at high risk of cervical cancer, ovarian cancer, and complications from pregnancies.

Prenatal Care

Only a fraction of adolescent girls receive prenatal care, and the care is directly proportional to proximity to advanced health care settings and individuals trained in childbirth and OBGYN practices. Adolescent women are less likely to visit a health clinic and are less likely to receive prenatal services throughout their pregnancy (Lion et al. 2009). These services are directly proportional to proximity to urban areas. The closer a woman is to an urban area, the more likely it is that she will receive prenatal services. In rural areas, adolescent girls are less likely to seek medical care during pregnancy. Human Rights Watch has stated that 40 % of all maternal deaths in rural areas of Nicaragua are to girls under the age of 19 (Silva 2010). There is concern that the divide between urban and rural areas in terms of health care is widening and that women in remote areas are at a greater risk of not receiving necessary prenatal and emergent care.

Cycle of Adolescent Pregnancy

There are risks in terms of the cycle of adolescent pregnancy. Mothers who give birth under the age of 15 are more likely to have their own daughters give birth as teenagers (Berguland et al. 1997). This is especially true with women from Latin American (Rowlands 2010; Lau and Flores 2010). This reality has much to do with socioeconomic factors that are passed down from generation to generation. Low self-esteem becomes a compounding factor as well. Young girls growing up in poverty with little hope of socioeconomic advancement are more likely to fear abandonment and isolation that then challenges associated with teenage pregnancy (Berguland et al. 1997). Mothers who first become pregnant as adolescents are also likely to have more children overall than mothers who delay the onset of their first pregnancy.

Barriers to Birth Control

The percentage of women using birth control in Nicaragua has steadily increased. Currently, 75 % of women aged 15–49 use some form of birth control (INDIE 2006). Historically, there was a belief that religious practices associated with the Roman Catholic faith were the primary reasons for women's resistance to birth control.

During the past 20 years, however, the percentage of individuals identified as Roman Catholic have declined, but the percentage of females consistently using birth control has not increased at the same rate. The reality is that in Nicaragua, there are other factors besides religion that have a significant impact on the willingness and ability of women to use contraceptives.

Education and Information

One of the key factors in terms of use of contraceptives is information and education. Most men and women have an understanding of birth control, but their knowledge is confounded by myths and misinformation. There is no consistent and mandated education on reproduction in the school systems, and many girls find out about sexual health via friends and family (Meuwissen et al. 2006a, d). This leads to disparities in the content and consistency of information regarding reproduction and sexual health. Women in rural areas, for example, are more likely to forego contraception altogether (Zelaya et al. 1996). Women of low socioeconomic status in rural areas had a rate of contraceptive use of 69 % as compared with 93 % of women in urban areas (Zelaya et al. 1996). In one remote area of Matagalpa, for example, women of childbearing age indicated that they knew about birth control pills but were afraid to use them in fear of contracting cancer. Myths and misinformation, however, are not just limited to non-professionals. Doctors, for example, have been reported to recommend the rhythm method, warned women about the dangers of birth control pills, and suggested that condom use was not effective and potentially cancerous (Meuwissen et al. 2006a, d).

Gender Issues

Some women choose to practice birth control methods that do not involve their partners in the decision-making process. This may be due to the fact that there is still a sense of machismo throughout the country in which men do not see the value or necessity of engaging in protection. As part of this culture is the belief that a man proves his virility and manliness by fathering multiple children (Lion et al. 2009). There is no corresponding expectation that men will be financially or socially responsible for these children, and there is an increase in consensual partnerships which provide no legal protection in terms of responsibilities of fathers. The burden of protection therefore falls on the women. In a study in León, the most prevalent form of birth control in women aged 15–49 was sterilization (39 %), followed by intrauterine device (16 %) and birth control pills (13 %) (Zelaya et al. 1996). Men in urban areas (78 %) were more likely to engage in the decision-making process regarding birth control than men in rural areas (57 %) with the most prevalent forms of contraception being sterilization, oral contraceptives, condoms, and IUDs (Zelaya et al. 1996). Men of higher socioeconomic status are also more likely to use condoms than men from backgrounds of poverty (Zelaya et al. 1996). Most men and women report dislike of birth control methods as the main reason for not consistently engaging in prevention.

Sex education and teenage pregnancy prevention programs are minimal as well. The Ministry of Health (MINSA) recognizes adolescent pregnancy as a significant factor in Nicaragua, but there are no consistent and integrated plans to address the issue nationwide. There is no reproductive health program in the school system nor is there any national plan to raise awareness on ways to prevent teenage pregnancy. Surprisingly, however, 70 % of all sexually active women between the ages 15–24 reported using contraceptives at least once (Lion et al. 2009).

Methods of Birth Control

Adolescents in Nicaragua are engaging and experimenting with sexual practices. Data analysis of the 2001 Nicaragua Demographic and

Health Survey results showed 35 % of girls aged 15–19 had at least one experience with sexual intercourse. The most common age of first sexual intercourse was 15 years. The average age of first sexual activity was 18.9 years, and the average age of first birth was 19.6 years, showing that the amount of time between sexual debut and pregnancy was limited (Lion et al. 2009). Early age of first sexual experience was a strong predictor of early age of first pregnancy. These results confirm data on the limited use of contraceptives among adolescents. Of the sexually active respondents, more lived in rural areas than urban areas and had not attended secondary school (Lion et al. 2009). Most of the adolescent women knew about contraceptives (96 %), but only a handful of the respondents were aware of their own reproductive cycle and health (Lion et al. 2009). Only 66 % of all respondents aged 15–19 had used a modern form of birth control, and less than half were currently using contraceptives. The most preferred method was DepoProvera. Only 1.9 % of adolescents used condoms, which is problematic in terms of the rise of STIs and HIV in Nicaragua (ENDESA 2006). The majority of young women who did not want to get pregnant but were not using contraception justified their behavior based on the fact that they were not cohabiting or involved in a serious union and/or did not have frequent sex (Lion et al. 2009). The results suggest that young women in marriage or domestic unions were more likely to practice family planning and delay the onset of their first child.

There are also distinct differences between adolescents in rural and urban areas. Girls in urban areas were more likely to have engaged in sex at an earlier age and entered into a first union (Samarandi and Speizer 2010). This may be explained by less traditional values and more sexual experimentation among women in metropolitan areas. The results, however, may be skewed by underreporting of sexual behavior among adolescents in rural areas. Women in urban areas were more likely to practice family planning methods than women in rural areas (Lion et al. 2009). The most recent National Demographic and Health Survey found that 31.4 % of adolescents in rural areas were either pregnant or mothers as compared with only 20.1 % in urban areas (INDIE 2006). This may be due to the prevalence of information and resources in urban areas that make it easier for adolescents to gain access to modern forms of contraception.

Birth control methods among Nicaraguan women are sporadic and inconsistent. Approximately 75 % of the population aged 15–49 report using birth control although there are disparities between urban and rural areas. The most common form of contraception is sterilization (25 %) followed by injections (23 %), and only 4 % of the population relies on condoms (INDIE 2006). The segment of the population least likely to use protection is that of adolescents aged 15–19, with only 61 % relying on birth control (INDIE 2006). Results from the 2001 Nicaragua Demographic and Health Survey indicated that only 3 % of women between the ages of 15–49 reported using condoms (WHO 2008). In 2001, the Instituto Nacional de Estadísticas y Census (INEC) and Ministerio de Salud (MINSA) reported a slightly higher rate of 7 % among females aged 15–19. This same study found that only 47 % of sexually active female adolescents used a birth control method other than condoms (Instituto Nacional de Estadísticas y Census [INEC] and MINSA 2002). These results present a significant problem as adolescents, in general, are more likely to engage in sporadic sex with multiple partners and are less likely to use continuous birth control methods such as oral contraceptives or injections (Lion et al. 2009). The issue is even more pronounced in rural areas where adolescents do not have continuous access to birth control methods. Because of this fact, teenagers may rely on natural reproductive cycles. Women are aware of contraceptives but are inconsistent in their use of these methods, thus leading to high rates of adolescent fertility.

Violence and Partner Violence

Another area of concern when exploring the issue of adolescents and reproduction is violence. Violence against women is, according to the Universal Declaration of Human Rights, a human rights issue. Partner violence is higher among pregnant women and increases risk of miscarriage, preterm delivery, and infant mortality (Valladeres et al. 2005). In Nicaragua, partner violence is high and often associated with pregnancy. Between the years 2005 and 2007, some 1,247 girls and women reported being victims of rape or incest (Amnesty International 2010). Of these cases, 198 ended up pregnant. Of these, 172 were girls between the ages of 10–17 (Amnesty International 2010).

The World Health Organization has designed a Multi-Country Study on Women's Health and Life Events which includes items on emotional, physical, and sexual violence (García-Moreno et al. 2005). A secondary data analysis of the study reported that 32 % of respondents suffered from violence during pregnancy, and 17 % of those experiencing abuse had suffered it from a combination of emotional, physical, and sexual abuse (Valladeres et al. 2005). Of the respondents reporting violence, 26 % had never experienced violence before pregnancy. Those who had experienced violence in their past reported more frequent and intense violence during the pregnancy. This shows that pregnancy itself is a risk factor in terms of partner violence (Valladeres et al. 2008).

Younger women report more violence during pregnancy than older women in Nicaragua. Women who were abused were also less likely to have a planned pregnancy (Valladeres et al. 2005). This is significant when exploring the use of contraceptives among adolescents and rates of teenage pregnancies. Both unwanted pregnancies and young age are associated with violence among pregnant adolescents. The perpetrators were often jealous, angry over refusal to engage in sexual practices, or blamed partner disobedience for the reasons that they initiated violence. Alcohol and substance abuse were also leading factors of violence (Valladeres et al. 2005).

Violence also has an impact on maternal and child health. Pregnant women who were abused were less likely to seek prenatal health care. Pregnant women suffer from severe forms of violence including punches and kicks in the abdomen. Over 60 % of all respondents who were abused reported repetitive acts of violence, but only 14 % actually sought medical attention for the damage. Consequences of not seeking medical care included internal bleeding and spontaneous abortion (Valladeres et al. 2005). These reports are consistent with reports in other similar countries in Latin America.

Many incidents of violence are unreported in Nicaragua. The culture in Nicaragua is based on the value that families deal with issues internally rather than involving outside law enforcement. Most pregnant women who experienced violence did not contact the police, and over 45 % of respondents had never reported the abuse to anyone (including parents). The majority of respondents (80 %) also reported that family problems, including violence, should be kept within the family, and 45 % stated that even in cases of violence, outsiders should not interfere (Valladeres et al. 2005). Some women who are victims also report that the man is justified in committing violent acts if the woman is unfaithful or disobedient. These responses speak to the distinct traditional and cultural values surrounding gender and power.

Abortion

Associated with violence is the controversy over termination of pregnancies. Nicaragua has one of the strictest abortion laws in the world with a total ban on abortion. Only 3 % of the countries in the world have similar policies (Amnesty International 2010). Until 2006, abortion was legal in Nicaragua when the health and life of the mother was in danger. The decision to carry through with an abortion was made through a panel of four medical professionals who could speak about the health and safety of the mother. In 2006, however, the National Assembly of Nicaragua enacted and the president signed a

total ban of abortion in Nicaragua, including a repeal of Article 165 of the Penal Code which had allowed for therapeutic abortion (Asamblea Nacional de la República de Nicaragua 2006). This ban includes any form of medical attention to pregnant girls and women that may endanger the life of the fetus, including treatment for cancer, HIV/AIDS, malaria, or cardiac emergencies. The law also makes no distinction between abortion and miscarriage, thus potentially violating the human rights of women who experience a miscarriage through no fault of their own. Finally, the law criminalizes medical practitioners who provide any treatment to pregnant females that endanger the life of the unborn child.

The repeal of Article 165 was enacted despite opposition from Nicaragua's Ministry of Health which advocated upholding the legality of "therapeutic abortions" in the specific events when the life of the mother was in danger. Repeal of this law has affected a number of girls and women who became pregnant due to rape or incest. In a recent case, a 10 week pregnant mother, age 27, who suffered from cancer that had spread to her breasts, lungs, and brain was denied chemotherapy because the treatment might harm the unborn child (Carroll 2010). Amnesty International's Executive Deputy Secretary, Karen Gilmore, has also voiced opposition to Nicaragua's new abortion laws, by saying "Nicaragua's ban on therapeutic abortion is a disgrace. It is a human rights scandal that ridicules medical science and distorts the law into a weapon against the provision of essential medical care to pregnant girls and women" (Amnesty International 2010). Since the total ban on abortion was enacted, maternal deaths have increased. There has also been an increase in pregnant teenagers committing suicide (Maloney 2009).

Pregnancy and Childbirth

Pregnancy can be a serious and sometimes fatal situation for adolescents. Pregnancy and childbirth are the leading causes of death among girls aged 15–19 in developing countries (Reynolds et al. 2006). The reasons for this include poor maternal and child health care practices. Young women from developing countries are less likely to know about reproductive health and prenatal care than older women from developed nations. Younger women are also less likely to access child health and immunizations services. The risk of death is 2–4 times as high for pregnant mothers under the age of 18 as compared to women aged 20 and older. Furthermore, the risk of infant mortality of babies born to mothers under the age of 20 is 34 % higher due to low birth weight. Children under the age of five born to an adolescent mother have a 26 % higher risk of death (Reynolds et al. 2006).

Adolescents who are pregnant are more likely to be from poor, rural, and traditional backgrounds. This applies to Nicaragua as well and leads to inconsistencies in terms of reproductive health care. The World Health Organization defines prenatal care as the experience of seeing a skilled healthcare provider at least once during a pregnancy (Reynolds et al. 2006). Prenatal care is significant in which health care professionals can detect women at high risk for medical complications and provide the intervention needed to increase high-quality maternal and child health. In Nicaragua, pregnant adolescents under the age of 18 were less likely to take advantage of prenatal care than older adolescents (Reynolds et al. 2006). This may, in part, be due to socioeconomic factors that limit access to prenatal care. Pregnant teenagers may also be less informed about the importance of prenatal care and the options available to them. Finally, there is the issue of stigma attached to being young, pregnant, and unmarried. For women in traditional communities, this stigma may deter desire to seek prenatal care.

The health risks continue to be a factor after delivery. Data show that children born to teenage mothers are at a greater risk of health issues. One of the greatest concerns is childhood immunizations. Although Nicaragua, through the Ministry of Health, has a nationwide and systematic immunization plan, children from young mothers are at a greater risk of not being immunized. Most teenage mothers followed through with the

first round of immunizations but were less likely to follow through with subsequent preventative vaccinations. Children born to young mothers were less likely to have received immunizations for measles and the third DPT. Some of the reasons for this include teenage mothers' lack of understanding and awareness of the benefits of immunizations and the necessity to follow through with those vaccines that are part of a long-term series. Other reasons include the inability of women in rural areas to follow through with immunizations due to the difficulties and high costs associated with transportation. Finally, the social status and limited decision-making power of teenage girls deter them from making informed choices regarding their health and the health of their children. These decisions may be left to older female relatives, thus diluting the self determination of adolescent mothers. Children born to adolescent mothers are at an increased risk of developing illnesses and disease. Education and access to resources are both needed to reduce this disparity.

Policy and Reproductive Health Care in Nicaragua

Conservative and Religious Backlash

Policies and programs designed to promote gender rights and equality in Nicaragua were successful and prevalent until 2006. Until 2011, Nicaragua had a progressive approach to sexual and reproductive health, which was favorable to reducing teenage pregnancies and promoting family planning. The trend turned with the National Assembly repealing Article 165 of the Penal Code, thus effectively banning all forms of abortion, including those in which the life of the mother is in danger. In 2008, the climate for programs promoting sexual and reproductive health of women became more unfavorable due to contentious municipal elections in which the Sandinistas won despite protests of fraud and corruption from women's organizations and NGOs. The result has been a decline in international aid and support for Nicaragua for those most in need of health care services.

The decline in health care services for women has been coupled with an increase in the government's alliance with the Roman Catholic Church. As early as 2003, the church condemned the Manual on Sexual Education which was hence censored by the Nicaragua government (Bendaña et al. 2003). The church has backed the total ban on abortion and even pushed back against programs designed to promote family planning. In 2008, two clinics run by ProFamilia, the Nicaraguan partner organization of the International Planned Pregnancy Federation, were shut down in the interior of the country.

Government Initiatives

Despite the controversy surrounding the 2008 elections and subsequent withdrawal of support from NGOs, Nicaragua continues to be committed to family planning. The National Development Plan of 2005 includes provisions for increasing family planning services and reduction in teenage pregnancies among married couples (Indacochea and Leahy 2009). In addition, the National Health Plan for 2004–2015 calls for a complete end to the unmet need of contraceptives, thus solidifying support for family planning. The 2008 Short-Term Institutional Plan Aimed at Results targets the health of women, children, and individual autonomous regions of Nicaragua. This plan calls for programs to increase family planning services for women of fertile age with a high priority on adolescents (Indacochea and Leahy 2009). The priority is on family planning, prenatal care, delivery services, and postnatal care.

International and Non-governmental Organizations

There are other programs designed to provide prevention and intervention in reproductive health. Project resource mobilization and

awareness (Project RMA) has partnered with Population Action International, the German Foundation for World Population, and the International Planned Parenthood Federation to increase "tangible financial and political commitment to sustainable reproductive health supplies through international coordination and support of national advocacy strategy development and implementation in developing countries" (Idanocochea and Leahy 2009). Project RMA works closely with Nicaragua to coordinate and supply contraceptives and to integrate national policies which provide for sustainable funding for contraceptives and family planning.

National Plan on Sexual and Reproductive Health

One important document in examining the development of future policies and programs related to adolescent health is the 2008 National Plan on Sexual and Reproductive Health (MINSA 2008). This plan, developed by the Nicaraguan Ministry of Health, emphasizes the need for sex education among adolescents (MINSA 2008). This plan calls for improved quality and access to sexual and reproductive education for adolescents. In order to achieve this goal, the health ministry calls for collective responsibility from multiple government agencies including the Ministry of Education, Institute of Social Security, institutions of higher education, and NGOs. The plan calls for the following (MINSA 2008):

1. formal education,
2. informal education,
3. cultural awareness and promotion of contraception,
4. adolescent-friendly health services with attention paid to culture, gender, and generation.

This comprehensive plan demonstrates the willingness of the Nicaraguan government to support programs designed to reduce teenage pregnancy and highlights the priority placed on collaborative efforts of governmental, non-governmental, and international organizations to achieve this goal.

Competitive Voucher Programs and Adolescent Health

There are several health care and prevention programs designed to target high-risk populations in Nicaraguan. Some are funded through the Ministry of Health, and others are conducted in partnership with international organizations. The Central American Health Institute of Nicaragua (ICAS) is one example of a non-governmental organization designed to reduce the number of teenage pregnancies in Nicaragua (Instituto Centroamericano de Salud [ICAS] 2010). The ICAS has received funding from the Ministries of Foreign Affairs of the United Kingdom, the Netherlands, and the United States to establish a competitive voucher program in Nicaragua. This program is designed to empower adolescents to take control of their sexual and reproductive health through free medical consultation.

The voucher program is based on the theory that health care delivery in free markets leads to disparities in treatment. Those with the greatest access to wealth are at greater liberty to pick and choose effective and high-quality health care. Those at the bottom of the socioeconomic scale do not have these same privileges and oftentimes receive medical attention that is limited and is of low quality. These disparities, however, are not just limited to the individual's health and well-being but impact the society at large because unwillingness or inability to access public health care and prevent disease leads to long-term, macro health consequences (for example in the spread of sexually transmitted diseases, HIV/AIDS, unwanted pregnancies, and childhood illnesses). Furthermore, a healthy society is beneficial to a nation, and in particular a developing nation, through productive work forces (Borghi et al. 2003).

Competitive voucher programs have been pilot-tested in several countries and backed by the World Bank as an effective strategy in enhancing health care access and delivery in developing nations. While many of these nations have put into place programs and clinics to address issues related to sexual and reproductive health, the reality is that some countries, because

of social and economic limitations, are not able to provide consistent, high-quality care. The competitive voucher program expands health care options by contracting not only with public entities but also with private and non-governmental clinics. Individuals, and in the case of Nicaragua adolescents, are then given the freedom and autonomy to decide which clinic or agency is right for him or her (Gorter et al. 2003).

The competitive voucher programs in Nicaragua include HIV/AIDS and STI prevention programs, cervical cancer prevention, and promotion of sexual and reproductive health of adolescents. Targeted population includes adolescents between the ages of 12 and 20 in the departments of Managua, Rivas, and Chinandega (Gorter et al. 2003). Vouchers are distributed through the ICAS and 15 other NGOs in the surrounding area. Vouchers have been distributed in neighborhoods, parks, sporting arenas, adolescent clubs, and schools (ICAS 2010). Through the vouchers, teenagers receive free access to medical consultation and follow-up at any of the 20 clinics and agencies contracting with the program. Adolescents can make their own decisions about where to receive health care rather than relying on social and economic mandates. Adolescents participating in the voucher program received sexual health education classes, condoms, counseling, treatment for HIV/STIs, and when needed, prenatal care. The purpose of this voucher program is to increase prevention of HIV, STIs, and unwanted pregnancies and empower adolescents to take charge of their health (Gorter et al. 2003).

In addition to provision of medical treatment, the voucher program established a public awareness campaign in 2004. This campaign is targeted at rural and underserved areas of Nicaragua where adolescents may lack or have misinformation on sexual and reproductive health. This campaign focuses on methods of communication familiar to adolescents such as peer training, entertainment and recreational venues, mass media, life skills, and community action (ICAS 2005). The design of this campaign is based on similar designs in other developing countries.

ICAS has submitted a proposal to expand the voucher program from individual-specific primary care and public awareness campaigns to communitywide initiatives designed to push back against adolescent pregnancy. If funded, this proposal would empower communities to become more active in preventing adolescent pregnancy and providing support for teenage mothers. The concept behind the proposals is that adolescent sexual and reproductive health is not only a micro issue but also a macro issue and that, in a sense, it does take a village to raise and protect a child. Community members will be trained as lay health promoters, and public campaigns will be designed to identify and bolster the role of communities in prevention and care of adolescent pregnancies (ICAS 2005). This proposal also takes into the account the role and responsibility of men for their own sexual health and the subsequent health of the community (ICAS 2005). The community empowerment model is designed to mobilize entire communities in changing norms and expectations related to gender roles, sexual health, and reproduction. The model also focuses on the community's role as a change agent through lobbying, advocacy, and policy design.

Recommendations

One of the most favorable factors in addressing the issue of teenage pregnancy in Nicaragua has been the support of the government. Through policies and programs, the government has been committed to reducing the rate of adolescent pregnancy and increasing family planning as a whole nationwide. The work of the Ministry of Health in terms of promoting sex education and providing contraceptives has been critical for the country as a whole. MINSA's Sexual Health and Reproductive Plan is especially notable in its dedication to increasing access and availability of contraceptives. The plan is also significant in which it targets not only females but males as well and is dedicated to changing cultural and gender attitudes toward contraception. The inclusion of men in this plan is critical to the

long-term success and sustainability of family planning initiatives. Future policies must continue to involve the Ministry of Health and local health clinics administered through SILAIS. These agencies are committed to family planning and have established local health centers which are crucial to the sustainability of health initiatives.

The Nicaraguan government has demonstrated a willingness to work with NGOs and international agencies. This welcoming environment should prove helpful in increasing and expanding programs dedicated to adolescent sexual and reproductive health. Regardless of political party, there has been no indication that Nicaragua will continue to be anything but supportive and welcoming of outsider intervention. One of the challenges of private funding and NGOs is to not duplicate services. This means that international agencies must be willing to work together despite historical and political relationships. The Internet is especially useful in developing international partnerships and collaborative efforts and should be an excellent venue for coordination of services.

The competitive voucher program has had success, especially in the areas of providing free, confidential consultation for adolescents, and in providing training for healthcare professionals on the benefits and limitations of contraceptives. There is evidence that the training is only as successful as the length of the voucher program, and once contractual services ended, health care professionals tended to promoting more traditional forms of birth control such as the natural rhythm method. Other medical providers continue to provide misinformation regarding oral contraceptives, and male doctors are more likely to dissuade adolescents from using condoms. This evidence suggests the need for more training and longer sustainability of the voucher program in order for a more sustained change in cultural attitudes toward contraception from healthcare professionals. In addition, the voucher program has been limited to specific areas of Nicaragua. An expansion of the program to other areas would be beneficial.

One area that has received limited attention and support services is the Atlantic region of Nicaragua. The northern and southern autonomous regions (RAAN and RAAS) are the poorest and most underserved areas in Nicaragua. Transportation to and communication within these regions are limited. Cultural and language differences within the indigenous and English Creole populations may mean that plans that work well on the western side of Nicaragua may not automatically transfer to the eastern seaboard. These two regions have higher rates of people who are living in poverty, unemployed, and illiterate. These areas also have higher rates of teenage pregnancies and lower rates of usage of contraception. Adolescents in RAAN and RAAS are also at a higher risk of drug addictions, STIs, and HIV partly due to drug trade along the coast. Continued and expanded healthcare coverage and support for all individuals, including adolescents, is critical. This should include awareness on the dangers of contracting sexually transmitted infections and HIV.

Conclusion

During the revolutionary period in Nicaragua, one of the many slogans was “Patria Libre o Morir” which essentially meant that those fighting for freedom would never give up—not until death. In many ways, this slogan represents the spirit of Nicaragua in the past, present, and future. The Nicaraguan people are loyal, genuine, and dedicated. Their fighting spirit of the past is evident in their present drive to press forward in current times, despite economic hardship, political unrest, and natural disaster. This energy and hope is manifested as well in the policies within the country designed to provide a better future in terms of social, educational, and health conditions.

The good news for those interested in medical, health, and psychosocial issues is that Nicaragua is a country with a rich history of working toward social change and embracing

external assistance from other countries, NGOs, and individual volunteers. The challenge for those genuinely interested in providing help is to keep in mind that while Nicaragua may be labeled as a "developing nation," the reality is that the country and her citizens are bright and engaged in the world around them. Those working in human services are knowledgeable about the world around them, informed on current public health issues, and highly trained on current medical practices. What the country needs, as evident through the data on resources and provisions, is consistent and sustainable access to health care, health education, and contraceptives.

Policies and programs designed to address adolescent pregnancy in Nicaragua must continue to provide outreach to the largest and fastest growing population in the country—the youth. Strategies must include creative ways to reach teenagers in rural areas, those living in urban poverty, and those living in the remote region along the Atlantic Coast. These methods will need to continue to incorporate lay health workers along with plans on how to bring sustainable aid in the form of contraceptives to remote areas. These efforts must also include programs that address the serious link between drug and alcohol consumption and unwanted pregnancies, and risk of STIs. International development workers should also consider ways to incorporate technology into these efforts. While the digital divide is a reality in Nicaragua, as elsewhere, there are plenty of youth and young adults in the country who are now communicating via cell phones, texting, e-mail, and online social networks. A simple search through the Ministry of Health will demonstrate the wide range of educational materials online. What is encouraging about Nicaragua is that conversations on sexual and reproductive health are not taboo and are openly discussed in many families and communities. Billboards, television, and radio announcements with messages on teenage pregnancy prevention and HIV/AIDS awareness are prevalent. Most health clinics will provide information on family planning. Even the Ministry of Education is committed to designing programs around adolescent reproductive health. Despite a sagging economy and decrease in foreign aid, the country continues to press forward in its quest toward more progressive and proactive solutions to social problems. The Nicaraguan people are most definitely resilient.

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Adolescent Pregnancy in Nigeria

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Keywords
Nigeria: adolescent sexual and reproductive health · Abortion · Child bride · Clitoridectomy (female genital mutilation—FGM) · Female husband · Maternal and infant mortality · Polygamy · Preference for male children · Sexual initiation · Traditional birth attendants · Vesicovaginal fistula

Introduction

Nigeria is unique in many ways. Located on the western coast of Africa, the region in which Nigeria is located has a rich and storied history. Long before the Muslim Kanem civilization moved into what is today Northern Nigeria around 1000 A.C.E., the Nok culture (established between 500 and 2000 B.C.E.) was one of the wealthiest and most sophisticated societies in ancient West Africa. In what is today southwest Nigeria, the Yoruba people (about 1000 A.C.E.) established the Oyo kingdom at Ile-Ife. Because of constant wars among the seven Yoruba states, over time some of them became part of the Benin Empire. The Benin civilization prospered between the 1500s and the 1800s. The Benin people became legendary for their brass, bronze, and ivory artwork and sculptures.

In 1900, Britain declared southern Nigeria a protectorate and established a system of indirect rule. Modern Nigeria was established in 1914 with the amalgamation of the northern and southern protectorates with the British indirect rule system of government. Local customs and traditions were not prohibited; rather the British used these customs to further their own interest.

Nigeria is about twice the size of California. It is the most populous country in Africa with a population of over 150 million. Within the national population, depending on the source, there are between 250 and 300 ethnic groups in Nigeria. This variation in ethnicity has contributed greatly to a Nigerian society that is a complicated mosaic of linguistic, social, and cultural differences. Among the population today, about 30 % identify themselves as Hausa/Fulani, some 20 % are Yoruba, 17 % are Igbo, and the remaining ethnic groups make up 33 % of the population. In terms of major religions, about half the people are Muslims, some 40 %

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are Christian, and the remaining 10 % of people practice an indigenous religion (Gall and Hobby 2007).

The people of Nigeria are young, and about 45 % are 15 years of age or younger, while 57 % are under the age of 24. Education is free and compulsory between the ages of 6 and 15; however, less than 50 % of Nigerian's children attend elementary school. The literacy rate is around 60 %. The two largest cities in Nigeria are Lagos (pop. 10.5 million) and Ibadan (pop. 1.4 million). About 45 % of Nigerians live in an urban area (Gall and Hobby 2007).

The birthrate is estimated to be approximately 42 per 1,000 people. The infant mortality rate is approximately 70 per 1,000 live births. The death rate is 13 per 1,000 people. This results in an annual population increase of 2.9 %. The average life expectancy in 1999 was 52 for males and 54 for females (PRB 2012). Nigeria was an invention of the British colonial administrators. Nigeria's boards were drawn with little consideration given to tribal lands, ancient tribal customs, or cultures.

The most recent changes in the sexual and reproductive lives of adolescent in Nigeria did not occur until the mid-nineteenth century. Over the millennia, adolescent girls in their early teens were considered to be of marriageable age. Much of the sexual customs and sanctions of the native people in this part of Africa was reflected in prescribed ritual behaviors designed to control adolescent female sexual knowledge and activities. Although there were numerous changes in the dominant culture over the centuries, people's sexual lives in the Nigerian region remained fairly constant over the decades. The introduction of Christianity into Nigeria gradually eroded the traditional culture and customs of the local people more so than the British form of governance. It is true that colonialism brought profound changes in customs and culture that eventually effected a change in the legal and socially accepted definition of adolescent marriage and childbearing (Zeilig and Seddon 2009).

Cultural and Traditional Influences: Social Views and Customs in Nigeria

Sexual norms and prohibitions have always been in a state of flux in Nigeria. This is true of all social groups and has been true over the centuries. Not unexpectedly, these vacillating definitions of sexuality were context specific and supported and promoted by the prevailing economic circumstances, political predilection, social norms of the time, and geographic location. This was true of the Nigerian pre-colonial societies as well.

Similar to conventional European society, sexual expression, pregnancy, and childbearing among traditional Nigerian societies were only sanctioned within the institution of marriage. When the wife or the husband was childless or could not have the number of children that the married couple desired, however, there were culturally approved remedies. Among some traditional Nigerian people, one practices to ensure children in most pre-colonial Nigerian cultural (i.e., Akoko Edo, Igbo, and Ibibio societies) was ritualistic *bride-capture*. If the traditional approach to marriage negotiations failed or were prohibited by the potential bride's family or the bride herself, bride-capture could be arranged. A more common tradition that continues to be practiced today is the taking of a child bride.

While adolescent girls were expected to marry during their mid-teens, the girls (but not the boys) were also expected to be a virgin when they married. In most early Nigerian cultures, bride virginity was honored and rewarded. Sexual activity among adolescent girls was only permitted within marriage. Even so, much like adolescent girls in modern society, girls in pre-colonial Nigeria often became sexually active before marriage. In such cases, whether the loss of a girl's virginity was the result of consent or coercion, there were various remedies. In the Edo culture, new wives were expected to confess any and all pre-marital relationships at the ancestral shrine of her husband, also practiced

among the Ikale people in Okitipupa area (Zeilig and Seddon, 2009).

In the Etsako culture, older women were responsible for verifying a new bride's virginity. They would examine the young woman's hymen to make sure that it was intact. The expectation that bridges should confess premarital relationships was also the custom among the Igbo people who lived in what is today southern Nigeria. Tradition required brides to confess any premarital relationships in front of the senior daughters of the village. If the new bride had been sexually active, it was a source of public shame for her and her family. To resolve the wrong, the man responsible for the loss of the bride's virginity would be required to compensate the husband and in some cases the new husband's family. There were also propitiatory rituals where the new bride sought absolution from the gods for her sexual indiscretion. In general, any deviation from the accepted sexual norms of the group was believed to incur the anger of the gods, and as such, society at large. Be that as it may, it was understood that for an unmarried daughter to have a child was an embarrassment for the family; in traditional societies such as the Ibibio, these children were integrated into the mother's family and became known as an *eyeyen,* or a child of the daughters of the land (Ikpe 2004).

Sexual norms and taboos were similar for most groups in this region of Africa even though it was unacceptable for parents to discuss sexual matters with the children, especially their daughters. What was conveyed to children about sexual behavior lacked specificity and was couched in terms of pride of brides in stories that were often confusing and misunderstood. Young girls, for instance, were sexually innocent before initiation into womanhood. As prepubescent girls, they often walked about naked. The young girls were told that "any touch by a man would result in pregnancy" and a man's "touch" had to be avoided until marriage (Ikpe 2004).

Whereas both girls and boys were never educated about sexual matters, they were taught about the attributes and characteristics associated with marriageable men and women as part of the initiation into adulthood. In general, the most marriageable young men had to be brave, industrious, in good health, honest, and freeborn. The most marriageable adolescent girls were industrious, diligent, good cooks, of good behavior (defined as not being sexually active with men outside of marriage), from good families, and possessing a rotund figure which was associated with the ability to bear many children.

These socially prescribed characteristics were beyond many boys and girls. As such, they served as a genetic prophylactic. Although many young people who did not possess all of these socially approved traits did marry, for the most part, people without these characteristics were unable to find a mate and thus were prevented from increasing the number of people in the community with their undesirable traits.

Marriage was a highly developed ritual process among traditional Nigerian people. When an eligible man found a possible wife, negotiations between the two families began. Negotiations could involve labor provided to the father of the potential bride by the suitor or members of his family. It could include gifts, slaves, and implements used in farming and war. Marriage negotiations concluded when the dowry was paid. At the successful conclusion to this formal process, the couple is bestowed with the rights to experience socially sanctioned sexual behavior within their marriage. Along with the rights of marriage, it was and in many cultures today, it is the couple's social responsibility to see that the wife becomes pregnant as soon as possible to demonstrate their ability to procreate. Considering the known health issues associated with adolescent childbearing the threat to the life and health of young adolescent wives would be substantial. One widespread custom that

lessened this considerable threat to a vibrant community was polygamy (Ikpe 2004).

Polygamy

Among most Nigerian cultures that succeeded before colonialism, men could have as many wives as they could afford. In this way, men were able to ensure many children, increase their wealth with their wives' dowry, and increase their household's security by establishing extended relationships with powerful families through marriage. In response to the depletion of the population especially among Ibibio and Igbo groups during the period when Europeans were in the business of buying and selling African slaves, multiple marriages were promoted to increase the number of children per woman. In the twentieth century, the culture promoting high birth rate has been blamed for poverty, unemployment, and the spread of HIV/AIDS (Northrup 1978).

The negative effects of polygamy in pre-colonial Nigeria gave rise to a number of customs that created serious difficulties for young men seeking wives in these communities. Polygamy made it more difficult for a young man to find an eligible bride. In most Nigerian cultures, it took a young man a great many years to acquire the wealth and prestige required to compete for wives with older established men. As a result, most men married brides that were much younger than there were. In fact, even today in the north of Nigeria where under aged adolescent girls can marry under religious law, the adolescent bride will often marry a man who is old enough to be her grandfather. For these adolescent wives, the age difference often becomes an issue of power and control. The adolescent wife is disadvantaged because her husband is her senior in a culture where adolescents are required to defer to their elders. The older husband was more knowledgeable and more experienced in the ways of their world. If the husband had other wives, the adolescent wife would typically be subordinate to older wives (Ikpe 2004).

At times, in pre-colonial societies, polygamy also led to a scarcity of eligible wives. The scarcity of wives, which gave rise to the practice of fetal marriage, is well documented among the Ibibio people, the Esan (Okojie 1994) and among the Uneme (Harunah 2003). Fetal marriage was the practice of a man's family negotiating a marriage between the suitor's family members and the family of an unborn child. When the child was born, if it was a girl, the man and the neonate were considered married. Nonetheless, after birth, the female child lived with her family until she reached the agreed upon age to be "handed over" to her husband (Ikpe 2004).

Bride-Capture

In pre-colonial Nigeria, families used alternatives to traditional marriage to ensure that there were enough children to carry on the family name or to increase the number of children born to women in the family. One of the alternative marriage practices that were socially acceptable in most pre-colonial Nigerian cultures (i.e., Akoko Edo, Igbo, and Ibibio societies) was ritualistic *bride-capture*. If the traditional approach to marriage negotiations failed or were prohibited by the potential bride's family or the bride herself, bride-capture could be arranged. In cases where the family accepts the bride price but the potential bride rejects the suitor, the family might conspire with the man and his family to go forth with a bride-capture. In other cases, if the bride price was too high, the suitor might carry out a bride-capture. In situations where parents did not approve of the suitor but the daughter did, bride-capture could be a solution (Ikpe 2004). It was believed that if a girl was captured and spent a night with her captor, she would be defiled and be unacceptable as a bride to other potential suitors. As might be expected, bride-capture did not always end

peaceful. Family conflicts, economic boycotts and even wars were fought to avenge the suitor and his people.

The Female Husband

Another substitute for the traditional marriage practice in some pre-colonial societies was marriage between two women. This practice was common among the Ibibio, Igbo, Ishan, Edo, Urhobo, and Yoruba people where the bride was unable to have children within a traditional marriage. Although sex between two women was familiar behavior in traditional Nigerian society, it was not the purpose of the custom known as a "female husband." This alternative to traditional marriage was for the purpose of producing children. In situations where a married woman was barren, she had the option of selecting and marrying a younger woman (and thus be known as a "female husband") so that her husband and the new bride could produce children to carry on the family name. During the 1800s, there were a number of Nigerian single women who acquired great wealth trading with the British and in other business endeavors. Because it was unacceptable to have children without being married, it was fairly common for these women to marry other women so that the other woman (the wife) could bear children to inherit their property. The female husband had the right to select the father of her wife's children. The wife in these unions was expected to comply with the female husband's choice. These wives and children of the female husbands worked in the business and provided a family for the female husband (Harunah 2003). A marriage between women is uncommon today even among the most traditional groups because Nigerian law does not recognize marriage between two women.

In other variations to the traditional marriage, among some Ibibio and Igbo groups, when a family did not have a son to carry on the family name, the family could ask one of their daughters to bear children that would be considered her father's child (Amadiume 1986). Among the Ibibio people, a daughter who agreed to bear children (hopefully sons) for her family was called an Ado-ette. In these arrangements, the daughters did not have sex with their fathers. Moreover, these daughters had a great deal of influence in selecting their sexual partner even though it was a family decision often based on desired physical and personality traits. Although, desired traits varied widely among different groups, families often encouraged marriages to specific types of women that would result in the birth of ideal types of children. Tall, well-endowed men and women who were agile of mind and body were preferred by some families, while other families preferred fair complexion (Amadiume 1986).

Adultery

If adultery is defined as an unapproved sexual relationship between a man and woman who are married to other people, in traditional societies in the Nigerian region, adultery was an affront to the spirits, nature, the family, and the husband. Nevertheless, for the purpose of producing children, there were instances where approved adultery was an alternative. In Ibibio society, for example, an *Abia Idiong* (*a* diviner) had the authority to select an *udo idem* (*a sexual* consort) for a childless wife whose husband was infertile. The selected male consort then would have a sex with the husband's wife until she became pregnant. Once pregnant, the relationship was to end. As might be expected, such relationships did not always end peacefully. Despite such problems, this alternative to traditional marriage was a way for the spirits to help infertile husbands, father children (Afigbo 1975).

In the some groups of Igbo, culturally permissible adultery was called *iko*. A man with many wives could permit a younger man to have a sexual relationship with one of his wives. The young man was required to ask permission from the wife's husband. Typically such arrangements

required that the young man offer gifts and a promise to work on the husband's farm.

While there were numerous acceptable alternatives to marriage with the purpose of producing children for the family, adultery without permission from the husband was unacceptable. In the pre-colonial Ibibio culture, the adulterous woman could be sold into slavery. The adulterous man would have to pay compensation to the offended husband and the injured family. In most cultures, adultery was regarded as a sin against the ancestors. Women were warned that the spirit of adultery (*Ekponkaawo*) would claim her life or the lives of her children. As dangerous as the spirit of Ekponkaawo was for women, the spirit did not harm men or their children (Ikpe 2004).

The Clitoridectomy

One of the most notorious customs for Western people to understand or accept, that is still found (albeit rarely) among some ethnic groups in Nigeria (i.e., Ibibio, Efik, Urhobo, Edo, Igbo, and Yoruba) is the clitoridectomy, or the surgical procedure known as female genital circumcision, or female genital mutilation. The clitoridectomy is typically performed on girls who are a few days old or at any time before puberty. These surgeries are described by the World Health Organization as Type I (clitoridectomy), the removal of the clitoral hood, which most often includes the removal of the clitoris; Type II, removal of the clitoris and inner labia; and Type III (infibulation), this includes the extirpation of all or part of the inner and outer labia, the clitoris, and the fusion of the wounds. A small opening is left for urination and the passage of menstrual blood. The small opening in the fused skin cover is enlarged for intercourse and for childbirth (WHO: Media Centre 2012).

To put it frankly, any form of a clitoridectomy is scorned by modern society as being barbaric, discriminates against young women, and because the surgery is dangerous. Various forms of clitoridectomy surgery, however, were performed in Europe and the USA until 1920s. In Britain, the clitoridectomy was performed in large numbers between 1858 and 1866. The medical rationale was that the clitoridectomy could cure female complaints, stop masturbation, reduce the severity of mental disorders in women, and prevent or stop nymphomania (Barker-Benfield 1975).

In modern day Nigeria, most people and ethnic groups reject the practice of female genital circumcision. The procedure has no health advantage or medical protocol. Even so, it is still being practiced among a few Islāmic groups in the north of Nigeria, and among a few traditionalists, most often in rural Nigeria. The Itsekiri people, however, are an exception. Traditions and customs among the Itsekiri people do not permit female circumcision, even when an Itsekiri woman marries a non-Itsekiri man whose own cultural tradition would require female genital circumcision. In addition, the Itsekiri woman would not permit her daughter to be circumcised.

Colonial Influence

When the Portuguese, the first Europeans to venture around the Horn of Africa, arrived in the region that today includes Nigeria in 1434, they set up a trading post on the Benin coast. Relations between the Portuguese and the Benin king started out amiably and trade between the two flourished. Among European merchants who traded in West Africa, the Benin people were viewed as the dominant social and military force in the region. Later, as the slave trade expanded in the Americas, the Benin kings who sold slaves they captured in the interior were soon caught up in the international competition between the British, Dutch, Portuguese, and other European *dramatis personae*. As the influence of foreign nationals spread in the region, relations between the Europeans and the Benin kings increasingly became antagonistic and hostile. Their subsequent conflict with the European nations

seeking to expand their share of the international slave trade spelled the end of the Benin authority in the Nigerian region (Zeilig and Seddon 2009).

As the slave trade became more repugnant to the people of Europe, specially the intellectuals and working class, and especially when the slave trade was abolished in 1807, expressing indignant outrage the British launched a campaign to end the international slave trade. In spite of professing moral outrage over the trading of humans, the reality was that the slave trade was in decline. Farm implements produced during the industrial revolution had rendered an agricultural model based on slave labor as inefficient and too costly. Supported by the British working class, Parliament used public opinion to justify their expansion into West Africa. Under the veil of righteousness (putting an end to the slave trade), Britain began boarding ships on the high seas looking for slaves, especially European ships suspected of transporting slaves. The British repatriated African captives found on those ships at Freetown in Sierra Leone. Under the same pretense, in 1861, the British seized control of the Port of Lagos. With the elimination of the slave trade, trade shifted from buying and selling slaves to selling palm products, timber, ivory, and spices (Zeilig and Seddon 2009).

Over the next 50 years, the British combined aggressive trade with aggressive imperialism and expanded their control of the Nigerian region beyond the Niger River using minimal military personnel and resources. They ruled the tribal peoples of Nigeria using their iniquitous model of control, subjugation, degradation, and exploitation commonly referred to as *colonialism*. This development is important because of its profound impact on the lives of native adolescent girls. The life that had been laid out for girls and women in this region of North West Africa came to an abrupt end in 1861 when Nigeria became a British colony. Their life and future determined by custom and culture and the socially accepted definition of adolescent marriage and childbearing became a pawn in the process of vilifying West African culture and social customs as being primitive, a sign of ignorance, and of being uncivilized.

By 1900, the Nigerian area, which had been administered by the British Niger Company, became the Protectorate on Southern Nigeria. This also included the Niger Coast Protectorate. Control of this area then passed from the British Foreign Office to the Colonial Office. Between 1900 and 1914, in the process of merging Northern and Southern Nigeria, some 21 British military expeditions were sent into the region that would become Nigeria (Slattery 1999). The British continued to rule until 1946 when Nigeria was divided into three regions. At that point, the British allowed each region to establish advisory assemblies of indigenous residents who continued to demand more input in how they were governed. The objective was eventual self-rule. In 1954, the three regions were reorganized as the Nigerian Federation, and the regional assembles were given more authority. On October 1, 1960, in the view of many Nigerians, the yoke of Colonialism was finally thrown off (Afigbo 1975).

The next 40 years following independence, however, was a period (1960 through 2003) of civil war, military coups, political assassinations, riots, and starvation for over a million people despite considerable international relief efforts. Civil rule finally succeeded in taking back control of the government in 2003. The general election of April 2007 was the first civilian-to-civilian transfer of power in Nigeria's history. The Nigerian government continues to face the difficult task of dealing with corruption, mismanagement, and squandered revenues from their petroleum rich, based economy. In addition, the civil government faces longstanding ethnic and religious tensions in its efforts to institutionalize democracy in the politics of the nation (Gall and Hobby 2007).

Postcolonial Sexuality

There continues to be an ongoing struggle between traditional customs related to an adolescent girl's sexual behavior that were maligned during the period of colonial rule and sexual norms imposed by, in part, to justify British and

Western imperial domination (McClintock 1995). Even so, for the intellectuals who have studied the effect of colonialism on African sexuality point out that the European model for expanding civilization and commerce control of the people, their "disturbing sexual energies had to be held in check." This was conceptualized as the white man being active, logical, dominant, and the master. While the "colonial other" was black, passive, emotional, and feminized, even when the "other" was male. It has also been pointed out that all women and girls were considered the "other" category. The impact of the colonial definitions of what constitutes an adolescent girl's sexuality has been in a state of flux (Osha 2004).

Religious Influences in Nigeria

The perspective on sexuality of Muslins, in the north of Nigeria based on Islāmic law, is obviously quite different from the perspective of Nigerians in the Christian south. Although Northern Nigeria is for the most part Islāmic, it is not a hegemonic society. For the Muslins of north Nigeria, Islam is both a religion and a way of life that is prescribed in Islāmic teachings. More than most other religions, Islamic laws guide values, rituals, human transactions, and morals. There are teachings that guide politics, economy, culture, toilet habits, and conjugal relations between couples. These teachings provide instruction on designing comprehensive sexual education for the devout from the cradle to the grave.

The various interpretations of Islāmic teaching, however, have resulted in a wide variation in Islam. The Islāmic group in the north and southeastern Nigeria is the Hausa/Fulani. The Hausa/Fulani amalgamation has controlled Nigerian politics for the most part since independence. The Hausa/Fulani continue to be one of the largest and historically grounded civilizations in West Africa. Shari'a law is loosely the law of the land and is defined by religious leaders known in Hausa/Fulani as a *Mallam.* Even so, because of the widespread practice of assimilating or substituting Islāmic teachings with cultural norms, the rights of Muslim girls and women under Shari'a law has been eroded over the years. Male control of the knowledge and teaching of Shari'a law within Muslim society has entrenched the male interpretation of women's rights and responsibilities within marriage and in the community. This has resulted in a major breach between what Shari'a law provides Islāmic women and the rights of women in different Islāmic groups. In Nigeria, two broad factors have been identified as causing the loss of female rights as found in the Koran: poverty of knowledge and resources. For many Hausa/Fulani religious leaders, especially in rural Nigeria, there is a profound ignorance of the comprehensive rights of women under Shari'a law. In other groups, among the Hausa/Fulani people, where a lack of knowledge is not the impasse, poverty and a lack of religious resources among girls and women makes it difficult for girls and women to obtain their rights (Yusuf 2005). Sheikh Usman Danfodio, the nineteenth century Islāmic reformer and founder of the Sokoto Caliphate criticized Hausa/Fulani men for exploiting and denying women their right to education. In his book, the Nurul Albabi, the sheikh states:

> What the ulama (teachers) of this land are doing in leaving wives, daughters and servants neglected in the way of their beliefs and rules of their ablutions, and their prayers and their fasting and other things whose learning God has made compulsory for them is a great error.

Based on the customs and behavior of the Hausa/Fulani people, most modern day observers would have to conclude that Hausa/Fulani men have ignored Sokoto's writings and discourse on the rights of Islāmic females (Yusuf 2005).

Early Marriage and Islāmic Teachings

Marriage (*nikah*) in Islam is the union of a man and a woman. The reality, however, is that in Nigeria by Islāmic custom, marriage is too often between and adult man and a young emotionally and physically immature girl. In particular,

among poorly educated rural families, daughters married while in their early teens. While Islamic instruction permits marriage of very young girls, traditional teaching affirms that marriage has to be in the best interest of the minor girl and that the marriage should not be consummated before the girl is physically mature. Furthermore, the girl must consent to the union. The problem is not Islāmic law, but the practice of *nikah* among some of Nigeria's rural Islāmic sects.

Early marriage and childbearing are a tradition among the Hausa and Fulani people, even though it is well known that early sexual activity, marriage, and childbearing have serious risks for the young adolescent girl. Physical health can be compromised. Vesicovaginal fistula (VVF), sexually transmitted infections (STI's) including HIV/AIDS are more common among married adolescent wives. Among the 200,000 cases of VVF, 70 % of patients who requested services from VVF health centers live in Sokoto, Kano, Katsina, and Jos (cities located in the north, northeast, and central Nigeria). Medical services provided included the repair and rehabilitation of a fistulae injury. Vaginal fistula typically occurs when severe or failed childbirth tears a hole (fistulae) between the vagina and rectum or between the vagina and bladder (Fatima et al. 2005).

In addition, young adolescent wives are at greater risk of not receiving or delaying quality obstetric care and too often as a result, they suffer from complications during pregnancy and childbirth. Complications during pregnancy and childbirth are much higher for young adolescent girls than they are for young women between the ages of 20–24 years of age. The rate of maternal mortality and morbidity in the north of Nigeria contributes disproportionally to a national average of 8 deaths per 1,000 births. This is one of the highest maternal mortality rates in the world. A study recently conducted in 2005 and reported an unexpected increase in maternal mortality in the city of Kano. Based on statistics from three hospitals located in Kano, researchers found that there were about 4 maternal deaths per 100 live births (Sedgh et al. 2009). In the USA, maternal mortality in 2005 was 11 per 100,000 live births. The Islāmic nation, United Arab Emirates has a maternal mortality rate of 3 per 100,000 live births. By far, most of these maternal deaths reported from states in north Nigeria could have been medically prevented. Medical interventions to prevent this rate of maternal death have been available since the 1950s.

This is a health burden that the Nigerian people do not have to bear. Public health prevention programs could immediately improve the health of Islāmic adolescent girls in Nigeria. However, an understanding of Islāmic religious teachings on sexuality in Nigeria must be considered when developing policy, and providing reproductive and sexual health services to Nigeria's Islāmic communities.

South Nigerian Perspectives

Where a majority of Nigerians living in northern states are Muslim; Christens make up the majority of the population in coastal and southern states of Nigeria. Each region is very different because of quite different religions and thus cultural orientation. The starkest difference between these regions can be found in their respective urban areas. Although changes are taking place in northern states, the context of adolescents experience and in particular adolescent girls experience in urban areas in the southern states are radically different than their counterpart in the north Nigeria.

The influences that effect adolescent pregnancy in the south of Nigeria will be very familiar to those from western societies. There are the typical variations among Christian denominations in Nigeria found in other western nations that are predominately Christian (fundamentalist to liberal sects). The variation in social pressure that shapes the face of adolescent pregnancy, however, is unique. In addition, to Christian religious precepts that shape adolescent behavior, there is a range of influences from postcolonial to modern secular morality that must be considered as mediators. The strategies of colonial domination that define relationships within the structure of a powerful hierarchy

continue to influence relationships and the African perception of self. Designated as "double consciousness," Franz Fanon used the concept to help describe the mental conflict associated with having a dual identity. In this case, the Nigerian defined by colonialism and the Nigerian who seeks an identity on the global stage. Adolescent exposure to global communication, exposure to variations in lifestyle, knowledge of the differences and advantages of wealth as opposed to poverty, and opportunity available to adolescents and young people around the world shapes the thinking and sexual behavior of adolescents in the southern states of Nigeria. Universal ideas about sexuality as an individual right, the promotion of products and services, and advertising scheme based on sex appeal are a powerful message that gravitates against religious and traditional sexual restraints. These influences go a long way in shaping sexual experiences and expressions of "thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships" (ARSRC 2003, p. 17).

Nothing has had more influence on adolescent sexual behavior in Nigeria than Internet access. Cyber cafes have been popular among adolescents and young adults since the 1990s. Access to factual sexual information on the Internet has filled the gap left by parents who are often reluctant to talk with their children about sexual matters. Access to material such as sex films and telephone sex has increased the variation in sexual experience that adolescents were not exposed to in the past. In particular, this has increased sexual activities among adolescents in the southern states (Nwagwu 2007).

Overview of Adolescent Pregnancy in Nigeria

To understand adolescent pregnancy in Nigeria, there are demographics characteristic that are important to consider. For instance, 52 % of Nigerians live in rural areas. This is similar to the percentage of people living in rural areas worldwide (50 %). In the USA, only 20 % of people live in rural areas. Rural versus urban are important in terms of attitudes of the people and the delivery of services. Moreover, 84 % of Nigerians live on less than $2 (US$) per day; worldwide, 48 % of people live on less than $2 (US$) per day. Of course, the remaining 16 % of Nigerians have a much higher income. Yet, when compared to the average gross national income (GNI) worldwide which was $10,240 (in US$)] in 2009, the Nigerian GNI was only $2,070 (US$)]. This is very low—this is less than 20 % of the worldwide average.

The people of Nigeria are young, 43 % are younger than 15 year of age; worldwide 27 % of people are under the age of 15. Nigerian women are also very fertile. The average mother in Nigeria gives birth to almost 6 children in her lifetime; worldwide, mothers give birth to 2.5 children over their lifetime. This high fertility rate is in great part due to the high infant mortality rate. Infant mortality in Nigeria is 90 for every 1,000 live births; worldwide, infant mortality is 45 for every 1,000 live births. A high infant mortality rate is typically correlated with life expectancy at birth. In Nigeria, life expectancy is age 51; worldwide, life expectancy is 70 years of age. Nigerian male's life expectancy is 51 years of age, while worldwide male life expectancy is 68 years of age. Nigerian female's life expectancy is 53 years of age, while worldwide female life expectancy is 72 years of age.

In Nigeria, where child/early marriage is widespread, fewer than 10 % of Nigerian adolescent girls give birth outside marriage. By comparison, in Kenya where early marriage is not as common as in Nigeria, more than 50 % of girls who are not married give birth before they are 20 years of age (WHO 2006). Despite a low percentage of births outside of marriage, the burden of sexual and reproductive health problems is substantially higher for Nigerian girls between the ages of 10 and 19, than for any other group of Nigerian people (PRB 2000). These adolescent girls have a high fertility rate. In 2003, 126 out of every 1,000 girls became pregnant during the year. At the same time, 55 % of all illicit abortions were performed on

Nigerian girls between 15 and 19 years of age (Rania and Lule 2004).

Early marriage: In Nigeria, over 46 % of all girls marry before the age of 18. Yet, among the poorest 20 % of these girls, 76.5 % marry before the age of 18.

Child birth: The average number of Nigerian girls who give birth before the age of 18 is slightly over 34 %. Yet again, among the poorest 20 % of these girls, almost 60 % give birth before they reach the age of 18 years.

Unintended births: For all Nigerian girls between the ages of 15 and 19, 21.2 % reported an unintended pregnancy. Among the girls from the poorest families, families in the bottom 20 % of poor families, only 12.1 % experienced an unintended pregnancy. At the other end of the economic continuum, the top 20 % of girls from the richest families experienced almost three times the unintended pregnancies, 33.5 % (Oyediran and Isiugo-Abanihe 2005). Of course, the richest families tend to live in urban areas. The girls in urban areas are aware of western attitudes about sexual behavior. They have access to western movies, magazines, and of course the Internet, and computer cafes. This is a very interesting finding. There are few examples where girls from affluent families have a higher rate of unintended pregnancy than girls from poor families. This is one of those situations. The reason this major difference is that girls from less affluent families are disproportionally found in families where their girls are often locked into a patriarchal social and family system where the males in the family exerts almost total control over the women and girls in the patriarch's family.

Health Problems

The statistics on health issues among Nigeria girls tells a story of a population that shoulders a health burden greater than that experienced by older women and males. While more than 75 % of all maternal deaths occur in developing countries, the maternal mortality rate for all women in Nigeria is estimated to be 1,100 per 100,000 live births; an adolescent girl in Nigeria who becomes pregnant is almost *three times* as likely to die from causes related to her pregnancy than older females between 20 and 34 years of age. The world rate of maternal death is estimated to be 400 per 100,000. On another revealing statistic, the *adult lifetime risk of maternal death*, which is the likelihood that a 15-year-old girl will eventually die from childbirth, is highest in Africa at 1 in 26 girls. Niger, which borders Nigeria to the north, has the highest estimated lifetime risk of maternal death at 1 in 7. Nigeria had the estimated lifetime risk of 1 in 18. By comparison, Ireland had the lowest lifetime risk of maternal death at 1 in 48,000. In terms of total maternal deaths, India led all countries with a total of 117,000 deaths per year. Nigeria had the second highest number of maternal deaths of all countries at an estimated 59,000 deaths. This high level of maternal mortality in Nigeria is directly attributable to forced child marriage and childbirth at a young age (UNICEF 2003; Maine 1991; Say et al. 2007).

Another explanation for a country's high maternal mortality rate is whether or not skilled medical personnel attended the birth. Worldwide, skilled birth attendants are present in slightly over 50 % of all births. In Nigeria, the number of births attended by skilled health personnel is about 35 %. For developed countries, skilled medical personnel attend virtually all births. The lack skilled medical personnel is also one of the reasons for a high infant mortality rate of 75 per 1,000 live births. The lack of medically trained people attending the birth also contributes to the mortality rate of children under the 5 years of age. Although unacceptably high, 133 children under 5 years of age die per 1,000 children under the age of 5. In Nigeria, the consequences poverty is seen in underweight children. An estimated 27 % of children in Nigeria is under the age of 5 is underweight (PRB 2012). A more sensitive measure of poverty is stunted growth. In Nigeria, 38 % of children show symptoms of stunted growth (UNICEF 2003).

Contraceptive use among Nigerian married girls and women between the ages of 15 and 49 is another contributor to the high birth rate and subsequent the high rate of maternal and infant mortality. Worldwide, over 60 % of girls and women use some form of contraceptive. In Nigeria, only 15 % of girls and women use any form of contraception (PRB 2012). This is a risk situation for child brides. In a number of different Nigerian cultures, child brides have no control over her life or fertility. Associated with sexual initiation, the younger the girls when they give birth, the more times they will become pregnant.

Sexual Initiation

The age of sexual initiation is an important issue in Nigeria. Because of the number of child brides in Nigeria, it is a concern because there is indisputable evidence both from Nigerian researchers and international studies that have found a strong correlation between' age of sexual initiation' and an "increased risk of serious physical and emotional problems" among young adolescent mothers and among children born to young adolescent mothers. For instance: (1) the younger the girl is when sexual initiation occurs, the greater the likelihood that she will become pregnant at an earlier age; (2) the younger the girl is when sexual initiation occurs the more children she is likely to have in her lifetime; (3) the younger the mother the more likely she and her child will suffer serious physical and emotional problems—including death; and (4) the younger the girl, the more likely a pregnancy will negatively affect the future of the young girl and that of her child(ren).

There are both secular and religious laws that protect girls, especially child bridges from becoming pregnant at an early age. Nevertheless, these are often overridden by customs and traditions that pressure young girls to "become pregnant early and have many children." The problem is widespread especially in the north and northwestern states in Nigeria (Ajuwon et al. 2006). Because of civil law, the marriage of a child cannot take place legally, so religious leaders defy civil authority and conduct them clandestinely.

Reasonably good studies that have examined early sexual initiation provide a view of adolescent life and sexual behavior among Nigerian young people. Studying predictors of early sexual initiation is important. Sexually transmitted diseases are a serious threat to very young boys and girls for many reasons. A lack of sexual knowledge and the inability to utilize such knowledge because of immaturity and powerlessness puts them at greater risk of contacting sexually transmitted diseases, suffering other health problems, and for girls, becoming pregnant. Having knowledge of circumstances and conditions that predict or are associated with premarital sexual initiation are necessary to develop effective programs and interventions.

Universally, the younger the girl at sexual initiation the more likely the girl and her child(ren) will experience more negative health and developmental problems than adolescents who are older when they have their first sexual experience. In Nigeria, there are predictors of early sexual initiation that are similar to adolescents around the world and other predictors that are unique to Nigeria. A study of demographic, psychosocial, and community-related issues associated with adolescents between 15 and 19 years of age, who were never married and who had experienced a sexual encounter, revealed important predictive behaviors that are different between adolescents who have experienced sexual initiation and those who had not had a sexual encounter. Knowing these differences is important in the process of developing effective interventions that will reduce early sexual initiation among Nigerian adolescents. In a nationally representative sample, Fatusi and Blum (2008) found that nationally among unwed adolescents, 18 % of boys and 22 % of girls had experienced sexual initiation. This percentage, however, was different depending on whether the adolescent lived in the south of Nigeria or the north of Nigeria. In the south of Nigeria, 24.3 % of adolescent boys and 28.7 % of adolescent females were sexually experienced as compared to the north of Nigeria, where only

12.1 % of boys and 13.1 % of females have been involved in a sexual encounter. The difference between those adolescents (both males and females) living in the northern states who had experienced a sexual encounter and those who had not was a higher degree of religiosity among the adolescences. In the case of adolescents in the southern states, girls but not boys who reported a higher degree of religiosity were older when they experienced sexual initiation than girls who reported lower religiosity. Among boys, but not for girls, educational attainment was also significant in extending the age of first sexual initiation. For boys and girls, the higher the knowledge level of HIV/AIDS predicted a later age for sexual initiation and less sexual activity.

Other psychological factors that played a role in predicting a younger age at sexual initiation were more positive attitudes regarding condom efficacy, a more positive attitude about using family planning services, and a greater belief that they had access to condoms. Among boys who had delayed sexual initiation, there was a stronger and more positive attitude toward girls and women, less alcohol use, a negative attitude toward premarital sex, nonliterate in English, and interestingly less radio and television exposure.

In contrast to the preventative effect of religion, in terms of early sexual initiation, girls with a secondary school or a higher level of education were significantly more likely to have participated in sexual behavior than girls with less education. Girls with a primary school education were more likely to abstain from sexual intercourse than girls who had completed a secondary school or higher level of education. Interestingly, family economic status has no predictive value in determining the age of sexual initiation among Nigerian girls. This is quite the opposite from the influence of family economic status on adolescent girls than the rest of the world. Internationally, poverty among adolescent girls is predictive of adolescent pregnancy. This is such a broad-based finding that adolescent pregnancy is often thought of as a health burden borne by adolescent girls living in poverty.

Another unique characteristic that stands out is the low percentage of Nigerian girls that report involvement in premarital sex. Even though girls in sub-Saharan Africa are slightly more likely to have been involved in premarital sex, approximately 22 % for Nigerian girls than their Nigerian male counterparts (approximately 18 %), the percentage of Nigeria adolescents who become involved in premarital sex is one of the lowest in the world. Even though there are wide regional disparities, many of the neighboring countries in this region of Africa also have low percentages of girls that involve themselves in premarital sex. In Gabon, premarital sex is estimated to be 19 %. In the Ivory Coast, premarital sex among adolescents is about 21 %. Premarital adolescent sex in Ghana is reported to be an estimated 22 % (Mensch et al. 2006). These numbers are much lower than the percentages of countries in Europe and North America.

Within this same region, other neighboring countries have much higher rates of premarital adolescent sex. Niger, which is Northeast of Nigeria, has one of the highest rates of premarital sex among adolescents in the regions at 75 %. Chad comes in second with an estimated 63 %, and studies of Mali's adolescents report 53 % involved in premarital sex.

Childbirth in Nigeria

Throughout its history, Nigeria has had a high fertility rate. It may be declining slightly, based on the 2003 Nigerian Demographic and Health Survey (NDHS 2003), but the fertility rate is still almost three times higher (6 children over a woman's lifetime) than most developed countries (2.5 children over a woman's lifetime). As mentioned earlier in this chapter, in large part, the high fertility rate is due to a higher rate of mortality. In Nigeria, 80 infants die for every 1,000 live births. Worldwide, on average, 45 infants die per 1,000 live births. Of course, as

Table 1 Percentage of women ages 20–24 who gave birth by age 18

Chad	48 %
Nigeria	28 %
Nicaragua	27 %
India	22 %
Switzerland	<0.5 %

PRB Family Planning Worldwide (2008)

with other issues related to adolescent pregnancy in Nigeria, fertility rates vary across the country. In the northwest, the average fertility rate is 6.7 children in a woman's lifetime. It is 7 children during a lifetime for women in the northeast.

One of the characteristics that are associated with higher rates of fertility among women in any particular country or culture is giving birth before the age of 18. In developing countries, the number of girls who give birth averages about 25 %. In Niger, half of all females give birth before the age of 18. In 17 other countries surveyed, mainly in Africa, more than a quarter of all girls become pregnant before the age of 18 (Table 1).

This region of Africa has the highest ratios of maternal mortality to live births in Africa. It is estimated to be about 10 maternal deaths per 1,000 live births. In Nigeria, maternal mortality is slightly lower, estimated to be 8 maternal deaths per 1,000 live births. Using the maternal lifetime risk of dying from complications during pregnancy and childbirth as a point of comparison, women in Nigeria have a 1 in 8 chance of dying from complications related to pregnancy. This lifetime risk can be compared to developed countries where the chance of dying from complications related to pregnancy is 1 in 10,000. In Nigeria, the leading cause of maternal death is from hemorrhaging (23 %). Infection (17 %) is next, followed by anemia (11 %), malaria (11 %), obstructed labor (11 %), toxemia/eclampsia/hypertension (11 %), and unsafe abortions (11 %). Other disorders that contribute to the number of maternal deaths, which includes HIV/AIDS, are responsible for roughly 5 % of maternal deaths. In addition to death, pregnancy complications result in large numbers of women who suffer both short- and long-term disabilities. One estimate suggests that for every maternal death, there are at least 30 women who suffer severe complications during pregnancy such as VVF (Galadanci and Sani 2009).

As would be expected, among Nigerian females, complications during pregnancy are one of the leading causes of death and disability. Again, the number of maternal deaths varies by regions in the country. In Nigeria's northeastern states, the maternal mortality rate is 10 times that in the southwest of the country; the maternal mortality rate also differs between urban and rural dwellers. In the urban areas, the maternal mortality rate is 35 per 1,000 live births. In the rural areas, it is over 80 per 1,000 live births. An estimated 60,000 Nigerian girls and women die annually from childbirth and preventable pregnancy-related causes.

Many of the adolescent girls who died from complications during pregnancy or birth die from causes related to their physical immaturity. The number of girls and women who die from complications related to pregnancy is only part of the tragedy. In developing countries, when a child under the age of 5 loses their mother, they only have a 50–50 chance of surviving (Tinker and Koblinsky 2002). In Nigeria, most newborn deaths occur during the first week of life.

Traditional Birth Attendants

One explanation for the high rate of maternal and child mortality is the widespread utilization of traditional birth attendants (TBA). On average, 58 % of women deliver their child at home. In the north of Nigeria, Galadanci et al. (2007) found that 85 % of women delivered their babies at home. Health facilities in the north were involved in 14 % of the births. About 0.6 % of deliveries took place in spiritual homes and other locations. Because of the large number of home deliveries that occur outside of the health system, TBA attends the vast majority of deliveries. As a group, TBAs are considered unskilled attendants. Trained medical personnel

in Northern Nigeria are only involved in about 20 % of deliveries, while 80 % of the deliveries are attended by TBAs that have little or no training in sanitary birthing techniques (Galadanci et al. 2007).

To appreciate the importance of the TBA in Nigerian society, particularly in rural Nigerian society, we need to know that the TBAs have held a major role in childbirth in the Nigerian area since ancient times. The role of the TBA described by Galadanci and Sani (2009) is typically an older woman between the ages of 45 and 70 years of age. TBAs practice childbirth using local traditional medicines. For example, TBAs prescribe girls and women with their first child herbs to ensure a healthy child. After the first child, the TBA is not called until labor begins. They end their involvement shortly after the child born.

When the TBA is called to assist with childbirth, the first step is to clean an area in a corner of a room with a woman will have her baby. In the corner is placed a stool for the woman in labor to kneel on. This stool is used because the cultural belief is that laying a pregnant woman on her back facing up would result in a loss of her spirits. A pregnant woman will remain in the kneeling position during the birth and until the placenta has been delivered. Most TBAs will use traditional medicines that are given during contraction. The TBAs do no vaginal examination to assess the birthing process. When labor starts, however, the TBA boils water containing several types of medicinal sticks. The water is used to bathe the mother and child after the baby is delivered.

After the birth, the TBA will cut the cord using a knife that is only used in the ceremonial cutting of the cord. The TBA then squeezes off the cord to stop any bleeding. Next the baby is bathed with a traditional black soap and wrapped in a clean cloth. When the placenta is expelled naturally, the mother is washed with the boiled water and recently cut leaves selected for the purpose of cleansing the mother. To complete the process, the TBA washes the placenta seven times, wraps it in a clean cloth, and buries it. Given a delivery without complications, the TBA washes all soiled linens used in the delivery. Finally, the TBA makes a traditional pap for the mother with potassium and spices to facilitate recovery and to stimulate breast milk production.

When the process does not happen as expected, for instance, if the placenta is not expelled naturally, the TBA may attempt to assess the process by shaking the woman's abdomen or causing her to cough by sprinkling red pepper on burning charcoal. If the TBAs efforts fail during or after childbirth, in most cases the woman is taken to a medical hospital.

Although on the one hand, the TBAs lack of training and knowledge about general hygiene and danger signs during a complicated delivery has contributed to the high rate of maternal and child mortality. On the other hand, providing basic medical training for TBAs similar to that provided midwives in other countries could do a great deal to reduce the rate of maternal and child mortality in Nigeria. Obviously, there is a large cadre of TBAs that are actively involved in childbirth in the north and rural areas of Nigeria. Rather than develop policies to prohibit the traditional use of these women during childbirth, policies that would provide training and linkage to modern medical resources could go a long ways in helping reduce the rate of maternal and child mortality in Nigeria. The combined effort of government and nongovernment entities should be to use approaches that will make these women part of the solution.

Spacing Childbirths

For the most part, spacing childbirths is universally accepted as a medically sound practice that is both physically and emotional beneficial to the health and well-being of both the mother and child. Spacing childbirths improves mother and child survival rates. This is particularly important in societies where custom, tradition, religious law, etc., support child or young adolescent brides and high fertility rates. Spacing childbirth also protects both the woman's and infant's health by protecting the woman from

high risk and unwanted pregnancies. Spacing and timing childbirth can promote appropriate child development.

Irrespective of custom, tradition, or religion, the lack of physical maturation of a female child's body makes delaying the first pregnancy and spacing between births essential to the adolescent girl and her child's health and life. Nevertheless, the program to encourage Nigerian women to consider spacing childbirth has had little impact. One reason is the culture of traditional families. Men are crucial in determining not only how often his wife(s) becomes pregnant but also how soon after the birth of her last child she again becomes pregnant.

Husbands and men in the traditional family make decisions that affect the sexual health of women in the family. In traditional families, men are the ones who make the decision to seek emergency medical attention when there are complications during delivery. They decide if and when a woman uses a child spacing method. They decide how and when to make resources available for prenatal care, care during delivery, and postnatal care. Finally, they decide when a woman during childbirth needs to seek emergency care due to complications. Public health educators in Nigeria are aware of the power of husbands in traditional families in relationship to childbirth. Educational efforts and policies need to consider the influence of men when designing public health efforts to improve childbirth outcomes.

Some of these traditional families believe that having as many children as possible as fast as possible is following religious law. This is incorrect, however, as Yusuf (2005) points out, the Shari'a law refers to child spacing through the Quranic injunction. It states: *Mothers shall suckle their children for two years if they wish to complete breastfeeding*. Al-Baqara 2:233 "and his weaning is in two years" (Luqman 31:34). In Islam, an argument for spacing childbirth is to avoid, *kwanika*—a situation where a wife becomes pregnant before she has finished weaning her child.

Another circumstance that works against adequate child spacing is polygamy. Once married, when adolescent girls reach her mid-teens, many become pregnant as soon as they possibly can. It is not uncommon for adolescent girls in a polygamous marriage to compete with co-wives by giving birth to as many children as possible. A wife with many children is thought to be more secure within the marriage. It also insures a larger portion of inheritance. Under Islāmic law, each child is allocated a specific share of the inheritance. Based on these customs and strategies among women in a traditional polygamous marriage in Nigeria, some wives have as many as 10 or more children.

Postnatal Care

Too often, after a birth, adolescent girls and young women do not have access to postnatal care. This results from a lack of power in the marriage. It also results from a lack of education among girls in general. This is a serious problem and contributes to the high rate on maternal and child mortality. Galadanci et al. (2007) found less than 20 % of girls and women return to clinics after the delivery of their child for postnatal care and checkups. Postnatal care in developing countries is extremely important for the survival of adolescent girls who give birth. In countries like Nigeria, it is not unusual for as many as 60 % of maternal deaths to occur during the postnatal period (Fortney et al. 1996). In another survey, women in rural areas who had given birth in their home were found to experience a 43 % rate of postpartum morbidity (Bang et al. 2004). Given the extremely high rate of maternal mortality during the postpartum period in Nigeria, policy to educate and encourage girls and women to utilize postnatal clinics would be extremely beneficial to Nigeria as a nation. Providing prenatal and postnatal care at little or no cost would fundamentally reduce the rate of maternal and infant mortality.

Preference for Male Children

In all patriarchal societies, the male child is preferred. In the rural areas and in many of the northern states, this preference for a male child

can be quite strong. This preference has led to practices that resulted in serious consequences for female children. Ibanga (1994) reported that female children more than boys experienced abandonment, discrimination, and rejection by their family. Boys in the family are also more likely to attend school than their sisters. Girls in the family often remain out of school doing housework, taking care of children, and working as a laborer to supplement the family income. Other researchers have reported that in many disasters and emergencies where entire families were threatened, there is evidence that parents have provided for their male child at the expense of their female child. Consequently, during the Nigerian Civil War, there were a number of accounts where parents fleeing from the fighting took their sons, their farm animals, personal belongings, and left their girls behind (Ejikeme 2003).

Abortion

Not only is abortion illegal in Nigeria, but also as reported by Okonofua et al. (2009) the Nigerian laws against abortion are the most restrictive in the world. In Nigeria, there are legal penalties for both those who perform an abortion and for those who request an abortion. There are also severe penalties for women who attempt or who induce their own miscarriage. Abortion is punishable under both penal law and criminal law unless an abortion is needed to save the mother's life. Even so, over 760,000 abortions are performed on Nigerian women annually. Of these, physicians in health care facilities perform an estimated 40 % of abortions; however, the remainder of the abortions is performed by nonphysicians (Adinma 2011; Henshaw et al. 1998).

Unsafe abortions are a serious health burden borne by the women of Nigeria and their families. Moreover, even though national policies exist to promote safe motherhood and reproductive health, no policies specifically deal with the issue of unsafe abortion. The best recent estimates are that 20–40 % of maternal deaths are the direct results of unsafe abortions. Additionally, abortion is reported to be the leading cause of chronic pelvic pain, ectopic pregnancy, infertility, recurrent pregnancy loss, and reproductive morbidity. This health burden is the heaviest on adolescent girls. As mentioned before, an estimated 55 % of all illicit abortions are performed on Nigerian girls between 15 and 19 years of age (Okonofua et al. 2009).

The number of abortions and particularly unsafe abortions could be discernibly reduced if family planning services were readily available. In Nigeria, however, there are only a few government programs that have been funded, even though modern contraceptives are used worldwide to prevent unwanted and unintended pregnancy. For instance, in the USA, modern contraceptives have been used by as many as 95 % of women. In Nigeria, the government funds few family planning programs. As a result, the rate of use of modern contraceptives was only 8 % in 2003, according to the last best estimate. This is one of the lowest rates of contraceptive use in sub-Saharan Africa (Oyediran et al. 2005). In part, the reason for the lack of nongovernment funding for abortion is because of the pressure exerted by what has been referred to as the "global gag rule." Although this may be changing, many organizations that provide family planning and post-abortion services have been fearful of losing their funding from the USA if they also work to provide safe abortions. In 2007, there was a concerted effort to change Nigeria's antiabortion laws. As in the past, a strong antiabortion lobby and influential women's groups fought against any changes in the law. The results, politicians, and policy makers did nothing to remedy the problem of unsafe abortions (Okonofua et al. 2009).

Programming

The National Adolescent Health Policy intended to promote the sexual and reproductive health among Nigerian youth was passed in 1995. The goal of the policy was to provide a legal environment that would force schools and health

providers to make available the knowledge and information adolescents need to make learned decisions about their sexual and reproductive health. The policy was updated in 2006 (Federal Ministry of Health, Nigeria 2007a).

The National Adolescent Health Policy was the basis for the development of the National Adolescent Reproductive Health Strategic Framework in 1999 and its revision in 2007. These strategic initiatives covered a number of issues that had not been addressed in the past at the national level. The strategies included plans to deal with adolescent career preparedness and employment, drug abuse, education, nutrition, parental responsibilities, and sexual behavior. These policies and initiatives also solicited and incorporated information from Nigerian government organizations, the World Health Organization, Nigerian regional ministries, and adolescents who would be effected by these programs (Federal Ministry of Health, Nigeria 2007b).

One of the federal programs started in 2002, designed to improve adolescent sexual and reproductive health in Nigeria, was the Family Life and HIV/AIDS Education (FLHE) program. Established by the state Ministries of Education with support from other government agencies and international partners, the focus was to provide sexual education for junior secondary school students. Soon after the FLHE program started, however, several major weaknesses became evident. Among the 36 states that make up Nigeria, by 2007 only 10 states had implemented the program and curriculum. Most of the resistance is related to traditional, religious, cultural norms, and the role of women in different Nigerian societies (Sedgh et al. 2009).

The FLHE program was also not practical for the rural areas of the country. Implementation of the program went fairly well in the wealthier urban area schools in the southern part of Nigeria. According to Sedgh et al. (2009), the program did not reach many adolescents who were not attending school and adolescents who lived in rural areas and northern states.

In an effort to provide similar services to adolescents in all parts of Nigeria, the FLHE developed a Web- and telephone-based program. They named the program, *MyQuestion.* The approach is similar to many Internet services available today that provides accurate information about sexual matters to primarily adolescents. In Nigeria, *MyQuestion* is a service designed to provide information and a place where adolescents can ask questions about sexual and reproductive health. The answers are sent back in e-mail or text messages. Of course, it is obvious that this type of service would not reach many adolescents who did not have access to a computer, the Internet, or a cell phone (Sedgh et al. 2009).

A more traditional program was called, *n centers* which were developed for adolescents who were primarily not attending school. These centers had the broader goal of building communities while providing factual information on sexual and reproductive health. Many of these *n centers* also provide counseling and referrals to adolescent friendly health care services. Although effective, these programs are reported to have had only a modest impact at the national and state levels. The barriers that explain this lack of success were poor coordination among governmental and nongovernmental entities, which resulted in a piecemeal effort (Sedgh et al. 2009).

Conclusion

Nigeria as a developing country continues to make progress despite periods of political unrest and corruption that prevents Nigeria's people as a whole from sharing in Nigeria's oil wealth. Additionally, Nigeria's medical and social welfare professionals have done a great deal to identify the extent and reasons for adolescent pregnancy. Their national, regional, and local studies have provided reliable knowledge on which to develop policy and programming that will reduce the number of Nigerian adolescent

girls who become pregnant and die from complications before, during and after childbirth.

There are modest and affordable maternal and child health care programming that can improve adolescent pregnancy outcomes, reduce the high number of adolescent maternal and child deaths, and for that matter the pregnancy outcomes of all Nigerian women. We start with the knowledge that adequate health care will reduce health risks and increase an adolescent's and young woman's chance of surviving her pregnancy. We also know adequate medically based health care increases her child's chances of surviving the pregnancy. In virtually all situations, adequate health care is associated with better survival rates and fewer complications before, during, and after pregnancy.

Adequate medically based health care starts with clinics that are medically equipped, supplied, and have medical personnel that can deal the most common obstetric emergencies. These basic modern obstetric services need to be available in all area of Nigeria, especially the rural areas where few medical services are available. These clinics should also have "well baby programs" and "nutritional programs" for the mother and her child. These services need to be affordable and available to all mothers, their children, and families. Finally, an ongoing public service campaign to inform the community of the medical and social services available, and where they can be accessed would begin a process that would dramatically change adolescent maternal and child health outcomes in Nigeria. Adequate medical health care would reduce the number of adolescent maternal and child injury, and death as well as reduce the number of maternal and child injury and death among all women and Nigeria.

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Adolescent Pregnancy in the Philippines

Laurie Serquina-Ramiro

Keywords
Abortion · Adolescent pregnancy · Age at menarche · Casual sex · Economic migration · Group dating · Influence of religion · Sex education social norms for women · Social norms on sex

Introduction

An archipelago of about 7,000 islands, the Philippines is located in South East Asia—north of Malaysia, south of Taiwan, east of Vietnam, and far west of Hawaii, USA. The country is divided into three island groups: Luzon in the north, Visayas in the center, and Mindanao in the south (Fig. 1). Politically and administratively, it is composed of 17 regions, 80 provinces, 138 cities, 1,496 municipalities, and 42,025 *barangays* (villages). The seat of the national government is in Manila, in the island of Luzon.

Having been under the Spanish (1521–1898) and American rule (1898–1946) and with traditional social and economic connections with neighboring Asian countries and the Middle East, present-day Filipinos, as the people are called, are a mixture of various nationalities. The large majority, however, are of the brown Malayo-Polynesian race whose ancestors were the Austronesians who came to the islands in 4000 BC. The earliest inhabitants were known to be the dark-skinned Negritoes who are thought to have begun inhabiting the island about 67,000 years ago. The country's current population is composed of more than 60 ethnolinguistic groups dominated by the Tagalogs, Cebuanos, and Ilocanos. About 10 % belong to cultural minorities that include the Aetas, Mangyans, and Manobos. Muslims are mostly found in southern Mindanao.

Although the Philippines has more than 150 local dialects, Filipino is the national official language. Filipino is based on the Tagalog dialect, which is the medium of communication in MetroManila and neighboring provinces. Filipinos, however, are relatively proficient in English, the language being the medium of instruction in secondary and tertiary schools. Older people are good in Spanish, as the Spanish language was part of the tertiary educational curriculum until the late 1970s. The Philippines is the only Christian country in the Far East where about 80 % are Roman Catholics.

Philippine economy is basically agriculture and aquaculture. People's incomes are also derived from such industries as food processing,

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textiles and garments, mining, and electronics assembly. According to the IBM Global Location Trends Annual Report (2011), the Philippines has become the world leader in business support functions such as shares services and business process outsourcing. Economically, however, there is a wide gap between the rich and the poor but with a burgeoning middle class. With a GDP per capita of $3,500, a third of the population lives below poverty line.

The Youth Population

The Philippines has a young population with an estimated median age of 22.9 years in 2010. About 19.8 million Filipino youths aged 15–24 were noted in the same year. This number comprised about 21 % of the total population of 95.8 million Filipinos. About 48 % of these young people are adolescents aged 15–19 years (National Youth Commission 2010). (See Fig. 2, Table 1).

In terms of education, the Filipino youth have adequate school attendance. The gross enrollment rate in public and private secondary schools for SY 2009–2010 was 82.15 % (DepEd 2011). The 2010 literacy rate for those aged 15–24 was 94.8 % with females (95.7 %) outdoing males (93.9 %) (United Nations Statistics Division 2010). In the NSO-Labor Force Survey of 2006–2009, 37.5 % of youth aged 15–24 were employed, where male employment rate was 46.7 % compared to a 28.2 % employment rate for female youths (DOLE 2010).

Developmentally, young Filipino men and women consider the time of the first manifestation of changes in their bodies as the start of adolescence. In Acaba's study (2006), the onset of menstruation and increase in breast size were perceived by his women-respondents as the initial physical changes. In men, it was the change of voice. These changes normally occur at age 12 although others show these signs at an earlier age of 9 or 10 years. In addition, personality changes become overtly observable. These

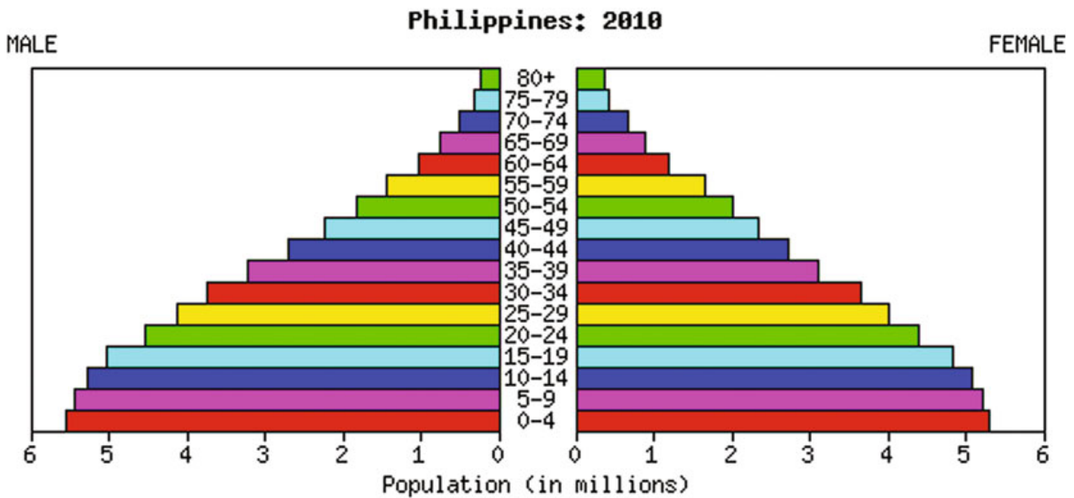

Fig. 2 Age and sex distribution for the year 2010 From: http://www.nationmaster.com

Table 1 Youth population characteristics, 1970–2010 Census

Year	Total Population (in millions)	Youth population 15–24 years (in millions)	Ratio of youth to total population	Median age	Youth population growth rate
1970	36.7	7.2	19.6		
1980	48.1	9.8	20.5	19.6	2.2
1990	60.6	12.4	20.5	19.3	2.3
2000	76.5	15.1	19.7	19.7	2.1
2010	95.8	19.8	20.8	22.1	2.3

Source Ericta (2003), NSO (2010)

include shyness, moodiness, increased sensitivity, impulsiveness, irritability, and being attracted to the opposite sex.

Just like any other group of young people who, at this transition stage, experience the best and the worst periods of their lives, Filipino teenagers engage in all sorts of lifestyle activities: from sports, leisure, and social networking to vices such as smoking, alcohol and illicit drug use, sexual adventurism, and the like. For instance, basketball and boxing are the favorite sports. The Universal McCann Wave 3 survey (2008) also reported that the Philippines ranks second globally in terms of number of people who have read blogs, and fourth in terms of writing personal blogs. The Philippines was also recently recognized as the "text capital of the world" as SMS texting has become a popular tool to keep in touch with friends and loved ones (Philippine domain.com 2011).

Filipino adolescents, however, are not without vices. One study showed that 40 % of Filipino youth are smoking, more than half are drinking alcohol, and about 8 % have used prohibited drugs (BSNOH 2000). According to the latest WHO report (2010), the smoking percentage of Filipinos in the age group of 13–15 years is 22.7 % with more boys smoking than girls, although the gap is closing fast. Women smokers in the country are getting younger, where three out of 10 female Filipino smokers are in their early teens (Kin 2009).

One of the most evident outcomes of adolescent risk-taking is teenage pregnancy. The World Health Organization (2008) estimates that about 16 million women aged 15–19 years give birth

each year. While the prospect of having a baby can be fulfilling and inspiring, pregnancy at a time when one is not yet ready to face the responsibilities of parenthood, can, oftentimes, be disadvantageous.

History and Culture: Adolescent Sex, Marriage, and Pregnancy

Marriage and pregnancy at a young age are not unusual occurrences in the Philippines. In olden times, early marriage was the norm, especially in traditional kinship-based indigenous cultures. Girls married as soon as menarche commenced. Arranged marriages were also common. These traditional practices were usually tied up with beliefs about gender roles, specifically women's role in society, traditional family norms, premium given to virginity, poverty, and lack of productive pursuits and educational opportunities for women.

Beliefs and practices about early marriage were also strongly influenced by the Islamic and Chinese culture, and centuries of Spanish Catholic traditions. Until the present times, early marriage is both a cultural and religious practice in Muslim-dominated areas of the country. Article 16 of the Muslim Code states that the minimum marrying age is 15 for both males and females. However, the Shari'a District Court may order the solemnization of the marriage of a female who is younger than 15, but not below 12 years (Chan Robles Virtual Library 2011). Similarly, Chinese Filipino marriages are often not between two people but between two families. Age of marriage may not be fixed although it is not unusual to see a Chinese Filipino woman marry at an early age (Philippine marriage.com 2011).

While early marriage in the Philippines was sanctioned then by society, getting pregnant outside of legal bounds was a big "NO"! Getting pregnant at an early age and in the absence of legal marriage was considered a taboo. By "legal," we refer to having an official license to marry from either or both church and government, or formal rites as in the case of tribal marriages. Being predominantly Christian, Filipinos normally practice heterosexual monogamy, perceived as the only sexual relationship that is legal and moral, except in the case of Muslim Filipinos who are allowed to have more than one spouse as long as they are financially capable of supporting their many wives.

During the Spanish era and several years after, women were encouraged to maintain their "Maria Clara" image—coy, conservative, modest, and submissive (Nakpil 1999). Expectations about sexuality differed between males and females. Males were expected or even encouraged to be sexually active (Medina 2001; Cruz et al. 2002). In fact, even up to the present, men are expected to be no longer "pure" (i.e., must be sexually experienced) upon marriage as a sign of their virility and machismo. Men must do the courting and the chasing of the hearts of women. They are allowed more sexual freedom including initiating dating and having multiple partners. In the early days, it was also customary for the man to work in the woman's household and give dowry before having the approval of the family to marry her.

In contrast, social norms for women tended to be more strict and conservative. Women must not do the outright courting of men; they just have to wait patiently for their man to come and woo them. As well, women must not immediately reciprocate any courtship proposal from a man; she must pass sometime, otherwise she will be perceived as "easy." Women could only go out on dates with a chaperon or an accompanying person. The chaperon must make sure that nothing happens to the girl or woman, for sure not being taken advantage of by her date partner. The practice of having a chaperon is also associated with an important Filipino value called *hiya* (shame). The woman must adhere to strict roles in courtship and dating and behave in socially approved ways; otherwise, these actions will bring *kahihiyan* (shameful condition) not only to the woman herself but also to her whole family. As church and society frown upon premarital sex, women (especially young girls) are expected to preserve their virginity and give in only to their partners within legal limits. Once

an unmarried woman gets pregnant, she as well as her whole family is ostracized and stigmatized, and the parents either force the man to marry their daughter, sometimes at the point of a gun, or put their daughter in exile, away from the piercing eyes of neighbors, friends, and relatives. Abortion was illegal until the present as it is regarded as a criminal offense and is considered by the Church as a mortal sin.

Social norms on sex, early marriage, and early pregnancy became somewhat liberalized during the American period when girls (as well as boys) were provided with free elementary education, albeit limited access to high school and college education. As a consequence, women's social standing improved, until the late 1950s when Filipino women achieved equal rights. In the 1970s, the "Maria Clara" image gradually changed with the influx of liberal ideas from the West and heightened by the feminist orientation and the women's liberation movement (POPCOM 2003). More and more Philippine society became egalitarian in its attitudes toward men and women (Bouis et al. 1998). Filipino women grew to be more liberated and assertive of their rights as their educational and economic opportunities improved. Young women (and men) in particular developed more self-confidence and aggressiveness as the good old ways of growing up were replaced by modern ideas and practices propelled by the advancement of technology, and the wasting away of traditional family structures and functions. While the traditional Filipino woman was expected to stay home, take care of the children, do domestic tasks, and support her man in all his endeavors, many Filipino women today enjoy their freedom, become educated, and hold key positions and leadership in universities, government, businesses, and in other institutions.

With these historical developments, today's Filipino adolescents can be characterized as increasingly becoming more "free thinkers" when it comes to sex and lifestyles (Ventura and Cabigon 2004; Kabamalan 2003). Although the old conservative attitudes and ways still prevail in general, in rural areas, these values are slowly eroding as many rural young women spend their teen years in the cities because of their schooling. One teacher commented that, "young people today are of a different character unlike our days" (personal communications). To make this point, although the 1994 Young Adult Fertility and Sexuality Survey (YAFS 2) showed that 80 % of Filipino youth did not endorse premarital sex, in the 2002 survey (YAFS 3), 23 % of the 19,798 Filipino adolescents sampled nationwide reported that they had engaged in premarital sex. The same study also noted that the degree of tolerance for women engaging in premarital sex has increased from 13 % in the YAFS 2–22 % in YAFS3 and that 11 % of females and 33 % of males agreed that it is alright for unmarried people to live together even if they have no plans to marry.

Group dating is a common way for Filipino youth to initiate acquaintances with the opposite sex (Medina 2001). Usually, adolescents begin to go out on group dates at ages 13–16 and then go on single dates a couple of years later (Cruz et al. 2002). On average, boys and girls have their first sexual encounter at the age of 18 and 18.3, respectively (Raymundo and Cruz 2004). More recent researches, however, showed that romantic involvement and sexual debut have become increasingly earlier. A study among 150 high school students aged 14–17 in Quezon City in 2010 reveal that early dating was common among more than half of the respondents, while 64 % engaged in romantic activities with 5.3 % having actually engaged in penetrative sex (Reotutar 2010). Moreover, Ramiro (2005) in her study on adolescent intimate relationships found that the average age for onset of romantic involvement is 15.5 years where 16.8 % of her respondents had already engaged in premarital sex (males: 19.8 %; females: 13.9 %). Sometimes, girls are coerced to have sex with their partners and risk pregnancy (Claudio 2002; Nancho 2004; CRR 2010). Verbal pressure in the form of *paglalambing* (sweet talking) and *pambobola* (verbal deception) are usually used to force these girls to engage in sex although physical assault is not uncommon (Ramiro 2005).

A focus group discussion (FGD) conducted with groups of college students further confirmed that the present crop of young women are more sexually aggressive than women of the past decades (Ramiro 2010). Today's girls are bolder about expressing their love for a boy, invite a boy on a date, and even entice them to have sex. Although, the degree of brashness varies from one girl to another. While some young woman do the flirting in subtle gestural and/or verbal ways, others may have the courage to tell the boy or man that they want to have sex with him. A common cliché', as revealed in the FGD, is "I am safe (i.e., safe from being pregnant) today. Can you come to my house tonight?" As many young men and women live far from home and away from the guidance and control of their parents (because of their schooling in the city), they reside alone or with friends in dormitories and condominium units where they are free to engage in all sorts of vices and activities (Laguna 2003).

Casual sex is also fast becoming the norm in physical intimacy. Casual sex is a type of sexual relationship between new acquaintances or mere friends. Casual sex means that if two people feel like having sex, then they just do it without emotional strings attached and with no money involved. In the gay world, they call it "sex eyeball," although this phenomenon is now becoming popular in heterosexual relationships. One type of casual sex is the so-called "clan". The "clan" is exemplified in the following case study:

> Chona (not real name) is a young lady aged 15 years. As practiced by many girls of her age group, Chona is fond of texting, where she meets new friends. There were not just tens but hundreds of them whom she met through this system. Through snowballing, social networks grow large and many virtual friendships develop. One day, these young boys and girls decide to see each other in person in a meeting they call "eyeballing." A facilitator sets the place and time to meet. However, the meeting does not end in the usual dining, storytelling, dancing, and the like but in sexual activities with a partner or with several partners they just met during that "eyeball" meeting.
>
> Chona was a victim of this system. Just recently, she gave birth to a baby girl. She does not know who the biological father is. Even if she thought she knew, she cannot compel the boy to provide support because part of the contract of the "clan" is for the man not to have any responsibility in case the woman gets pregnant.

Casual sex has been recently found to be practiced by young men and women working in call centers (UPPI 2010). Although more common among men, one of nine female call center workers surveyed said they had casual sex experience. As in the case of Chona, most casual sexual encounters are unprotected (PNAC 2005).

A variant of casual sex is another system called Fucking (F'K) Buddies or Fubu. The Fubu phenomenon involves non-romantic sexual intercourse done regularly within a particular group. In this style, group mates exchange sexual partners, but the activity is limited only to members of their own group to ensure the "cleanness" of the partner, as all members know each other relatively well. Each member of the group is expected to be loyal to the group alone when it comes to sexual matters. However, an interview with some male college students revealed a trend. They said that "many men engage in Fubu and casual sex. However, seldom would they consider marrying a woman known to be engaging in casual sex because they would still prefer a virgin or someone who had sex with them and only them." When asked if in case the woman in the Fubu got pregnant, would they ever think of marrying the woman? The unanimous answer was "…a difficult decision because I am not sure if the child is mine." One of them however added, "if I really love the woman, why not?" Therefore, sexual matters in the Philippines have a gender-based component. The double standard of morality known centuries ago still persists in modern Philippines. In the end, it is the woman who suffers physically, emotionally, socially, and economically. But then, as the saying goes, "it takes two to tango."

Perceptions about marriage also changed. Under the Family Code of the Philippines, the legal age of marriage is 18 years for both women and men. Individuals aged 18–21 need written parental consent and must undergo marriage counseling, while individuals aged 21–25 need parental advice before getting married. Personal communications with female students who are and have been pregnant revealed that not everyone would consider marriage despite having a child with the man. An example is Jenny:

> Jenny (not real name) got pregnant by her boyfriend of five months when she was 18 years old, and she was in her third year in college. She had a hard time deciding whether to give birth to the child or have an abortion. Finally, however, she decided to have the child. Jenny was lucky because she had a supportive boyfriend. Even the parents of her boyfriend wanted her to be their daughter-in-law. Jenny also had the understanding and support of her parents and older siblings, although she admitted that her parents felt devastated when they learned that she was pregnant. They wanted her to be a doctor someday.
>
> Even before she gave birth, the boyfriend already offered her, marriage. Despite the pleadings of her parents who wanted her condition to be more stable, she refused to accept her boyfriend's offer of marriage. This went on until she gave birth and even now that her child is almost a year old. Her reason for not getting married was that she felt she, "…was not yet ready for a long-term commitment," "marriage with the man who fathered my child can wait"; and "that she first wanted to fulfill her parents' dream of her becoming a doctor."

"Other students who were in the same situation as Jenny claimed that they could do more in their lives without restrictions from a man," or the man was not yet emotionally and/or financially stable. Others girls claimed that they did not love the father of their child and thought that they might be able to find a better man in the future. Another interview with a 17-year-old girl who was out of school yielded similar results—no marriage until the man is financially ready and emotionally prepared for his responsibilities. As a consequence, many of these women remain as single parents, or marry at a later age, normally in their late 20s or early 30s.

Epidemiology of Adolescent Pregnancy in the Philippines

Studies in the local setting provide varied information on the prevalence of adolescent pregnancy in the Philippines, depending on source and time of survey as well as age of respondents. In 1982, the first Youth and Adult Fertility Survey (YAFS1) revealed that 87.2 % of sexually active young females became pregnant. This proportion increased to 88.9 % in 1994 during the YAFS 2 study. YAF2 also showed that the average age of having a first child was 19 years of age and that by the age of 20, almost 22 % had given birth to their first child. The succeeding YAFS 3 survey in 2002 further reported that one-third of women aged 15–24 had already given birth to their first child before reaching their twenty-first birthday (Balk and Raymundo 1999).

Figure 3 shows the percentage of women aged 15–19 who already have children or are currently pregnant, according to the National Demographic and Health Survey (NDHS 2008). From 1992 to 1996, 6.5 % of women aged 15–19 of age had a child or were currently pregnant. This increased to 8 % in 2004 and 9.9 % in 2008. It was found that about 10 % of girls were already mothers at age 18; 25 % at age 20; and at age 24, 50 % had given birth to their first child. Pregnancy was unplanned in 92 % of the cases. In 2006, a study by the UP Population Institute and Guttmacher Institute showed that 6 out of 10 Filipino women reported having an unintended pregnancy.

Among the age groups, the highest frequency of those who have begun childbearing was found among those aged 19. Rural adolescents were more likely to experience early pregnancy compared to those from the urban areas. Similarly, young women with no or only elementary schooling and those in the poorer wealth quintiles are more likely to have started childbearing earlier than better educated and wealthier young women. Therefore, out-of-school youth faces a higher risk of teenage pregnancy (Republic of the

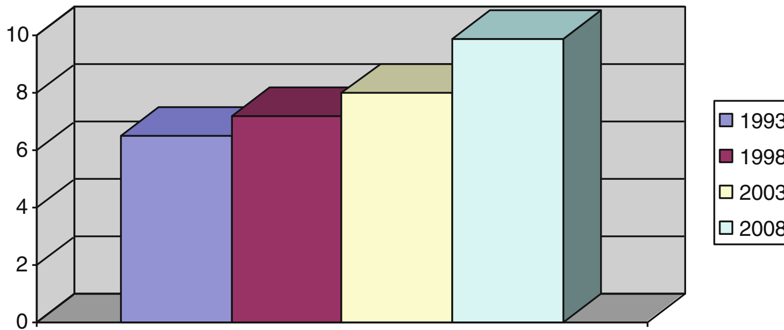

Fig. 3 Teenage mothers (percentage of women aged 15–19 who had children or are currently pregnant) in the Philippines (*Source* National Demographic and Health Surveys by Macro International)

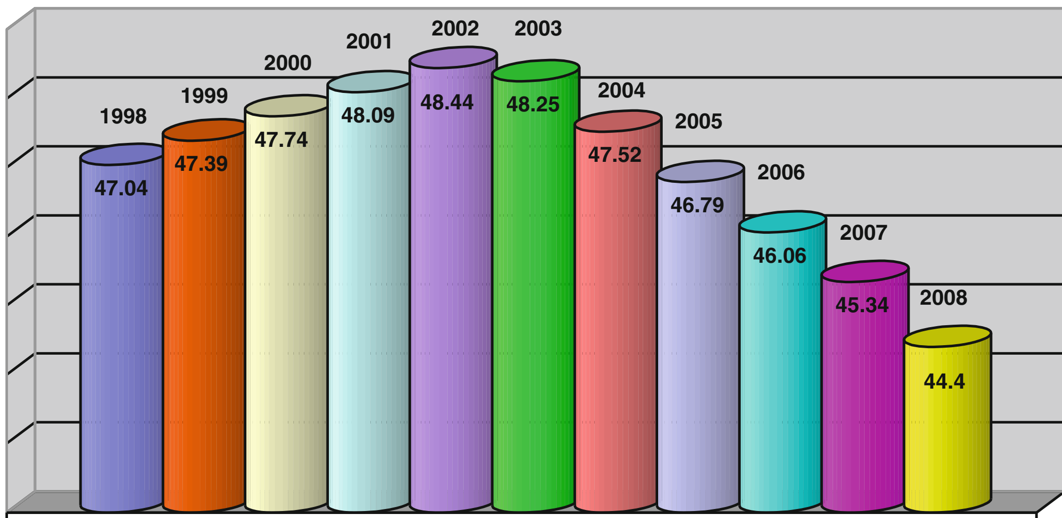

Fig. 4 Adolescent fertility rate (births per 1,000 women aged 15–19), Philippines (1998–2008) (*Source* United Nations Population Division, World Population Prospects)

Philippines, Commission on Population 2003; Balk and Raymundo 1999). Otherwise, the rate of teen pregnancy ranged from 18 % in Metro Manila to 37 % in southern Luzon (NDHS 2008).

Figure 4 shows the trends in adolescent fertility rates (AFR) from 1998 to 2008, based on data from the UN Population Division. Adolescent Fertility Rate is the number of births per 1,000 women aged 15–19. The data show a decreasing prevalence with an AFR of 47.04 in 1998, reaching its peak in 2002 at 48.44, to an AFR of 44.4 in 2008. However, a more recent UNICEF (2011) data show an AFR rate of 53 births per 1,000 women aged 15–19 in 2009.

Looking at all the official data, teenage pregnancy seems rather moderate in the Philippines. In 2008, only about 4–5 per 100 females aged 15–19 have been reported to have begun childbearing, although by age 24, one-third have already borne 2–3 children. However, this information may be inaccurate. With the current drift in sexual activities among the young, it can be surmised that many of the cases go unreported, especially among adolescents and young women who opted to abort their pregnancy.

Consequences of Adolescent Pregnancy

Adolescent pregnancy has become an increasingly alarming issue in the Philippines. Maternal deaths account for 14 % of all deaths among women, and because young girls' bodies are not ready for pregnancy and childbirth, 75 % of these maternal deaths happen to girls aged 14–19. Complications due to early pregnancy were found to be a major cause of death among Filipino girls. The death rate from pregnancy complications is much higher among girls who gave birth under the age of 15. Since these young girls are more likely to have inadequate prenatal care, they suffer from under nutrition and premature or prolonged labor. About a fifth of the overall fetal deaths were also attributed to teenage pregnancy (CRR 2010).

Aside from these complications, many pregnancies among adolescents are unintended, which result in induced abortion, often under unsafe conditions. One in every seven pregnancies is terminated by abortion. An estimated 800 women per year die of unsafe abortion (Singh et al. 2006). Among Filipino adolescents, about 319,000 cases were reported in 2000 and could approximately reach 400,000 by 2015 (Varga and Zosa-Feranil 2003). The increase in the number of unsafe teenage abortion cases is highest in Metro Manila and the Visayas.

An unsafe abortion is "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (WHO 1992). In the Philippines, the common methods used are the following: painful massages by traditional midwives or *hilots,* insertion of catheters, and medically unsupervised use of misoprostol (Cytotec) through oral ingestion and vaginal insertion. Cytotec is a regulated drug but can be purchased illegally outside drug stores.

Studies show that Filipino adolescents opt to terminate their pregnancies because they want to (1) avoid conflicts with school, (2) avoid problems with their partner, (3) or because they consider themselves too young to have a baby (Singh et al. 2006). Young pregnant women also resort to abortion because they are not ready for the responsibilities of parenting, they do not want their parents to know about their situation, or because their male partner abandons them upon learning of the pregnancy (Tripon 2001). A case in point is the story of Sandra (not real name).

> Sandra had her first pregnancy when she was 16 years old, her second pregnancy at age 17, and now her third at 19 years of age. The first two pregnancies were aborted, but with the third one, she intends to keep the baby. When asked why she decided to abort her first two pregnancies, she said that with the first, she was too young and was still in high school. She said that she was also scared about how her parents would react, especially her father whom she described as "strict and punitive." With her second pregnancy, her boyfriend left her upon learning that she was pregnant, and she felt no other recourse but to have an abortion. With her third pregnancy, Sandra now feels guilty for her "sins to God" and wants to rectify her previous decisions and actions. She also thinks that God has given her another chance to have a baby, though out of wedlock, and she fears that she might not have this opportunity again. It is good that her current boyfriend supports her all the way.

In 2008 alone, about 90,000 women sought treatment for complications from an abortion and 1,000 of these girls and women died (CRR 2010). Many of these adolescents die without their parents even knowing about their children's pregnancy. Here is the story of Nina (not real name).

> Ramon and Nina were 18 years old when the latter got pregnant. It was an unintended pregnancy as they were still in school. While Ramon was ready to face his responsibilities to the child and mother, Nina was hesitant to continue with her pregnancy. Often, they quarreled about this, but it seemed that no one or nothing could force Nina to reverse her decision. She wanted to abort the child. Without Ramon's knowledge, Nina went to an abortionist, and the procedure was successful. However, she encountered complications. Her friends in the dormitory where she lived brought her to the hospital for treatment. A week later, Nina died of excessive bleeding and infection. The parents only learned about the pregnancy of their only child upon her death.

In the Philippines, adolescent pregnancy also brings with it numerous threats to physical and psychological health. They include the following:

- Being twice as likely to experience cervical lacerations during abortion,
- Higher risk for post-abortion infections such as pelvic inflammatory disease and inflammation of the lining of the uterus (endometritis), which may be caused either by STD's or by microorganisms found in the surgical instruments used in abortive procedures,
- Lowered self-esteem,
- Poor relationships with friends and family,
- Moral confusion, as these adolescents often perceive themselves as having committed a crime, and are living in fear and shame. The experience leads to self-censorship, isolation, and the invisibility of their experiences (Raymundo 2001),
- Fears of consulting a doctor for fear of disapproval, being reported to authorities, moral condemnation by healthcare providers, and being treated roughly during medical consultations (De Guzman 2002).

Having her first child during adolescence makes a woman more likely to have more children during her life time. Teen mothers are also found to have decreased educational attainment or are about two years behind their age group in completing their education (Pineda 2010).

Medical studies likewise show that 10 % of babies born to young mothers are malnourished. One of every five babies of teenage mothers dies of various causes (Ramos 2008).

Factors Related to Adolescent Pregnancy

There are several key factors that influence the occurrence of adolescent pregnancy in the Philippines. They include the following:

- Biological factors such as age at menarche,
- Religion.
- Globalization, media, and the advent of modern technology.
- Peer group and other models.
- Inadequate information.
- Parental influence.
- Effects of economic migration.
- General attitudes toward sex and sexuality.

Age at Menarche

The association between age at menarche, sexual intercourse, and pregnancy is well known in the literature (e.g., Udry 1979; Talashek et al. 2000). Local studies show that age at menarche is significantly associated with early sexual debut and if unprotected with early pregnancy (Obong 2006; WIA 2008). Recent findings point out that today's Filipino girls experience menarche at a younger age compared to girls some decades ago. The National Demographic and Health Survey (2008) indicated that menarche occurs at 13.2 years of age on average, although one in ten Filipino girls experience her first menstruation before age 12. In a study done in the mid-1980s, 82.9 % had begun menstruating by age 15 (Zablan 1988). Even among indigenous peoples, Goodman and associates (1985) found that Agta women had their first menstruation at an average age of 17 years.

Influence of Religion

Religious institutions influence adolescents' sexual and reproductive health in a variety of ways:

- Provision of sex education in schools.
- Formulation and prioritization of government policies.
- Establishment of reproductive health services for the youth.
- Impact on school attendance of the affected youth.
- General attitudes toward issues concerning adolescent sexual and reproductive health.

Religious dogma exerts a major influence on sex education in primary and secondary schools. The Roman Catholic Church, for instance, has a major voice in the way sex, sexuality, and reproductive health are taught or whether it should be taught at all. For one, the church believes that exposure to sex education may only make children and adolescents more curious

about the issue, leading to actual experimentation and sexual promiscuity. This traditional opposition of the church to sexuality and reproductive health education in schools has affected the scope and quality of information made available to young people.

Especially during the post-Marcos era, the Roman Catholic Church had influenced government policies, particularly on the types of legislation that should receive attention and be passed by Congress. As of this writing, there is a current debate between Church and government on whether or not to pass the Reproductive Health Bill. This bill aims to "guarantee universal access to medically-safe, legal, affordable, effective and quality reproductive health care services, methods, devices, supplies and relevant information and education thereon even as it prioritizes the needs of women and children, among other underprivileged sectors" (The Youth Population, 15th Congress Reproductive Health Bill). However, this bill is being strongly opposed by the Catholic Church on grounds of referring to some contraceptives as abortifacients and referring to contraception itself as evading the natural consequences of the sexual act. Because it condemns the use of modern contraceptives, the major consequence is the inavailability or inaccessibility of these pregnancy-protective products and services to both adult and adolescent women.

Since premarital sex is considered a sin and sex outside marriage is prohibited by the Church, pregnancy among unmarried adolescents is looked down upon. The stigma created among the population inhibits pregnant adolescents to be open about their situation. Often, adolescents seek ways to hide their condition either by straying away from home or by aborting their pregnancy.

Furthermore, in Catholic schools, girls who are found pregnant out of wedlock are either expelled or asked to take a leave of absence from school. In many cases, these girls are unable to finish their education either because the previous school no longer accepts them, they need to earn a living, or they become preoccupied with their motherhood. In 2009, however, the Magna Carta of Women (R.A. 9710) was passed by Congress that bans all forms of discrimination against women including a school's refusal to grant enrollment or work to unmarried, pregnant students and teachers. Section 13 on "Equal Access and Elimination of Discrimination in Education, Scholarships, and Training" states "Expulsion and non-readmission of women faculty due to pregnancy outside of marriage shall be outlawed. No primary or secondary school shall refuse admission to a female student solely on account of her having contracted pregnancy outside of marriage during her term in school."

Influence of Culture

Filipino adolescents' sexual and reproductive health is shaped by a combination of other social and cultural factors. These include a tightly knit, extended family support system with some clannish inclinations and dependence upon parents and older siblings.

The family is the most significant and influential social system in the Filipino culture. In the majority of the cases, all individual decisions include a consideration of the family's integrity, dignity, and welfare. It is not therefore surprising that any individual action that challenges family stability such as a child getting pregnant outside of marriage is seen as a "slap" on the family's face.

The Filipino culture also encourages dependence within the family. Even as adults and despite having their own families, Filipinos experience an extended period of emotional and economic dependence on parents and older family members. It is not uncommon to see people in their 30s or 40s still living with and, to a certain extent, financially dependent on their parents or siblings. While such dependence makes the family more solid and cohesive, this mode of socialization does not prepare young people to make appropriate decisions in life including their sexual and reproductive choices.

Globalization, Media, and Advent of Modern Technology

Globalization, media, Internet, and new communication technologies—all of these influence adolescent norms and behavior—including their sexual attitudes and practices. One of the newest trends is "sexting" (Wagner 2008). Using mobile phones, teens engage in "sexting" by sending and receiving enticing and flirtatious messages. Simple adolescent flirting via texting may seem harmless, but in reality, frequent engagement is such virtual bantering or teasing could change one's moral and social values. Over time, these text messages may also become dangerous as it may lead to invitations for actual sexual encounters. The same can be said of cybersex. A form of sex trafficking, sex through the Internet may be initially undamaging but can be risky in the long run, as it may lead to physical sex meetings. Through the Internet, liberal ideas about sex and pregnancy can be also obtained.

Media in general has become an important source of information by the youth. According to Ogena (2001), media has been the "youth's touchstone and source of authority regarding what is right and wrong and what is important." Two decades ago, the Filipino youth spent at least three hours daily watching the television; today, teenagers do not only spend their time watching TV, but they spend their time texting and on the Internet either surfing, blogging, or simply chatting with friends and establishing new social networks.

Peer Group and Other Models

The peer group is perhaps the greatest influence among the youth, not only for positive values such as loyalty, trust, commitment, camaraderie, cooperation, and the drive for excellence, but also for the whole gamut of adolescent behavior, attitude, manner of speech, appearance, interests, and activities including harmful habits such as smoking, taking prohibited drugs, drinking alcoholic beverages, and having sex-related experiences (Lanuza 2000). With many parents working for a living and parents working abroad, parental absenteeism has led the youth to turn to their peers not just for friendship and companionship but for nurturing, intimacy, security, and guidance as well (Gastardo-Conaco et al. 2003).

Modeling their favorite celebrities is also another factor of influence among the Filipino youth. Although there is no sufficient hard evidence to show the relationship, it has been observed that the increasing number of young pregnant actresses may have a trending effect on ordinary young women. In the FGD conducted in 2010 (Ramiro 2010), one participant who has experienced pregnancy in her earlier teens admitted that she felt less guilty being pregnant because "my favorite actress underwent the same experience as mine."

Inadequate Information

As evidenced by the increasing incidence of teen pregnancy, Filipino adolescents, in general, lack information about protected or safe sex. It appears that both home and school were amiss with their obligation to educate the youth with regard to sex and reproductive health. Previous studies have shown that parents are hesitant to discuss such matters openly with their children due to embarrassment, shame, or fear that such knowledge may lead to sexual promiscuity (Varga and Zosa-Feranil 2003). Even teachers were found to be ineffective because they tend to teach sexual education as objectively, cautiously, and as formally as possible in order not to "pollute" young people's minds. Many teachers believe that their students are too young to hear about sex education. If ever teachers do allow questions from their students, they are too embarrassed to answer questions, or were insecure about truthfully answering the questions, which made them unable to facilitate any deeper discussion and understanding. One teacher told this story:

> I teach developmental psychology in college. My students are mostly in their second year and aged 17 to 18. Whenever I teach the section on prenatal development, I am always in the quandary of whether to include a discussion on the use of both natural and artificial family planning methods. I wanted to teach them about protected and safe sex because I know some of them may need it, but at the same time, I fear that the lecture may give them ideas about sex, leads them to early sexual debut and eventually become sexually promiscuous.

Since sexuality education is being challenged by conservative forces in the Philippines, young people are getting all source of information from the Internet, particularly from watching pornographic materials, from other forms of media, and from their peers. These kinds of information sources contribute largely to the misinformation and misconceptions on sexual matters among adolescents and young adults.

Effects of Economic Migration

There are about 11 million Filipino workers (OFW) working in countries other than the Philippines (NSO 2009). About 53 % are women. Young Filipino women are contracted into employment as domestic workers, factory workers, or dancers. There were some news reports that these migrant jobs for young women are sometimes veiled fronts for prostitution. These have evident ramifications for young women's sexual and reproductive health status.

The current economic situation in the country has led to increasing reliance on foreign currency earned through migrant labor. However, a study done in 2009 shows that despite the economic benefits, OFW children have difficulty adjusting to the new family environment (Ramiro 2009). Having an incomplete family, having no one to depend on in times of need, feelings of envy with classmates/friends with intact families, and feelings of emptiness also led these children to seek emotional security from their peers. Therefore, having unsupervised homes and absentee parents make adolescents more vulnerable to negative influences outside the home. Romeo's case is an example:

> Romeo's mother has been working as an accountant in the Middle East for 18 years. His father, who is an engineer, soon followed the mother, so both parents are working abroad. Romeo is the eldest of three children and as the eldest child he takes care of all the needs of his younger siblings. An aunt, who stays in the same compound as Romeo's family, supervises the three children.
>
> In the beginning, Romeo felt the emptiness of having no parents to guide them. Sometimes, he does not understand why both of his parents have to work abroad, leaving them—their children—on their own. Later, however, he learned to enjoy his freedom. With his friends, he started to engage in all sorts of "exciting" adventures that include mountain climbing, computer gaming, smoking, drinking alcohol, and having sex. At 30 years of age, Romeo remained single but is now a father to two boys aged 9 and 5. The two boys stay with their respective mothers, and once in a while, Romeo visits them.

An association was also seen between having a detached relationship between mother and daughter, and teenage pregnancy (Tripon 2001).

Parental Influence

Studies have indicated that the extent of family connectedness and parental permissiveness, as well as the quality of parent–child communication are significant predictors of all types of risky sexual activities among adolescents (Marquez 2004). Parents are considered to be the ideal sources of information when in comes to matters regarding sex and sexuality. However, most of the discussions between parents and children revolve around gender roles and the "don'ts" of sexual activity (Tan et al. 2001). A discussion of sex is often masked with secrecy, guilt, and discomfort, and often, the home is surrounded with an "imposed silence" (Ujano-Batangan 2003). As a result, adolescents receive less information or are oftentimes misinformed and do not regard their parents as confidantes with regard to sexual matters (Raymundo and Laguna 2001).

Local studies also indicated that adolescents who perceived their parents as liberal in their attitudes were more likely to engage in all sorts of vices that include smoking, drinking and drug

use, as well as premarital sex (Cruz et al. 2001). Furthermore, a study about adverse childhood experiences and health risk behaviors among adults in Metro Manila revealed that psychological and sexual abuse during childhood are strongly associated with early and unintended pregnancy (Ramiro et al. 2010). Although not common, transactional sex may also be encouraged by parents due to poverty (USAID 2003).

General Attitudes Toward Sex and Sexuality

The previous sections show that indeed adolescent sexual norms are affected by a variety of factors. Despite the strictness of the law on abortion and the rules of the church on premarital sex, however, early sexual debut, teen pregnancy, and abortion are still on the rise. Ironically, many adolescents still find talking about sex and sexual relationships embarrassing and uncomfortable, but appear thrilled to experiment with it (Pineda 2010; CRR 2010).

Generally, as the population becomes younger, adolescents become less traditional in their views on sexuality issues (e.g., homosexuality, premarital sex, virginity, unmarried mothers, living in cohabitation, marriage, and physical intimacies). Younger generations have more liberal views compared to older generations (De Irala et al. (2009).

Policies and Programs Related to Adolescent Pregnancy in the Philippines

Amidst the alarming adolescent situation in the country, what has been done so far to help young people in need? All laws and policies on adolescent development follow the basic provisions of the 1987 Philippine Constitution. Under the Philippine Constitution, it is the right and duty of parents as well as the State to ensure the welfare of and instill proper moral development of children. The constitution is silent when it comes to sexual and reproductive rights, especially of adolescents, although certain provisions are somewhat relevant. For instance, the 1987 Philippine Constitution states that the State "shall equally protect the life of the mother and the life of the unborn from conception." Unborn babies are regarded as human beings; thus, according to the Revised Penal Code of the Philippines, enacted in 1930, abortion is a criminal offense. As stipulated in Articles 256, 258, and 259, a woman who undergoes abortion, as well as any person who assists in the procedure, be they the parents, doctor, nurse, midwife, or local *hilots*, shall be given a penalty ranging from one month to 20 years of imprisonment.

The Philippines is signatory to numerous international agreements related to women in general, with some implications for teenage pregnancy. These include the International Conference on Population and Development (ICPD) Programme of Action signed in Cairo, Egypt, in 1994 and the Beijing Declaration and Platform for Action, developed during the Fourth World Conference on Women in Beijing China in September 1995. Some of the other international agreements entered into by the Philippine government are the Fourth World Summit on Social Development (WSSD), World Conference on Human Rights Programme of Action, and the Convention on the Elimination of all forms of Discrimination Against women (CEDAW).

In 2009, the Magna Carta for Women (RA 9710) was passed into law by Philippine Congress. This law seeks to eliminate discrimination against women by recognizing, protecting, fulfilling, and promoting the rights of Filipino women. These rights include the following:

- Protection from all forms of violence, including those committed by the State.
- Participation and representation.
- Equal treatment before the law.
- Equal access and elimination of discrimination against women in education, scholarships, and training.
- Comprehensive health services and health information and education.
- Equal rights in all matters related to marriage and family relations.

To implement these agreements and laws, several policies and programs have been instituted to protect the sexual and reproductive health rights of Filipino women, including the female adolescent. Under Administrative Order No. 34-A series 2000, the Department of Health issued the *Adolescent and Youth Health Policy,* which regards young people, aged 10–24, as a priority group who should be provided with quality comprehensive health care and services. As part of its implementing guidelines, the Adolescent and Youth Health Unit under the Program for Child Health Cluster for Family Health was established. In particular, the unit seeks to reduce the incidence of childbearing among girls aged 15–19 by giving access to contraceptive service centers, promoting health seeking behavior, increasing the proportion of healthcare facilities, providing services for adolescents, and integrating gender sensitivity training and reproductive health in secondary school curriculum (CRR 2010). Modular training seminars are given to parents and guardians to enhance their skills in educating and guiding their adolescent children to be more responsible with their sexual activities and reproductive health. At the national level, the Medium-Term Strategic Plan for Adolescent Health and Development was formulated to ensure the provision of necessary information and services for adolescents and young adults. The Adolescent Health Unit is implemented in collaboration with other agencies like the Department of Education and Department of Social Welfare and Development. The local government units have the primary responsibility for its implementation of these programs.

In 2008, the DOH also formulated a national integrated Maternal, Neonatal and Child Health and Nutrition Strategy to be implemented by local health care systems. Under the strategy, post-abortion care is a part of Basic Emergency Obstetric and Neonatal Care.

Another relevant program is the National Population Education Program of the Department of Education. The National Population Education Program tackles four basic components: (1) reproductive rights and health, (2) family life and responsible parenthood, (3) gender and development, and (4) population resources and environment. In addition, the Population Awareness and Sex Education (PASE), authorized by Administrative Order No. 950, is a population and sexuality education program specifically targeting to out-of-school youth. The program is administered by the Bureau of Youth Welfare of the Department of Social Welfare.

The Population Commission (POPCOM) has the Adolescent Fertility Program, which addresses the fertility and sexuality-related needs of adolescents, with the main aim of reducing incidence of early marriage and teenage pregnancy.

Non-government organizations have also their share of programmatic initiatives to help young people in need. The guidelines of the Family Planning Association of the Philippines (FPOP) stipulate that all individuals of reproductive age (specified as aged 15–44) have the right to information, counseling, physical examinations, and contraceptive supplies, specifically condoms or contraceptive pills.

Indeed, these initiatives have truly good intentions, but have they been successful in improving the quality of life of Filipino adolescents? As the statistics show, teenage pregnancy and the number of maternal and infant deaths continue unabated. Political bickerings and religious interference have greatly impeded the smoother management of the adolescent reproductive health programs. As mentioned, the existing attitudes toward premarital sex and the stigma imposed on teenagers who get pregnant and those who subject themselves to induced abortion affected the quality of health and social services given to these young women.

As if lacking in law, another bill with the same goals as the others, called the Philippine Reproductive Health Bill (RH Bill), was formulated in 2009. The RH Bill, currently renamed as Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354) has passed Congress and was already signed into law by the President of the Philippines in December 2012. However, in March 2013, the Supreme Court halted its implementation indefinitely due to petitions challenging the law's constitutionality.

Among the controversial provisions are the following: (1) offering sex education in schools where gender and human sexuality will be discussed in high school, while basic sex education will be taught in the grade school and (2) promotion of modern contraceptives and making it accessible even among the young.

Summary and Conclusions

The Philippines has a young population. While early marriage was sanctioned by society in the olden days, getting pregnant at an early age and outside marriage bounds was a taboo. Moreover, even with the increasing liberalization of ideas on sexuality brought about by a heightened feminist orientation and advancement of technology among others, these conservative attitudes still prevail, resulting in a confused state of psychological and moral values among the young. In 2008, about 4–5 per 100 women aged 15–19 have been reported to have begun childbearing. Official prevalence rates may be low, but with the current adolescent lifestyles, it can be surmised that many of the cases go unreported.

The Philippines is signatory to numerous international agreements on women's health, rights, and empowerment. The country is not lacking in laws nor policies and programs that could protect and empower women of all ages. Political bickering, religious interference, and the population's ambivalent attitudes toward sex and reproductive health have negatively affected the effective implementation of adolescent reproductive health programs in the Philippines.

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Adolescent Pregnancy in Portugal

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Keywords
Portugal: Abortion · Adolescent childbearing · Adolescent fertility rates · Contraception · Medical complications · Prevention programs · Psychosocial complications · Sexual activity · Sexual education · Prenatal depression

Introduction

In recent decades, adolescent pregnancy has become an important health issue in Portugal. Its incidence has significantly declined in the past 30 years. In 2010, there were 14.7 births per 1,000 girls aged 15–19, leading to 3,660 births. Though this rate continues to gradually decrease, the truth is it has one of the highest incidences of pregnancy in this age group in Western Europe (Statistics Portugal 2011a, b).

Portugal has been a democratic country since 1974. Until then, adolescent pregnancy was not an issue since most women were married in late adolescence/early adulthood. Heavily influenced by a long-standing catholic culture, social control strongly discouraged premarital sex. If conception did occur, this was usually followed by a clandestine abortion or an early marriage. As the economy developed, education and training of young people was gradually extended to girls and young women. Alongside, parental authority and family control progressively declined. A gradual shift occurred away from extended family structures and toward a nuclear families structure.

In 1967, a Portuguese nongovernmental organization called "Association for the Planning of Family" was established and had a crucial role struggling against political and religious adversities. Even so, it was only in 1976 that a law was passed allowing family planning consultations in health centers integrated in maternal infant health services. Nevertheless, the development of these family counseling services in health centers was slow, and only by the end of the 1970s did the majority of health centers provide this kind of service. In 1984, another important law was approved, in which the Portuguese government guaranteed the right of all to sexual education. The State also assumed the responsibility for promoting free access to family planning consultations and birth control methods. However, we had to wait until 1985 for the application of

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the 1984 law to take effect. Those resistant to the law were concerned about the access of adolescents to the Centers of Attendance, a program that was created especially for adolescents. Another major change in national health politics, with great influence on maternal health, occurred in 1984: abortion, that until then was banned in any circumstances, was permitted under restrictions. Voluntary abortion (until 10 weeks of pregnancy) was not legalized until in 2007. (Diário da República 2007).

So, important social changes happened in Portugal over the past 30 years. In the first 10 years of the twenty-first century, as a consequence of increased schooling and postponing marriage until their late 20s, women became pregnant later, and birth rates decreased. In the same period, adolescent pregnancy also steadily decreased. In 2010, overall birth rates were 9.5 per 1,000 women, the mean age at marriage for women was 29.2, and the mean age of first live birth was 28.9, and the number of children per women was 1.4 (Statistics Portugal 2012).

Following the country's social and health development, adolescent pregnancy has become a source of concern, affecting not only the teenager's and their offspring's physical, psychological, and social well-being but also their families and society. Given this reality, programs to prevent adolescent pregnancy have been developed and implemented, leading to where the country currently stands on this matter (Alves Diniz et al. 2007; Orientação da Direcção Geral de Saúde 2010).

Sexual Activity and Contraception

Psychosexual development occurs much earlier in life, but it is in adolescence that definitive sexual organization is initiated from the somatic, psychological, and sociological points of view—and when acquiring a sexual identity becomes most important (Bekaert 2005). Adolescents seek to construct their identity integrating feelings, needs, and desires. Therefore, it is a time when many individuals initiate sexual activity (United Nations Children's Fund 2002). Unfortunately, this is not always accompanied by a consistent sexual education or knowledge concerning physiology or the biological aspects of sex and reproduction. Thereby, many individuals do not use contraceptive measures (United Nations Population Fund 2003; Ferreira et al. 2006) or misuse or inconsistent use of condoms, which increase not only the risk of unwanted pregnancy but also the risk of sexually transmitted infections (STI). Various studies have shown that both female and male adolescents are currently initiating sexual relationships earlier and that sexual activity in adolescence is often associated with other risk behaviors such as alcohol consumption, smoking, and other drug use (WHO 2004; Vesely et al. 2004). Portugal is no exception.

Recent studies show that currently 26–52 % of Portuguese high school students already initiated sexual activity. The average age at first intercourse is 15.6 (Fronteira et al. 2009; Santos Ferreira and Reis Torgal 2011; Rodrigues et al. 2007). Girls and boys differ in the age they first experience sexual relationships, being girls slightly older (Santos Ferreira and Reis Torgal 2011). According to what is expected in relation to autonomy, search for sexual identity, and greater freedom, the proportion of older adolescents who already had sexual intercourse is significantly higher than that of younger adolescents (Fronteira et al. 2009; Santos Ferreira and Reis Torgal 2011; Rodrigues et al. 2007). However, 16–20 % of girls and 26–30 % of boys report having had intercourse before the age of 15 (Santos Ferreira and Reis Torgal 2011; Currie et al. 2004). A large majority of adolescents in the study reported having used contraception at coital debut (89–91 %); as the age at first sexual intercourse increases, so does the proportion of adolescents using some form of contraception. Condoms were the most chosen contraceptive method in the first sexual encounter (89–96 %). Nevertheless, in those who have a sexually active life, up to 18 % do not always use contraception and up to 39 % report not using condoms consistently (Fronteira et al. 2009; Santos Ferreira and Reis Torgal 2011). Given the risk of unintended pregnancy

and STI, this is a matter of serious concern. Gender, age, and school grade do not seem to be associated with the chosen contraceptive method (Santos Ferreira and Reis Torgal 2011). Rates of current sexual activity are high: 44 % of high school students report coitus in the past 7 days (Fronteira et al. 2009). There does not appear to be an association between gender and frequency of sexual intercourse. The majority (62 %) only had one sexual partner, but boys and girls significantly differ in relation to the number of sexual partners, which is higher in the case of boys. In a recent study, most of the girls (74 %) had only one partner and rarely had more than three. For boys, the number ranged from one (46 %) to nine (1 %) (Santos Ferreira and Reis Torgal 2011).

A research study funded by the European Union, to assess information on sexual and reproductive health indicators, was conducted and data were collected among students between the ages of 16 and 19 and entering grades 10, 11, or 12 in 2005. Adolescents reported that school teachers were the most frequent source of information on biological aspects of reproduction (41 %). However, they reported that their most important source of information on puberty were books and magazines (36 %) (Fronteira et al. 2009). The data also shows that only 48 % had attended classes on reproductive health. This is a concern because it has been a requirement that classes on reproductive health be provided by Portuguese schools since 1984. In 2009, classes on reproductive health became mandatory from grades 1 to 12 as part of a larger project on health education. In addition to sexuality, three other areas were included: education for potential dangerous consumption of alcohol and other drugs, violence, and nutrition (Orientação da Direcção Geral de Saúde 2010). Only the future will tell whether these initiatives have a positive impact on adolescent behaviors, life styles, and health.

It is known that information/education concerning contraceptive methods and the importance of practicing safe sex is not a guarantee that adolescents will use such knowledge or methods. Many acknowledge the need to use condoms but forget them at the time of intercourse. A lack of ability to talk with the partner about sex, the perception that risks are low, and the circumstances in which it occurs (i.e., unexpected, lack of condoms) can lead individuals to engage in unprotected sexual relationships (UNICEF 2002).

Less than a third (15–31 %) of Portuguese youths reported having sought out health facilities to receive services or information on contraception, pregnancy, abortion, STIs, or simply to monitor their health (Fronteira et al. 2009; Santos Ferreira and Reis Torgal 2011). Of those who did receive services, most attended a consultation on a health unit, and the remainder went either to a maternity hospital or a unit providing care specifically to adolescents. Girls were the ones who most frequently attended family planning consultations. Even though the percentage of adolescents who visited health facilities is low, those who did express high levels of satisfaction (75 %) (Santos Ferreira and Reis Torgal 2011). This is encouraging to health workers. Positive feedback improves worker's attitudes and behaviors, which seem to be a critical determinant of health services utilization, especially among adolescents (Dixon-Woods 2001).

Most adolescents reported knowledge about the risks of having sexual intercourse without a condom. However, when the specification of these risks is requested, answers showed that about a third of them did not associate the use of condoms with protection against STIs and pregnancy. Boys especially were found to lack adequate knowledge of such risk (Santos Ferreira and Reis Torgal 2011). Furthermore, only 12 % of Portuguese high school students reported to have heard about *Chlamydia trachomatis* infection. This is a much smaller proportion than the one of Estonia (51 %), Belgium (31 %) or Czech Republic (29 %) (Fronteira et al. 2009). A recent study on pregnant adolescents, performed in two main obstetric hospitals in Lisbon, showed that the prevalence of *C. trachomatis* infection was 12 % (with 67 % being asymptomatic) and the prevalence of *Neisseria gonorrhoeae* infection was 5 % (60 % also being asymptomatic) (Borges-Costa et al. 2011).

Several authors pointed out that the consumption of alcohol may facilitate engaging in sexual activities and that the beginning of sexual life is associated with alcohol consumption and smoking (Institute of Alcohol Studies 2007; Parkes et al. 2007). A recent Portuguese study conducted among high school students showed that the larger percentage of adolescents who already initiated sexual activity were among those who consumed alcohol regularly. There was also a significant relationship between the commencement of sexual activity and smoking (Santos Ferreira and Reis Torgal 2011; Rodrigues et al. 2007).

Trends in Adolescent Childbearing

Despite decreasing rates and, according to the United Nations Population Division data, Portugal's adolescent fertility rate is still high, when compared with other countries of the European Union (Instituto Nacional de Estatística 2011; WHO 2012a). In 2010, the number of live births of mothers under 20 years was the lowest since the late 1970s (it peaked in 1977, with about 20,000 births), even though it was still above 3,660 (Diniz 2009). This means that, each day, about 10 adolescent girls give birth in Portugal.

Live births of adolescent women

According to the World Health Organization, in 2009, the highest adolescent fertility rate in the European Union was in Bulgaria. Portugal ranked eighth on the same list (14.7 births per 1,000 adolescent girls). The average adolescent fertility rate in the European Union was 8.4 births per 1,000 girl aged 15–19 (United Nations Department of Economic and Social Affairs 2010; WHO 2012a).

According to a Portuguese study carried out from 2008 to 2010, the lower rates of adolescent pregnancy were associated with: increased schooling, the perspective of building a career and not having a future focused exclusively on maternity, and greater access to reproductive health (Diniz 2009). Accordingly, accompanying the decrease in adolescent pregnancies, the global number of births decreased from 111,616

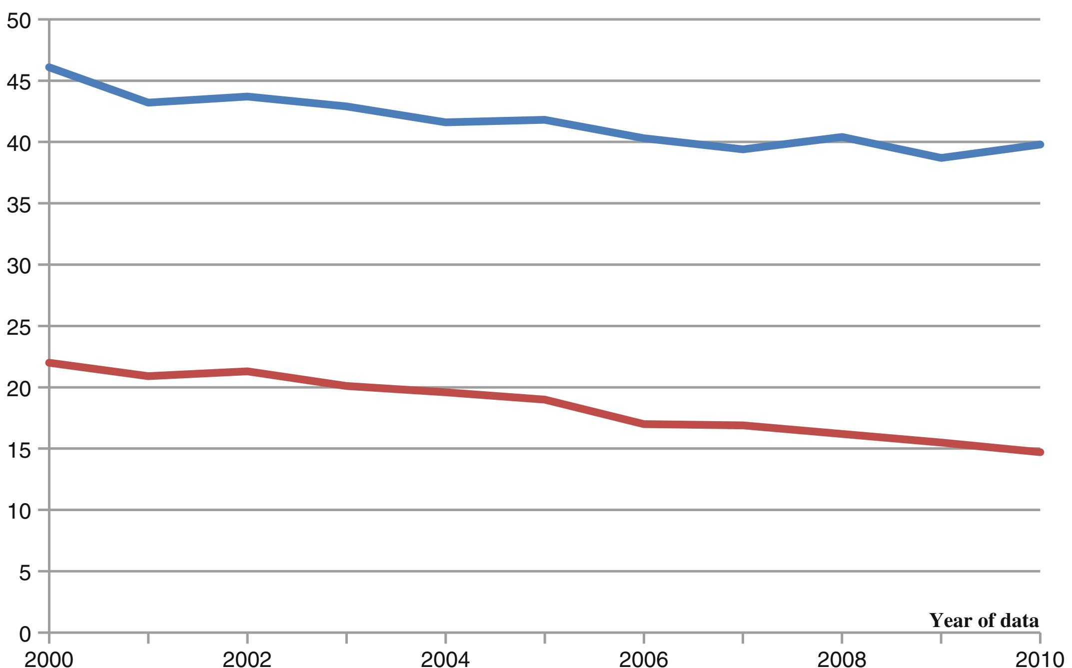
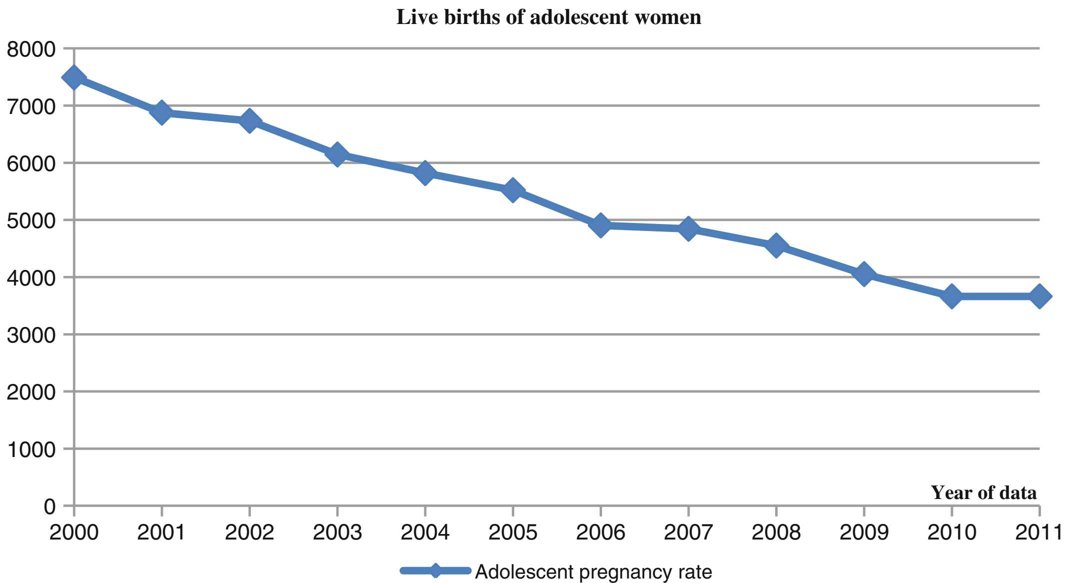


Fig. 1 General and Adolescent Fertility Rates (%). *Source* Statistics Portugal, information accessed on July 1st, 2012



in 2003 to 96,856 in 2011. As in other Western European countries, in Portugal, women wed and became pregnant at an increasingly older age. In 2010, the mean age of their first live birth was 28.9 and the number of children per woman was 1.4 (Direcção de Serviços de Promoção e Protecção da Saúde 2010).

Traditionally, lower rates of adolescent fertility reflect a higher socioeconomic status. However, recently some researchers are questioning whether the global economic crises are not contributing to the decreases in adolescent pregnancy rates. Nevertheless, most authors argue that in a community that does not provide the chances of education and career options for adolescent girls, maternity is high because of the lack of other options in their life; not to mention that poverty tends to shape health policy in ways that often deviate from the best practices in reproductive health (American Academy of Pediatrics 2005, Wellings et al. 2006).

Abortion

Abortion in Portugal was legalized in April 2007. The law allows the procedure to be done on-demand if a woman's pregnancy has not exceeded the 10th week (Diário da República 2007). Before 1984, it was banned under any circumstances and after this date was permitted under some restrictions (Diário da República 2007). In 1997, changes to the law were made and, since then and until 2007, abortions were restricted to the following cases: to save the life of the mother (until 12 weeks), in case of rape (until 16 weeks), and in the case of fetal defects, or incurable syndromes (until 24 weeks) (Diário da República 2007). As it was illegal, no data is available on abortion requests until 2007.

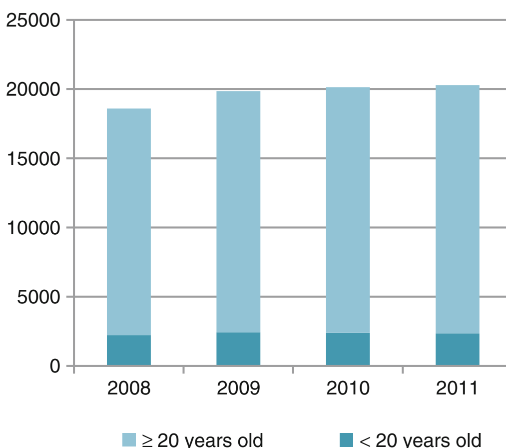
From 2008 to 2011, there was a 9.9 % increase in legal abortions because of unintended pregnancies (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2009, 2010, 2011, 2012). This was mainly due to a sharp increase in the first year; currently, the situation seems to have stabilized (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2010). In 2011, legal abortion ratio was 193 per 1,000 live births for all ages (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2012). This rate is far below the European average (WHO 2012b). Of all legal abortions, 98 % were upon request, because of unintended pregnancies.

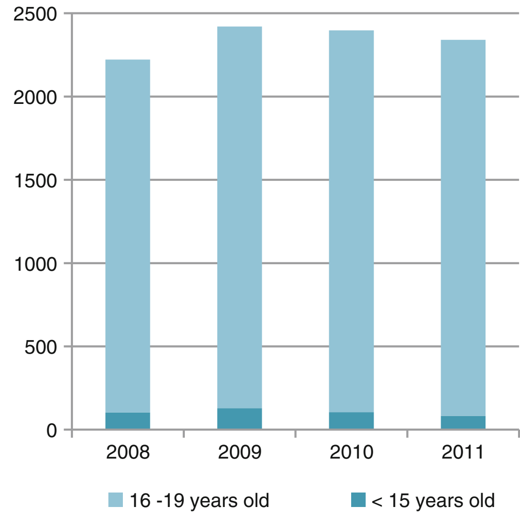
Of these, 11.7 % occurred in adolescents (0.4 % in woman under 15, and 11.3 % in those aged 16–20) (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2012). As in all ages, adolescent abortion increased from 2008 to 2009 (0.3 %) (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2009, 2010). Since then, it has been steadily decreasing, particularly in the group of younger teenagers (under the age of 15) (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2011, 2012).

Within Portugal, the numbers of abortions vary, reflecting the differences in demographic, social, cultural, religious, and economic asymmetry of the country. Additionally, the numbers are probably affected by unequal reproductive health services. The highest abortion ratio exists in the metropolitan area of Lisbon and in the south region of the country (Direcção Geral de Saúde, Divisão de Saúde Reprodutiva, Divisão de Estatística de Saúde 2012).

Legal abortions in Portugal, distributed by age, 2008–2011

Source Register of abortions of the National Health Department (2008–2011).





Legal abortions in Portugal, in women aged 11–19, 2008–2011

Source Register of abortions of the National Health Department (2008–2011).

Medical Complications

Traditionally, adolescent pregnancy has been associated with a higher incidence of medical complications involving mother and child than experienced by adult women. The facts are that the medical risks associated with adolescent pregnancy are associated with younger adolescents, typically 15 years of age and younger. Medical risk among older, more physically mature teenagers is similar for that among adult women (American Academy of Pediatrics 2005; Forrest 1993; Satin et al. 1994). While not conclusive, several studies showed that the incidence of having a low birth weight infant among adolescents is more than double that of adult women. The neonatal death rate for adolescent girls is almost three times higher than for adult women (Amaya et al. 2005; Davidson and Felice 1992). Additionally, the mortality rate for

the adolescent mother, although low, is about twice that of adult pregnant women (Forrest 1993; Moore et al. 1998). Other medical problems, such as poor maternal weight gain, prematurity, pregnancy-induced hypertension, anemia, and STIs, have also been described (Amaya et al. 2005; Davidson and Felice 1992; Moore et al. 1998; Kirby 2001; Fraser et al. 1995). An inadequate lifestyle, poor nutritional intake, high rates of substance abuse, and also social factors such as poverty, unmarried status, low educational levels, and inadequate prenatal care all may contribute to poor birth outcomes (Fraser et al.1995; Conde-Agudelo et al. 2005; Lubarzky et al. 1994; East and Felice 1996). Even though studies performed in the decades of 1980 and 1990 suggested a higher risk of instrumental vaginal delivery and cesarean section, especially in the youngest adolescents (Bacci et al. 1993; Kanje et al. 1992), more recent ones came to counter some of these concepts (Lao and Ho 1998; Lubarzky et al. 1994; Santos et al. 2008). Some even support that, probably due to the higher low birth weight rate, adolescents have less surgical deliveries. However, when adolescent pregnant women are integrated in differentiated perinatal care, with wide access to medical appointments and social and psychological support, their performance is similar or even better, when compared to adult pregnant women (Silva et al. 1993; Metello et al. 2008; Zhang and Chan 1991).

A study performed in 10,656 Portuguese pregnant women enrolled in maternity services that offer differentiated perinatal care showed that 46 % of adolescents only attended medical care after the first trimester (Gortzak-Uzan et al. 2001). They began to monitor their pregnancy later (OR = 2.4) and missed appointments more often, resulting in inadequate prenatal care (OR = 3 in women aged 16–19 and OR = 5 in those under 16 years old). This is consistent with studies performed in other countries that also concluded that younger teenagers are the ones that monitor their pregnancies later and more irregularly (Furstenberg and Brooks-Gunn 1985; Glasier et al. 2006; Raatikainen et al. 2006). Girls under the age of 16 had a higher risk of delivering prematurely (OR 1.6). Notwithstanding, most premature deliveries occurred between the 34th and the 37th week. Teenagers had more eutocic deliveries (OR = 1.9) and fewer cesarean sections (OR = 0.47) than adult pregnant women. Cesarean rates were lower in adolescents aged between 16 and 19. Those under 16 had higher rates of low birth weight when compared with older women (12 vs. 7 %).

According to another study involving 204 pregnant adolescents receiving medical care in two main Portuguese obstetric hospitals, the following sociodemographic factors were significantly associated with an adverse birth outcome: low gynecological age (chronological age minus age at menarche being <2 years) and prematurity; educational attainment not higher than primary school (equal to no more than 4 years of schooling) and labor dystocia among younger adolescents, and severe premature births (Borges-Costa et al. 2011). The same study also shows that during pregnancy, among these adolescent girls, the prevalence of *C. trachomatis* infection was about 12 % (67 % being asymptomatic), and the prevalence of *N. gonorrhoeae* was 4.9 % (with 60 % also being asymptomatic). Both these infections were associated with low birth weight. Furthermore, infection with *N. gonorrhoeae* among these adolescent pregnant girls was associated with maternal morbidity (fever during or after child delivery, chorioamnionitis, puerperal endometritis, preeclampsia, and eclampsia). Infection by STI can cause adverse birth outcome (Glasier et al. 2006). The percentage of cases attributed to STIs, however, is not known; especially in age groups, such as adolescents with a high risk of a preterm births. However, the window of opportunity that pregnancy in adolescents offers to healthcare providers to screen for STIs and provide prevention education and counseling about STIs should not be missed.

Psychosocial Complications

Teenage pregnancy is a main cause of concern because of its association with social exclusion, lower social class, lower educational attainment in mothers, mother's depression, and subsequent poor parenting of the child, including child maltreatment and neglect (Glasier et al. 2006; Furstenberg and Brooks-Gunn 1985; Thomas and Rickel 1995; Gunter and Labarba 1981; Hudson et al. 2000; Lang 2003; Figueiredo 2000; Wang and Chou 2003; Hillis et al. 2004; Pacheco et al. 2003; Milan et al. 2004; Schmidt et al. 2006; Figueiredo et al. 2005). The impact of each of these factors in Portuguese adolescent pregnant girls has been recently addressed.

A study that aimed to compare the experience of pregnancy in teenage years and later adulthood, involving 130 pregnant women, showed a clear relationship between teenage pregnancy and various indicators of disadvantage in both social class and marital terms (Figueiredo et al. 2006). Adolescents were much more likely to have lower educational attainment and social class, to be unemployed and to have partners who are unemployed, and to be single and living with family of origin in larger households. They also experienced more parental separation in childhood suggestive of worse early life experience. However, on the positive side, most were in contact with the infant's father. Moreover, their individual relationship with their partner or other was very close. Pregnant and parenting adolescent relationships, in general, were as supportive as those among pregnant and parenting adults.

A recent study of 161 Portuguese third trimester pregnant adolescents found that a disproportionate number of the girls could be characterized by their lower social economic status, poor health circumstances, low educational level, low professional qualifications, underemployment, problems in the family of origin, adverse life events, undesired pregnancy, lack of prenatal care, and use of tobacco (Figueiredo et al. 2006).

The incidence of depression during pregnancy and the postpartum period is quite high, as reported in several studies carried out in different parts of the world (Andersson et al. 2003; Eberhard-Gran et al. 2003; Gorman et al. 2004; Costa et al. 2007). One study involving 108 Portuguese pregnant women indicated that adolescent mothers had higher rates of depression and depressive symptoms than adult women, both in pregnancy (26 vs. 11 %) and in the postpartum period (26 vs. 9 %) (Figueiredo et al. 2007). Contrary to what has appeared in some studies, in this population, depression rates were not just due to low socioeconomic conditions.

Another study that aimed to explore the relational contexts that promote vulnerability and protection against early pregnancy, in a potentially high-risk group of Portuguese adolescents, compared two groups of female adolescents of low socioeconomic status: pregnant adolescents ($n = 57$) and adolescents without a history of pregnancy ($n = 81$) (Pereira et al. 2005). The results suggest that lower levels of mother's protection and father's emotional support were associated with early pregnancy in adolescent mothers. Moreover, lower level of emotional closeness in peer relationships and a higher number of school failures were significantly associated with adolescent pregnancy.

Prevention Programs

The prevention of unintended adolescent pregnancy is currently an important goal of the Portuguese health department and society (Diário da República 2002; Orientação da Direccção geral de Saúde 2010; Circular Normativa da Direcção Geral de Saúde 2017; Santos and Rosário 2011). A number of prevention strategies have been implemented; not only by the Portuguese government, but also by a number of social and religious institutions. Parents, schools, and adolescents themselves also have important roles in reducing unintended pregnancy. Most programs focus largely on sexual

behavior, contraceptive knowledge and availability, and job training. Efforts to prevent adolescent pregnancy at both national and local levels have increased in recent years. Primary (first pregnancy) and secondary (repeat pregnancy) prevention programs have been developed and implemented, with particular attention to high-risk adolescents. An important effort is being made in schools, where, since 2009, classes on reproductive health became mandatory from grade 1 to 12. Additionally, groups of health professionals are available to counsel adolescents on sexual activity (inside and outside medical facilities).

Conclusion

Portuguese adolescent pregnancy rates tend to rise and fall and are similar to international rates. During the 1970s, adolescent pregnancy and childbirth were increasing at an amazingly high rate. Then, the rate plunged for both adolescent pregnancy and adolescent childbirth. Even so, much of the programing continued to focus on programs designed to control adolescent sexual behavior. By the 1990s, however, contraception was available to adolescents, and national law required sexual education in Portuguese schools. The next steps are to improve the equal distribution of maternal health services nationally, expand sexual education in the areas of relationships and domestic violence. As well, prevention efforts need to continue to focus on delaying childbirth and preventing STDs. Hopefully, some of these program models will result in healthier and safer adolescent sexual behaviors.

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Adolescent Pregnancy in Russia

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Keywords
Russia: Abortion · Adolescent mothers · Adolescent pregnancy · Family planning centers · Nonmarital births · Sex education · Sexually transmitted infections

Introduction

Adolescent pregnancy rates in the U.S. and Russia were among the highest for developed countries in the 1990s, a comparison trumpeted by a Guttmacher Institute report released in 2000. The headline of the press release blared, "United States and the Russian Federation Lead the Developed World in Teenage Pregnancy Rates." According to the report, the U.S. teenage pregnancy rate was "high" at 83.6 per 1,000 women; Russia's rate was classified as "very high" at 101.7 per 1,000 women. The actual teen birthrate for the two countries was somewhat lower 54.4 and 45.6, respectively. Comparing the overall pregnancy rates with the birthrates revealed that Russia's abortion ratio was higher than the U.S.; more teen girls in Russia were ending their pregnancies by abortion than were their peers in the U.S.

Since then, adolescent birthrates in both countries have dropped, though they remain above average for developed countries. Russia's rate declined from an all-time peak in 1990, while the U.S. rate fell from a late-1980s uptick in an otherwise downward trend that began in the late 1950s. In Russia, the birthrate for 15–19-year-olds in 1990 was 55 per 1,000 women. It dropped into the high 20 s and held there through early 2000s (Ivanova 2006), increasing again to 30.2 per 1,000 women in 2009.

While Russia's overall adolescent pregnancy rate and adolescent birthrate may have fallen, they are neither insignificant nor yet a cause for celebration. First, these rates are still higher than in other developed countries. Second, an adolescent birth rate of 30.2 represents more than 131,000 births in 2009—and does not include the thousands of adolescent pregnancies that end in abortion, posing another set of challenges for young women and society as a whole. In 2009, the abortion rate for 15–19 year olds was 23 per 1,000 women (Demographic Yearbook of Russia 2010). Finally, the growing share of nonmarital births deserves attention, as it indicates young mothers who may be more vulnerable to disadvantage than their partnered peers. Nonmarital births among Russian adolescents have grown

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from 18.7 % in 1980 to 47.2 % in 2004 (Ivanova 2006). In the same period, social supports for young families have dwindled.

Until recently, early marriage was widespread in Russia. A common arrangement for centuries, "early marriage was also widespread in the Soviet Union due, in particular, to public housing provision that enabled young couples to get married and start a family earlier than their western counterparts" (Daguerre and Nativel 2006). This provision ended in 1995. Due to changing social norms and the post-Soviet restructuring of the welfare state, from that point on, if a marriage includes one partner who is younger than 18, the family is ineligible for benefits intended to help support young families. The post-Soviet welfare state dramatically reduced government benefits for young families (Stukalova 2011). Thus, with adolescent marriage rates down, those adolescents who do become pregnant and give birth are increasingly likely to become single mothers.

Adolescent Pregnancy Rates

What is keeping Russia's adolescent pregnancy rates higher than those in Western Europe, even as adolescent marriage rates decline? Scholars attribute Russian adolescent pregnancy rates to a combination of factors, including the trend toward earlier sexual debut for both sexes in the latter half of the twentieth century and the beginning of the twenty-first century. A greater percentage of Russian teens are sexually active than in the past. According to data from the Russian Longitudinal Monitoring Survey, a representative survey, the average age of first sexual contact is 16.2 for women and 15.6 for men among young 14–20 years old; while for those 41–49 years old, the average ages were 20.2 and 19, respectively (Gurko 2002). A more recent survey of adolescent girls found that the average age of sexual debut was 16.08 years old.

Another important aspect of adolescent pregnancy is risk-taking behavior and coercion connected to sexual activity. For example, among 14–20 year-olds, 48 % of boys and 35 % of girls used alcohol the last time they had sex, according to the Russian Longitudinal Monitoring Survey (Gurko 2002). In addition, the majority of the youth surveyed did not use contraception the last time they had sex. Echoing what Gurko (2002) found, only 10 of 140 respondents in a study of women who had been pregnant before age 18 had used a condom the first time they had sex. So, although adolescents are more apt to be monogamous and more of them practice safe(r) sex than adult women, teens who had been pregnant are more likely to have had an unplanned sexual debut, including coerced sex (10 %), and are much more likely not to take measures to protect themselves against sexually transmitted infections or unwanted pregnancy. Some adolescent girls who have been pregnant have also been involved in sex work (Sirotkina 2010).

In line with these findings, scholarly discussions of teen pregnancy in Russia usually refer to "low contraceptive culture" among adolescents (or Russians in general). Attempts to implement sex education on the federal level met with a potent backlash in the 1990s (Ivanova 2006; Meylakhs 2011), thereby hampering efforts to improve youth's knowledge of sexual health topics through classroom instruction. There are, however, some signs that contraceptive knowledge among gynecologists is improving, and thus the quality of individual contraceptive counseling is also increasing (Larivaara 2010), which could benefit adolescent girls.

General inequality also plays a role in adolescent pregnancy. In particular, "rising income inequality and child poverty since the early 1980s, with attendant effects on the health of Russian youth" are part of the social background against which youth become pregnant. Russia's GINI index, a measure of inequality in the distribution of family income, rose over the 2000s, from 39.9 to 42 between 2001 and 2010. Similarly, inequality also rose in the United States over a similar period, from 40.8 to 45 between 1997 and 2007 (CIA World Factbook 2009).

Such levels of inequality put the U.S. and Russia on par with many developing and the least-developed countries. (In contrast, the Scandinavian countries all had indices below 30, ranking them among the countries with the most income equality.) Thus, with the loss of state support noted above, pregnant adolescents must increasingly rely on familial resources, at the same time that many families have seen a decline in income.

It is important to note, however, when making such observations, that adolescents from all social classes experience pregnancy. Adolescent mothers also come from well-to-do and high-status families (Gurko 2002), and "there is no link between growing up in single-parent families and the occurrence of early motherhood" (Ivanova 2006).

Risks Associated with Teenage Pregnancy in Russia

In addition to the general medical risks of teenage pregnancy that hold true across countries, teenage pregnancy in Russia takes place within the context of high rates of sexually transmitted infections, particularly syphilis, and HIV. Syphilis rates in the 2000s remain higher than 1980s and 1990s (Ivanova 2006). Nearly a million Russians are HIV-positive. Women are 20 % of those infected, and of those women, 30 % are teens 15–17 years old (Ivanova 2006). While HIV transmission in Russia is mainly through infected needles, there is a risk of transmission through heterosexual contact. In light of the low use of barrier methods of contraception, as indicated above with the infrequent use of a condom or any other sort of contraception among adolescents, adolescents exposed to the risk of pregnancy are also exposed to the risk of contracting these STIs.

Another cause for concern is the number of adolescent pregnancies that end in abortion and the culture surrounding abortion in Russia. While high rates of abortion are by themselves not inherently negative, many Russian women undergo unsafe abortions for a variety of reasons.

A Short History of Abortion in Russia

In 1920 the Soviet Union became the first country to make abortion legal. Subsequently, abortion became the main form of birth control for most women. High rates of abortion were due not only to "poor material conditions in the state health service generally and long-term neglect of maternity and family planning services in particular" but also social acceptance of abortion as an unpleasant necessity (Remennick 1993). Soviet society largely viewed abortion as a routine medical procedure. This tolerance was partly a result of Soviet era "destruction of religious consciousness," which would typically attribute personhood to a fetus and therefore motivate people to object to abortion (Remennick 1993: 46).

Further, in the Soviet Union, access to hormonal contraception was limited. Modern contraception was not available until the 1980s and was expensive and widely distrusted (Ivanova 2006).

In particular, the birth control pill was viewed with suspicion, linked to the "sexual promiscuity of the West," while its "risks [were] exaggerated and the benefits never mentioned" (Remennick 1993: 56). Thus, contraception was less acceptable and accessible than abortion.

Nonetheless, despite abortion being legal and widely practiced in-hospital, the procedure was not without attendant risks and discomforts. Abortion in the Soviet Union took place in the context of "lack of disposable instruments and gloves; shortages of drugs, including inefficient anesthetics insufficient skills of doctors and nurses…and overloading in clinical premises performing [induced abortions]" (Remennick 1993: 59).

Thus, it is less surprising that some Soviet women sought to avoid official, in-hospital abortions:

> …there have been many out-of-hospital terminations motivated by fear of publicity (until recently the procedure required two or three nights hospitalization with its cause clearly stated in a sick-leave document), or by advanced gestational age, or both. In distant rural areas gynecological clinics are

often difficult to reach, their waiting lists are long and fear of rumor is very powerful. It is reckoned that up to three quarters of out-of-hospital terminations are self-induced (Remennick 1993: 50).

Death was also a possibility for Soviet women who underwent abortion, more so than it was in other countries. For example, in the mid-1980s, the Soviet Union had a death rate of 10.9 per 10,000 abortions, while in the U.S., the rate was 0.6 (Remennick 1993: 60).

Therefore, Remennick cautions against thinking of abortion as something Soviet women "chose," since there was little opportunity to use other forms of birth control and a number of potential negative outcomes. Instead, she deemed abortion in the Soviet era as "a pressing necessity emanating from the lack of any alternative" (1993: 46).

Abortion is still a common way of dealing with unwanted pregnancy in the post-Soviet era. In Russia (and Poland), "economic liberalism has been accompanied by as religious backlash that has eroded women's reproductive rights. In particular, access to abortion, which used to be a major family planning method in both countries, has been severely restricted, thus prompting a rise in backstreet abortions" (Daguerre and Nativel 2006: 15).

Current Russian law stipulates that women older than 15 years are entitled to access anonymous sexual health services, including abortion, without parental permission. In practice, however, fears about anonymity linger from the Soviet era, leading women to seek unsafe abortions. According to Russian women, informal abortion (via acquaintances) is still practiced—nominally free, but, in practice, in exchange for money or gifts (Gurko 2002). Many of these abortions are done at for-profit facilities, but not officially recorded. For instance, an adolescent seeking an abortion might not want to go to the official women's clinic because she is afraid of running into a neighbor or afraid of will the doctor tell her mother why she went to the clinic. In addition, it is not uncommon for medical personnel to treat patients rudely, a situation that women hope to avoid by paying for services (Gurko 2002).

Unfortunately, illegal and out-of-hospital abortions frequently result in secondary infertility and account for a substantial part of Russia's high maternal mortality rate (Sharapova 2003). This practice shows no sign of abating; in fact, there are indications that restrictions on the grounds for obtaining an abortion have only shifted demand to out-of-hospital abortions (Fokin et al. 2006). In 2003, the government cut the number of social (not medical) justifications for having an abortion from 13 to 4: If the woman has been stripped of her parental rights, if she is incarcerated, if the pregnancy is a result of rape, or if the father is disabled or dead (Ivanova 2006). Afterward, the number of illegal abortions rose as women more than 12-weeks pregnant sought abortions (Fokin et al. 2006). In 2011, further restrictions were placed on abortion: Abortion must take place within the first 12 weeks of pregnancy, except for women who cannot afford to have a child, who are allowed to have an abortion until 22 weeks of gestation (Associated Press 2011). (The Russian Orthodox Church had proposed additional measures to regulate abortion including requiring a husband's consent for a married woman and a parent's consent for a teenage girl to get an abortion (Associated Press 2011), but these restrictions were not adopted.) Experts anticipate these restrictions will primarily serve to motivate women to seek abortions elsewhere.

Sveta's Story: A Vignette of Adolescent Pregnancy in Russia

Sveta (to protect respondent anonymity, the names used here are pseudonym) was 14 when she and Vlad started dating in the late 1990s. Within a year, the couple began having sex, and Sveta became pregnant. Looking back on that experience 14 years later, Sveta can come up with three main causes for her pregnancy.

"First of all, there was no sex in the USSR," she says, repeating a truism about the Soviet Union. By that, Sveta means that her parents did not give her "the talk," and she never felt that she could ask them about sex. As a result, the

first conversation the family had on the subject was when she told them she was pregnant.

Her father responded loyally, she remembers, though her mother was more shocked. “At that time, it was a disgrace,” Sveta says. However, unlike many Russians faced with an unplanned pregnancy, Sveta said she never considered abortion. As a Russian Orthodox Christian, she says, she believes that if she got pregnant, then she had to give birth. Her parents did not try to pressure her into having an abortion, though that was a common way of dealing with unwanted pregnancy in the Soviet Union and the present-day Russian Federation. (Sveta said her own mother had nine abortions.)

Sveta and Vlad decided they would get married and have the baby. Sveta missed the last three months of school, when her pregnancy finally started showing. She got her final grades thanks to her mother going around, “blushing for me” and explaining the situation to her teachers. “Only later did I realize how tough it must have been for her to stand up for me,” Sveta says.

Another point Sveta makes about how she could have become pregnant at 15 was that there in late-1990s Russia, there was neither sex education at school, nor widespread Internet access. As a result, Sveta says she did not realize what the outcomes following sex would be.

After their daughter was born, 16-year-old Sveta and Vlad bounced between their parents’ apartments, trying to stretch their parents’ wages to cover their new family. Sveta received a modest childcare credit from the government, but because she had not worked before her pregnancy, she was not eligible to have paid maternity leave.

The young parents divorced after two and a half years. Nine months later, Sveta filed for alimony, which she waited nearly 10 years to receive.

In the meantime, it was up to Sveta and her parents to provide for her and her daughter. When her daughter was old enough to start attending a government-run daycare, Sveta went to technical school to become a secretary.

Sveta found a low-paying secretarial job, but when her daughter started catching illnesses from the other children at daycare Sveta started working as a daycare provider, so she could keep an eye on her daughter herself. Her daughter was elated, Sveta says, and even though the wages were low, Sveta was glad they could spend their days together. Perhaps just as importantly, the daycare also kept both her and her daughter fed.

Eventually, Sveta decided it was time to get a college degree. She left the daycare for a taxi company, where she worked two days, two night shifts, then had four days off. She enrolled in paid correspondence courses. Somehow, Sveta managed to coordinate her work with studying, spending time with her daughter and getting her to and from daycare. Because her mother worked as a night watch woman, Sveta explained, she was able to take her granddaughter to work with her the nights when Sveta was at the taxi company.

When explaining this period in her life, Sveta says that not only was being a young single mom tough on her morale, it was hard on her physically. In time, however, she finished her studies, worked her way up in the taxi company and even had enough money, and energy to take her daughter on a seaside vacation. In a few more years, Sveta would meet her second husband, with whom she now has a second, toddler-aged daughter.

As the mother of two girls, Sveta says she will approach sex education differently than her parents did. Her older daughter is already a young teen, and Sveta says the two have discussed contraception. Regarding her own contraceptive use, Sveta has used an IUD, but now takes birth control pills, as she and her husband are planning to have a second child together.

The Big Picture

If giving birth to a third child works out, Sveta will have more children than the average Russian woman. The total fertility rate in Russia has hovered around 1.6 children per woman

since 2009 (International data base 2012). Sveta's plan to have a multichild family (mnogodetnaya sem'ya) is in line with government desires to stabilize or grow the Russian population. The country's population fell to 142.9 million as of the last census in 2010, from 145.2 million at the time of the 2002 census. In response to this population decline, or what some have deemed a demographic "crisis," the government implemented a baby bonus to promote population growth in 2007, awarding women who had a second or subsequent child "maternal capital" for improved housing, the child's future education or the mother's pension equivalent to about $10,000.

During her pregnancy, Sveta's visits to women's clinics and the maternity ward were also different than what most women experienced, in that she has no complaints about the nurses and doctors who saw her through her pregnancy (Gurko 2002). Some women complain of indifferent, if not outright hostile attitudes on the part of medical personnel.

Sveta's experience of the first several years of motherhood, however, does fit the norms. Being or becoming single, grappling with poverty, and living with and/or relying on the help of child's grandparents are common for many adolescent mothers in Russia (Gurko 2002). Such intergenerational challenges and negotiations, as Utrata (2008) points out, are not unique to adolescent mothers; it is the same for adult single mothers who undertake the task of supporting their children. Other items on the laundry list of troubles that single adolescent mothers face also factored into Sveta's story, including the difficulty of finishing secondary school, finding work, and being economically dependent on parents and relatives (Sirotkina 2010).

Sveta's evaluation of the causes of adolescent pregnancy was spot on, when compared to the responses of social workers in a focus group: changing social-sexual norms, transformation of marital/family relations, and the absence of a government system of sex education (Sirotkina 2010). Without the combined efforts of parents and educators to arm youth with information about the outcomes of sexual activity and ways to protect themselves against sexually transmitted infections and unwanted pregnancy, Russian youth are left to decide on behavior for themselves, while their peers are increasingly sexually active and sexual permissiveness is widely displayed via mass media.

Though adolescent mothers face the challenge of taking care of themselves and their children, they are not included in the legal category of socially disadvantaged individuals entitled to some special benefits. This lack of special support can be understood against the general backdrop of the situation of all youth in Russia, which Daguerre and Nativel (2006) characterizes as an atmosphere in which "commitment toward young people's well-being remains virtually non-existent." And, while adolescent mothers can receive monthly child benefits, as do all mothers, they are likely not to have worked formally and therefore are ineligible for maternity pay, as was Sveta's experience.

The lack of sex education within Sveta's family is still an issue for Russian teenagers today. Parents themselves must possess knowledge about sex and contraception in order to pass it on to their children. In a survey of mothers of teenagers, more than half of them had not received enough sex education themselves: 42.7 % of them did not know what "safe" sex was, and 15.1 % did not know any methods of contraception. Thus, of the teens surveyed, 55.8 % of them had incorrect perceptions of what safe sex is, 7.7 % had no knowledge of modern contraception, and 8.1 % were sure that no safe methods of contraception exist.

The Battle over Sex Education

Sveta explained that she did not receive school-based sex education in the 1990s, a result of cultural battles in Russian society (Meylakhs 2011). It was not for lack of planning that the programs were not implemented. In the 1990s, the Russian Department of Health had a family planning program in which it developed sex education programs and family planning centers.

The Department of Education created a public awareness campaign about family planning, and a "Safe Motherhood" program was also created to improve maternal and infant care (Ivanova 2006: 193). In 1995, the United Nations Population Fund (UNFPA) started work in Russia, and new public organizations, such as the Russian Family Planning Association, started youth centers. However, the "moral backlash against progressive health policies" was virulent in that it successfully portrayed "sex education and family planning as foreign concepts that undermine the very fabric of Russian society," shutting down the effort for universal sex education (Ivanova 2006: 194–195).

The battles over family planning contained echoes of the Soviet-era suspicion of birth control. Opponents of sex education accused proponents of being under foreign influence, "agents of international pharmaceutical corporations (who are interested in distribution of condoms and birth control pills) and also as geopolitical enemies of Russia (usually from the West) who want to destroy Russia and/or implant 'alien ideas' in Russian society traditions" (Meylakhs 2011). Proponents of sex education, on the other hand, accused their opponents of being radically religious and extremely conservative. They also suggested that opponents of sex education were interested in growing Russia's population at any cost. This accusation was expressed in the following newspaper article: "It's not difficult to understand that attempting to solve the problem of the birth rate at the expense of schoolgirls impregnated because of their own ignorance is stupid, cruel, and most importantly, pointless" (Mashkina 1998).

Suspicion of family planning information remains today, even as sex education proponents and opponents alike feel pressure to confront the country's HIV epidemic, as an analysis of Russian media coverage of sex education found in 2011 (Meylakhs). For example, in 2003, a writer for the business newspaper *Kommersant* opined, "10 years ago various international organisations spread in schools 'sexual textbooks of enlightenment kind.' These programmes were of American or Chinese origin. It is clear that they tried to find ways how to reduce population, how to prevent an unwanted pregnancy. This way does not suit us. Children should be taught, [*sic*] how to keep their honor, not how to use contraceptives" (Meylakhs 2011: 248).

Despite continuing controversy, there are sex education projects and programs in Russia today (Meylakhs 2011: 243). However, as of 2012, there were still few sex education programs included in the schools' curriculum (Grisin and Wallander 2002). One such sex education project outside schools is the set of UNICEF-sponsored youth clinics, which provide consultations for youth about sexual health and healthy lifestyles. The first such clinic offering "Youth-Friendly Services" (YFS) opened in St. Petersburg in the late 1990s. In addition to offering medical and psychological services, these clinics also train teens as volunteer peer educators. This model may prove effective, given that Russian youth are shown to rely on friends and family for sexual information and advice. As of 2011, there were more than 130 such clinics in 30 cities and regions of Russia, but there are still no such clinics in the Russian Far East (UNICEF 2011).

Services for Adolescent Mothers

Russia has fewer than 20 crisis centers that provide housing for underage mothers and their children (Channel One Russia 2012). One such center is "Malen'kaya Mama" in St. Petersburg, which opened in 1998 as a wing of a government-run women's crisis center. It claims to have been the first shelter to serve adolescent mothers with infants in Russia and was the only one as of the mid-2000s (Ivanova 2006). As of 2012, Malen'kaya Mama had beds for sixteen teens (http://www.sirota-spb.ru/merge/merge_2.html). In the fall of 2011, a similar service opened as part of a women's crisis center in Velikiy Novgorod, a city of about 200,000 and the administrative center of the Novgorod Oblast. The center was able to house six teens with infants when it opened with plans to house ten by the end of 2011 (Novgorod.ru 2011).

In Moscow, "Goluba" has provided consultation services for pregnant and parenting women and girls under 21 years old since 1994 (Zhenshina i informatsia 2010). These services include consultations to resolve medical, legal, psychological, and educational issues. The organization also helps with material goods, such as providing cribs, strollers, and children's clothes when possible (Bezukh 2011: 84).

Despite the existence of such clinics, shelters, and centers, adolescent mothers still face difficulties. Social workers identify such difficulties as small benefits, bureaucracy, few help centers, lack of information, the absence of help in registering a child for daycare, and incompetent personnel engaging with the problem (Sirotkina 2010: 36).

Future of Adolescent Pregnancy

While the drop in the teen pregnancy rate in the 2000s can be seen as a positive sign, as can the expansion of UNICEF-associated youth health clinics, there are still troubling facts about teen pregnancy in Russia. For those teens who do become pregnant, associated STDs, the proliferation of potentially dangerous out-of-hospital abortions, and the lack of specific state support for teen mothers remain problematic. Few facilities are able to house teens with infants. It is unclear what, if any, sexual health services are available to youth in the Russian Far East. Ivanova (2006: 197) sums up the situation pessimistically: "adolescent reproductive and sexual rights remain purely formal." The lack of support affects not only pregnant teens, but also their children: A quarter of new mothers who relinquish their children up to the state are teens (Channel One Russia 2012). Thus, future research should track the development of these issues. It also remains to be seen whether Russia's current pronatalist policy, a baby bonus for a woman's second child born between 2007 and 2016, will encourage more adolescent mothers to have multiple children in their teens. If this were the case, it could bode poorly for vulnerable adolescent mothers and their children.

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Pregnancy Among Young Women in South Africa

Catriona Macleod and Tiffany Tracey

Keywords
South Africa: adolescent abortion · Adolescent childbearing · Adolescent friendly clinics · Adolescent pregnancy · Contraception · First sexual intercourse · Pregnancy prevention · Rights-based legislation · Sexual education · Termination of pregnancy

Introduction

In 1994, South Africa witnessed its first democratic elections after centuries of colonial and then Apartheid rule. The globally recognized figure of Nelson Mandela served as the country's first democratically elected leader, and with his inauguration began the process of rehabilitating the country from its segregationist past. Virtually, every facet of social and political life was set on a path of transformation, including sexual and reproductive health.

As time passes since the euphoric moment of 1994, the difficulties of this transformation have become evident. In terms of sexual and reproductive health, HIV/AIDS is acknowledged as one of the most significant challenges, with South Africa having one of the highest infection rates globally (UNAIDS 2010). Pregnancy among teenage girls is receiving increasing attention as well. For example, public concern has been expressed that the recently introduced Child Support Grant (CSG) acts as a 'perverse incentive' for young women to bear children, and both the Departments of Education and Health separately commissioned reviews of research to inform their interventions (Panday et al. 2009; Department of Health 2009).

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In the following, we paint the political and legal context with regard to 'adolescent'[1] sexual and reproductive health in South Africa. We talk to the rates of 'adolescent pregnancy' and termination of pregnancy (TOP) and outline cultural, social, and health issues associated with early reproduction. We discuss public policy and interventions, including preventive measures and care for young people who do conceive. We provide a brief evaluation of the research being conducted in South Africa and conclude that the rights-based approach adopted by the South African government is one the factors contributing to the decrease in the rates of unintended 'adolescent pregnancy.'

Context

In 1994, the African National Congress (ANC), the major anti-Apartheid liberation party that formed the first and all subsequent democratically elected governments, released its *Reconstruction and Development Programme* (RDP). The RDP was accepted as policy and set the tone for future policy in various sectors. In the Health Care section, the following is proposed:

> One important aspect of people being able to take control of their lives is their capacity to control their own fertility. The government must ensure that appropriate information and services are available to enable all people to do this. Reproductive rights must be guaranteed and reproductive health services must promote people's right to privacy and dignity. Every woman must have the right to choose whether or not to have an early TOP according to her own individual beliefs. Reproductive rights must include education, counseling, and confidentiality (African National Congress 1994, non-paginated).

This reproductive rights approach has underpinned legislation developed in the last two decades. In addition, the need to set sexual and reproductive health as a priority for youth has been emphasized as evidenced in the *HIV and AIDS and STI National Strategic Plan for 2007–2011* (Department of Health 2007a), and *The National Youth Policy 2009–2014* (South African government 2009).

This impetus has resulted in the passing of a number of important pieces of legislation that directly affect young pregnant women. In particular, the South African Schools Act (No. 84 of 1996) and the Promotion of Equality and Prevention of Unfair Discrimination Act (No. 4 of 2000) stipulate that school learners who become pregnant should not be unfairly discriminated against. Thus, in 2000, the Council of Education Ministers issued a statement indicating that schools may not expel pregnant learners, a frequent occurrence prior to this intervention. In 2007, the Department of Education published its Measures for the Prevention and Management of Learner Pregnancy (see later fuller discussion). The dual-pronged approach (prevention of pregnancy and management of pregnancy where it does occur) is framed within 'the right to equality, the right to education, and the rights of the child (including the newborn child)' (Department of Education 2007b non-paginated).

The Choice on TOP Act (No. 92 of 1996) (henceforth CTOP Act) legalized abortion in South Africa. Women may now request abortions up to the 12th week of pregnancy. After this, up to the 20th week, abortions may be performed if, in the opinion of a medical practitioner, continued pregnancy will pose a threat to the woman's physical or mental health, the fetus is likely to be severely physically or mentally abnormal, the pregnancy resulted from sexual abuse, rape or incest, and finally, if continued pregnancy will significantly affect the woman's social or economic circumstances. After 20 weeks, termination may be performed only if two doctors (or a doctor and a registered midwife) determine that continued pregnancy would endanger the woman's life, result in severe malformation of the fetus or pose a risk of injury to the fetus. The Act promotes the provision of non-mandatory counseling before and after the abortion is performed. Minors should

[1] We have chosen to write the terms 'adolescent pregnancy, 'adolescent,' and 'adolescence' in quotation marks throughout this chapter to highlight their socially constructed nature. Thus, while deploying these signifiers, we wish to simultaneously trouble them through drawing attention to their historical and social specificity.

be counseled to notify their parents or guardian but do not require consent from the latter. The CTOP Amendment Act of 2008 makes the rights of women to terminate a pregnancy more accessible by extending the conditions under which a legal TOP may take place.

The parental consent sub-clause of CTOP Act (in which parental consent, or even consultation, is *not* required for minors to undergo a TOP) led to court action in 2005 by the Christian Lawyers Association (CLA), who had previously failed in their application to have the whole of CTOP Act declared unconstitutional. As in the first case, the judge found in favor of the state and the sub-clause remains intact (Christian Lawyers Association vs. Minister of Health and Others 2005).

The CSG, introduced in 1998, is a grant aimed at ensuring that young children living in poverty are provided financial assistance. The grant is small and is meant to supplement, and not replace, household income. Primary caregivers of children below the age of 15 have to meet the criteria of a means test in order to be eligible for the grant. The CSG is the state's largest social assistance program in terms of the number of beneficiaries reached (Department of Social Development, SASSA, UNICEF and CASE 2008). Concerns have been expressed with regard to the grant acting as a 'perverse incentive' for teenagers living in poverty to conceive (see later discussion with regard to this controversy).

Rates of Pregnancy and Termination of Pregnancy

National statistics paint an interesting picture that negates the popular opinion in South Africa that rates of teenage pregnancy and childbearing are escalating. The 1998 South African Demographic and Health Survey (SADHS) (Department of Health 2002) indicated that 35 % of women had had a child by the age of 19 years, while in the 2003 SADHS survey (Department of Health 2007b), this had decreased to 27 %. However, the SADHS 2003 questions the validity of its fertility data. Nevertheless, Moultrie and McGrath (2007) argue that teenage fertility fell by 10 % between the 1996 and 2001 censuses. The age-specific fertility rate (defined as the number of births in a certain year per thousand to women in a specific reproductive age group) for 15–19-year-old women is estimated at 66/1,000 (Makiwane and Udjo 2006). In a nationally representative household survey, Pettifor et al. (2005) found that 15.5 % of 15–19-year-old women reported having ever been pregnant (including pregnancies resulting in abortion, miscarriage, and birth).

Some localized data also points to a decline in fertility rates. Moultrie and McGrath (2007) report that, in the Demographic Surveillance Site in rural KwaZulu-Natal, teenage fertility rates fell from just over 100 births per 1,000 teenage girls in 1995, to 88/1,000 and 73/1,000, respectively, in 2001 and 2005.

According to the 2003 SADHS, pregnancy rates decrease with increasing education. Thus, in this survey, 20 % of 15–19-year-old women with a Grade 6–7 education, and only 7 % with a higher education, reported having ever been pregnant.

The rate of teenage fertility is lower in South Africa than the overall rate in sub-Saharan Africa. It is comparable to many middle-income countries, but higher than most European countries. A sociological difference between teenage fertility in South Africa and other sub-Saharan countries, however, is that in South Africa childbirth to teenage girls tends to take place outside of marriage (Makiwane and Udjo 2006).

Some research has pointed to the fact that a small minority of young women plan their pregnancies. In the surveys conducted by Manzini (2001), Garenne et al. (2001), the Planned Parenthood Association of South Africa (PPASA) (2003), and Pettifor et al. (2005), 29, 24.6, 9.2, and 33 % of respondents, respectively, planned their pregnancies. For the rest, pregnancy was unintended.

Unintended is not, however, the same as unwanted. In the 2003 SADHS, distinction is made between 'wanted then' (at time of conception), 'wanted later,' and 'wanted no more,' as seen in Table 1.

Table 1 Fertility planning status

	Wanted then	Wanted later	Wanted no more	Missing	Total
<20	20.8	42.6	34.4	2.2	100
Total across age range	50	24.1	23.2	2.7	100

Adapted from SADHS 2003

Thus, it appears that although a smaller percentage of teenage girls plan their pregnancy than older women, for a substantial percentage (42.6 %) the pregnancy is unintended but not unwanted.

Conceptualizing and defining unplanned, unintended, and unwanted pregnancies can be complex. A relatively reliable indicator of the unwantedness of a pregnancy (for whatever reason) is TOP. Buchmann et al. (2002) found the following age-related TOP rates at a hospital in Soweto, as measured over an 8-week period:

- 13–16 years: 23 %
- 17–19 years: 14.9 %
- 20–34 years: 12.7 %
- 35+ years: 16.2 %.

According to these statistics, more young teenage girls have unwanted pregnancies that result in a TOP than do adult women. Low rates of TOP (3 %) were reported in the national household survey (Pettifor et al. 2005). This low level of reportage may, however, have to do with the stigma attached to TOP. Minors account for about 12 % of people presenting at TOP clinics (Department of Health 2006).

Cultural Issues

Cultural issues have been taken up by researchers to, firstly, understand the occurrence of 'adolescent pregnancy' and, secondly, to explore the cultural management of 'adolescent pregnancy.' The exploration of cultural factors in relation to the occurrence of adolescent pregnancy falls into two broad camps: the breakdown of tradition and the cultural value placed on fertility. The statement by Boult and Cunningham (1992) captures the essence of the first of these factors (viz., the breakdown of tradition):

> Rapid urbanization and westernization has eroded many of the traditional norms and values of the black family in Africa and South Africa. The percentage of out of wedlock births has grown steadily during the past 30 years in South Africa (p. 161).

This particular tack of thinking has, for the most part, received less attention from researchers in the last 10 years. The practice of virginity testing, which was reported as one of the traditional practices that was being broken down, has, however, been debated. Recent initiatives have attempted to use this rite (in which older women inspect the vaginas of younger women to check that their hymen is intact) to promote abstinence from sexual intercourse and as a means of avoiding STIs and pregnancy. Maluleke (2003) argues that while there is reason to believe that the rite can be used to pass on valuable information regarding reproductive health to young women, it is a gendered cultural institution. The procedure is seen as demeaning to the women who are tested, and as a violation of personal privacy. There are also possible unintended outcomes, including older men seeking out younger women because of their potential virginity and low HIV risk status (Simbayi et al. 2004).

The cultural value placed on fertility has also received less attention in recent years, although Preston-Whyte (1999) and Jewkes and Christofides (2008) discuss the issue. They indicate that women of all ages in most African societies experience pressure to have children. Importance is placed on fertility and procreation, such that young women may be labeled as barren if they do not conceive. Pregnancy is understood as the epitome of womanhood. Childbirth may be regarded as a rite of passage, and thus raises the status of a young woman. Furthermore, pregnancy is valued by young African women

for the meaning it imparts to relationships. In the context of multiple relationships, an acknowledged pregnancy may strengthen bonds between partners.

In terms of the cultural management of 'adolescent pregnancy,' Preston-Whyte and Louw's (1986) early work explores one set of Zulu cultural responses which seek to contain 'adolescent pregnancy' in a 'ritual manner derived from, but by no means identical with, the way in which it is reported to have been dealt with in the past' (p. 361). They describe *umgezo* (a cleansing ritual) and *amademeshe* (damages, or compensation) due to the young woman's parents or guardian as some of the ways in which the occurrence of early pregnancy is managed. More recently, Mkhwanazi (2004), in her ethnography of 'adolescent pregnancy' in a South African township, argues that, with the waning of formal female initiation rites, the management of 'adolescent pregnancy' acts as a transition rite in townships, with many of the activities emulating those previously used in female Xhosa initiation.

Health Issues

In the first author's earlier literature review of South African research (Macleod 1999a), it was indicated that a number of studies tried to tease out the obstetric outcomes of 'adolescent pregnancy.' Some of these studies showed increased risks, while others ascribed the risk to socioeconomic status or poor antenatal care. We failed to locate any recent South African research on the obstetric outcomes of early pregnancy.

Instead the focus has shifted to concerns over the increased risk for young women in terms of contracting HIV (Jewkes et al. 2001). This is an issue not only for medical practitioners but for young people as well. Rutenberg et al. (2003) suggest that concern about the danger of HIV infection has become part of young women's perceptions of the (non)desirability of pregnancy.

The 2008 national estimate of HIV prevalence among South Africans of all age groups is 10.6 %. In the age group 15–19 years, the prevalence among males is 2.5 % and among females 6.7 % (which points to the gendered nature of the epidemic). There was a drop in HIV prevalence in the youth category 15–24 years from the 2005 to the 2008 survey. The drop in HIV incidence among 15–19-year olds is substantial for the 2008 survey year compared with the incidence figures calculated for the 2002 and 2005 survey years (Shisana et al. 2009). These figures are being held up as examples of the (relative) inroads the government's HIV prevention program has been making.

Social Issues

The disruption of schooling is one of the key social issues highlighted in relation to early reproduction in South Africa (Morrell et al. 2012). This must, however, be seen in light of the general completion rates. It is estimated that 10 % of youth aged 16–18 years are out of school. Repetition of grades is high. Some 38 % of youth aged 19–25 have Matric (Grade 12, the terminal grade in our schooling system) or the equivalent, while 17 % are still in school (Social Surveys and CALS 2009).

The relationship between early pregnancy and school disruption is complicated. Among the pregnant teenagers in the survey conducted by Manzini (2001) in KwaZulu-Natal, 20.6 % had left school prior to conceiving. The 2003 General Household Survey statistics indicate that of all the females who had dropped out of school, only 13 % cited pregnancy as a reason (Crouch 2005). This percentage was higher in a different household survey, in which 38.4 % of respondents cited pregnancy or care of a child as a reason for dropout (Social Surveys and CALS 2009). There are numerous factors, besides pregnancy, that lead to school leaving, including poverty, frustration associated with the inexperience of teachers, a lack of relevance of the curriculum and teaching materials, the absence of parents at home, and the need to care for siblings or sick family members, which is particularly pertinent in the current HIV/AIDS epidemic (Human Sciences Research Council 2007).

The Schools Act prevents discrimination against pregnant learners. For those who leave because of pregnancy, a significant new factor may be the Department of Education's (2007b) guidelines entitled 'Measures for the Prevention and Management of Learner Pregnancy' that makes it possible for educators to 'request' that learners take a leave of absence of up to 2 years. Manzini (2001) found that 48 % of young women who left school because of pregnancy returned to school. The major reason cited for not returning to school was the need to care for the child. In the survey by Grant and Hallman (2006), 29 % of the 14–19-year-old women and 52 % of the 20–24-year-old women who had dropped out of school because of pregnancy had returned. With every year that passes the chance of a return to school diminishes, with very little chance of return after 4 years (Grant and Hallman 2006).

Various reasons for the dropout from, and return to, school of pregnant and parenting young women have been explored. Lloyd (2005) ascribes the dropout rates to the CSGs (see later discussion of the controversy regarding this). Grant and Hallman (2006) found that prior poor school performance (e.g., non-pregnancy-related repetition of grades) and having to be the primary caregiver for the child are strongly associated with the likelihood of dropping out when pregnant. In terms of returning to school, Kaufman et al. (2000) suggest that the increased bride price that accompanies higher educational status is a motivating factor for parental support in this regard. Grant and Hallman's (2006) data suggest that young women are more likely to return to school if they have never repeated a grade or withdrawn temporarily from school before, and if they live with an adult female. The presence of older female relatives allows a young mother to relinquish domestic duties to older women and return to school (Morrell et al. 2012). Young women who marry and move to their husband's household may, however, have increased domestic responsibilities and there may be less support for their continued education (Mathews et al. 2009a). In addition, the unequal and gendered load of pregnancy and parenting found in broader society is replicated in schools, as shown by Morrell et al. (2012).

Grant and Hallman's (2006) study debunks the frequently made assumption that, were young women not to conceive, they would continue their education. They discuss the concept of disengagement from school in which young women perceive few opportunities emerging from participating in education. If there is little incentive to participate in school, there is also little incentive to avoid pregnancy. For some young women, it is a rational option to leave an unsatisfactory situation at school for the role of motherhood.

The second major social issue is the introduction of the CSG. The popular concern, as raised in the South African media, that young women are deliberately conceiving in order to access the CSG, is supported, to a certain extent, by the PPASA (2003) survey in which it was found that 12.1 % of pregnant teenage girls who had deliberately conceived cited the CSG as the reason. However, other research (Department of Social Development 2006; Makiwane and Udjo 2006) concludes that there is no evidence that the CSG leads to a 'perverse incentive' to conceive. These authors base their conclusion on the following: (1) early fertility decreased after the introduction of the CSG; (2) only 20 % of teenage mothers are beneficiaries of these grants; (3) older female relatives who take over care of the child are often beneficiaries rather than the teenage mothers; (4) of those who would qualify for the grant, the proportion of teenage mothers taking them up is considerably lower than those in older age groups; and (5) during the period in which the CSG has been offered, rates of TOP have increased.

Indeed, the fact that many young women who are eligible for the grant are not receiving it should be of concern. In general, the CSG is associated with an increase in school attendance, and improved child health and nutrition, which in turn contributes to school-readiness of the child, as well as extra money to pay for school fees and uniforms (Case et al. 2005).

Public Policy and Interventions

Prevention

Substantial efforts have been put into preventive programs in the area of sexual and reproductive health in South Africa. Although some of these efforts have been spurred by concerns regarding 'adolescent pregnancy,' the main driver has been the HIV/AIDS epidemic. In the following, we discuss the major prevention programs in South Africa, these being Life Orientation and sexuality education in schools, family planning services, the National Adolescent Friendly Clinic Initiative, media campaigns, peer education programs, and *loveLife*. We conclude this section by discussing the combined effects of these prevention efforts in terms of knowledge and use of contraception, the timing of sexual debut and violent/coercive sex.

Life Orientation and Sexuality Education in Schools

Life Orientation was introduced post-democracy as a compulsory learning area in schools. Life Orientation is defined by the (Department of Education 2007a) as 'the study of the self in relation to others and to society' (p. 7). It is an examinable subject. One of the areas covered is sexuality education.

Initial indications are that this program is of some benefit in terms of promoting sexual and reproduction knowledge and perceived condom self-efficiency (Magnani et al. 2005). However, a systematic evaluation of school-based sex and HIV education programs in South Africa showed that while the programs had positive effects on knowledge, attitudes, and communication about sexuality, they had little or no effect on behavior (Mukoma and Flisher 2008).

It is acknowledged by the Department of Education (2007b) that the effectiveness of this program may be hampered by teachers' capacity to convey these life skills. In particular, their capacity to deal with sensitive issues may impinge on their ability to support learners. An evaluation of a program in KwaZulu-Natal found that teachers tended to stick to factual issues rather than engage in developing life skills (Reddy et al. 2005). Resistance among educators and principals in terms of offering sexuality education programs in schools may be coupled with teachers experiencing discomfort in teaching areas of the curriculum (such as safe sex practices) that conflicted with their own value system (Ahmed et al. 2006; Francis 2011).

As a result of the introduction of Life Orientation, a number of newly constructed texts have been published in South Africa. Authors of these books draw on the post-democracy educational philosophy in South Africa, outcomes-based education. They include a number of learner-centered activities, asking learners to debate issues, to research topics and to produce assignments that express their own opinions. In the first author's (Macleod 2009) analysis of the sexuality education sections of Life Orientation manuals, she argues that, despite these learner-centered and critical approaches, there is a concentration on danger and disease as motivating factors for responsible sexual behavior. This emphasis has serious limitations in that the metaphor of danger and disease intermeshes individual disaster with social calamity, placing responsibility for averting disaster within the domain of individual self-management.

Family Planning Services

Family planning service provision is well established within the Department of Health and uptake of this service is good. Reported national contraceptive prevalence among reproductive age women is high at 62 %. This high proportion, however, masks differences in access in terms of setting, race, and age. For example, only 51.2 % of rural African women use contraceptives, as compared to 80.1 % of Indian women. More women between the ages of 20–24 years (68 %) use contraceptive methods than any other age group, although a large proportion of young women aged 16–19 years (64.4 %) also use contraceptives (Smit et al. 2004).

Research in various settings across the country indicates that family planning service providers complain of having insufficient time to counsel young people with respect to contraceptives. Other barriers include some health service providers' belief that some contraceptives are inappropriate for young people to use and, at times, disapprove of young people using contraceptives as this indicates sexual activity (Varga 2000). Negative attitudes among sexual and reproductive health professionals have been cited as a reason for youths avoiding family planning and antenatal clinics (Wood and Jewkes 2006).

National Adolescent Friendly Clinic Initiative

The National Adolescent Friendly Clinic Initiative (NAFCI) is an initiative intended to overcome some of the barriers young people experience in accessing sexual and reproductive health care. NAFCI works with service providers to improve the quality of adolescent health care so that services become more accessible and acceptable to young people. The program also aims at setting national standards and criteria for adolescent health provision that is youth-friendly, including having adolescent-specific policies and nonjudgmental staff, ensuring privacy and confidentiality, having an attractive environment, and following good practice clinical guidelines (Dickson-Tetteh et al. 2001).

Research that compared NAFCI clinics with control clinics found that the NAFCI clinics fared significantly better on the standards of adolescent friendly care than did the control clinics. The longer a clinic had been part of the NAFCI, the higher their 'adolescent friendly' score was. In particular, service providers were knowledgeable about the rights of adolescents and had a nonjudgemental attitude (Dickson et al. 2007). A study using requests for HIV testing from NAFCI and regular clinics showed that young people visiting NAFCI clinics were less likely to be turned away without a test. However, on other indicators, such as attitude of health staff toward youth, respect for confidentiality, and the appropriateness of counseling services offered to young people, the NAFCI clinics fared no better than other clinics (Mathews et al. 2009b).

Media Campaigns

As a result of the HIV/AIDS epidemic in South Africa, several national mass media campaigns have been launched, including radio programs, television programs, print material, and posters. These have been supported by localized face-to-face activities such as workshops or the formation of clubs. Although the focus is on HIV, there is spin-off benefit in terms of unintended pregnancies because of the discussion of sexual behavior and practices.

Evaluating the effect of mass media campaigns is complicated because of their national scale and the difficulty of attributing effects to the media component rather than some other intervention. Nevertheless, a national HIV and AIDS communication survey, which estimated the impact of eight national communication programs on HIV-related outcomes, demonstrated the efficacy of these programs on such things as condom use, self-efficacy in using condoms, communication with friends and partners, faithfulness to partners (Kincaid Parker 2008). These findings are not youth specific. Other research has shown, however, that teenagers' exposure to messages in the mass media is positively associated with increased condom usage (Katz 2006), condom use knowledge, self-efficacy, and delaying sex (Peltzer and Promtussananon 2003).

A survey of young people in KwaZulu-Natal reveals that 52 % of participants had been exposed to media campaigns in the previous month (Rutenberg et al. 2001). A smaller survey by Oni et al. (2005) suggests that the reception of such messages may be gendered, with 54.2 % of male and only 21.5 % of female respondents reporting that they had received a television or radio message about contraception.

Peer Education Programs

Given the HIV epidemic, peer programs have emerged as an important vehicle for the promotion of sexual and reproductive health among the youth on the basis that they utilize existing networks of communication and interaction, and because peers have been identified as important determinants of sexual attitudes and behavior (Panday et al. 2009). In 2000, the Department of Health initiated the *Rutanang* project (*Rutanang* is a Sotho word meaning 'learning from one another'). The project aimed at setting a rigorous set of standards of practice and evaluation for peer education. A set of documents that talk to creating a sustainable process built on reflexivity, evaluation, and programmatic improvement has been developed (Deutsch and Swartz 2002).

Ward et al. (2007) indicate that there are a large number of peer programs being implemented. These vary in methodology and take place in a range of settings although most target school learners. Many use an abstinence message, and not all use the *Rutanang* guidelines.

Although no systematic impact assessment of peer education programs has been carried out in South Africa, international literature suggests that peer education programs, especially if theoretically based, well conceptualized and well planned, are effective (Caron et al. 2004). However, there are a number of factors that may act as barriers to effectiveness in the South African context. These include lack of conceptual clarity around aims, methods, implementation, and evaluation; lack of theoretical grounding (Bastien et al. 2008); a preference among the peer educators for utilizing didactic methods and a biomedical model of sexuality; unequal gender relations between peer educators; the teacher-centered and regulated nature of schools; negative learner attitudes to peer education programs; limited opportunities for discussion about sexual matters outside of the peer educator program; poor adult role models of sexual behavior; poverty and poor resource bases (Campbell and Macphail 2002); programs not conducting needs assessments, setting up referral systems or conducting adequate monitoring and evaluation (Panday et al. 2009).

LoveLife

There is a range of South African non-governmental organizations broadly involved in sexual and reproductive health among youth. Here, we highlight the most well-known one with a national footprint. LoveLife is a multi-dimensional, multi-media program that focuses specifically on sexual and reproductive health of youth between the ages of 12 and 17. While HIV and AIDS are specific foci, the organization sees 'adolescent pregnancy' as closely associated with HIV infection and thus includes unintended pregnancy as a risk behavior that intervention can reduce. It is an organization with a strong focus on marketing, including a strong brand identity. It aims to provide young people with a positive, optimistic, but also realistic, understanding of sexual and reproductive health. It emphasizes choice, while still attending to the social and political factors that contribute to the complexity of the HIV epidemic (Harrison 2007).

Its activities include: peer education; a program that encourages frank and open discussion between parents and teenagers; public marketing strategies using cell phone messages, billboards, print, television, and radio media; telephone help-line centers that provide a range of services to young people; a train that takes the *LoveLife* messages across the country; games that include activities intended to encourage healthy choices and lifestyle. A corps of youth volunteers known as *groundBREAKERS* implements many of the programs.

In a national survey of youth in South Africa, it was found that 85 % of South African youths have been exposed to *LoveLife*, with 34 % having participated in at least one of *LoveLife*'s programs. Sexually experienced youth who participated in *LoveLife* programs were significantly less likely to be HIV infected (of course, this does not necessarily mean that the lower

infection rate was directly caused by the participation, as it is possible that those who participated in *LoveLife* programs were systematically different than youth who did not participate with regard to their HIV risk profile) (Pettifor et al. 2005). An evaluation of the *groundBREAKERS* program indicates that the intervention has positive effects on youth who take part (VOSESA 2008).

In the following sections, we highlight the possible combined effects of these preventive programs by briefly discussing research on the knowledge of contraceptives, the use of contraceptives, the timing of first sex, and violent and coercive sex among teenagers.

Knowledge of Contraceptives

Within the context of HIV, much emphasis has been placed on education about condom usage. James and colleague (2004) found that secondary school learners in the Midlands district of KwaZulu-Natal had a high level of knowledge regarding condoms. However, in studies more directly related to contraception (e.g., Oni et al. 2005; Richter and Mlambo 2005), young people's knowledge has been found to be variable, with some misconceptions abounding. For example, in Rutenberg et al. (2001) household survey in KwaZulu-Natal, few respondents (8 %) knew about the menstrual cycle and the times a woman has the greatest chance of becoming pregnant. This knowledge improved slightly with age. White respondents, urban African respondents, and female respondents were more likely to know of more than one method of contraception than other respondents.

Knowledge of emergency contraception is poor. Mqhayi et al. (2004) found that only 17 % of the young women they interviewed at urban and rural public health clinics had heard of emergency contraception, with significantly more urban-based women knowing of its existence than rurally based women. These trends seem to mirror the knowledge of this kind of contraception in the general population (Smit et al. 2001).

Use of Contraception

Ehlers' (2003) survey suggests that young women in Tshwane know about contraceptives, but that this knowledge is not necessarily associated with effective usage. In this study, 45.9 % of the sample of pregnant young women knew of contraceptive methods but had still conceived. Abel and Fitzgerald (2006) argue that a rational, decision-making model regarding contraceptive usage, that equates knowledge with usage, ignores contextual issues which may prevent young women, especially, from negotiating condom usage. This is taken up later in this chapter in terms of the high levels of coercive and violent sex experienced by young women.

It appears, however, that some inroads are being made in terms of contraception use among teenagers. Moultrie and McGrath (2007) report from the Demographic Surveillance Site in rural KwaZulu-Natal that between 2000 and 2005 the proportion of young people who had ever had sex remained relatively constant, but that contraceptive usage increased significantly. Simbayi et al. (2004) report a similar trend of increased contraceptive usage in their national survey as compared to findings from the 1990s. Dinkelman et al. (2007) found a significant increase in condom usage and a decrease in multiple partners between 2002 and 2005 among women aged 17–22 years surveyed in the Cape Area Panel Study.

Although contraception usage appears to be increasing, this varies considerably depending on a number of factors, including location (usage is higher in urban areas) and education (usage increases with educational status) (Department of Health 2007b; Kaufman et al. 2004; Mqhayi et al. 2004). Factors that prevent the use of contraceptives include perceived lack of risk, peer norms, gender power relations (MacPhail and Campbell 2001), lack of availability and access, fear of adult attitudes to contraceptive usage, and the economic context of 'adolescent' sexuality (Ehlers 2003). Using condoms at sexual debut and speaking to partners about condoms have been reported as indicators of

condom use at the respondents' most recent sexual interaction (Hendriksen et al. 2007), with one survey finding that younger respondents were less likely to speak to their partners than older ones (Manzini 2001). In the study by Mqhayi et al. (2004), only two out of 193 women had used emergency contraception, despite the fact that 39 % reported having had unprotected sex in the last year although they did not wish to conceive.

Timing of First Sexual Intercourse and Violent/Coercive Sex

The average age of sexual debut reported in recent research is somewhat older than that reported in Macleod's (1999b) review of 'adolescent pregnancy' research, where the average reported age at first coitus was around 14 years. In the 2003 SADHS (Department of Health 2007b), the median age of first intercourse is reported consistently across all age groups to be around 18 years; in Pettifor et al's. (2005) nationally representative survey it is around 17 years, and in Simbayi et al.'s (2004) nationally representative survey, 16.5 years. In the 1998 SADHS survey, 46 % of women reported that their first sexual encounter occurred before the age of 18. This percentage dropped to 42 % in the 2003 SADHS survey, indicating a possible general trend in delaying first intercourse. Despite this, early sexual debut is a feature for a sizable minority of young teenagers. Factors affecting sexual debut include education (higher education means later sexual debut), provincial location (earlier sexual debut was found in two of the poorer provinces), race (lowest among African teenagers), and orphan status (Department of Health 2007b). The latter is particularly significant in light of the increase in orphans and the occurrence of child-headed households as a result of the death of parents or guardians from AIDS. Research has shown that teenagers orphaned through HIV tend to have an earlier sexual debut than non-orphans (Thurman et al. 2006).

Of specific concern in the context of unintended pregnancy is the extent of forced sexual debut. Dunkle et al. (2004) found that the median age of first intercourse among their sample of women attending antenatal clinics was 17 years. However, 97 % of women who reported first intercourse before 13 years, and 26.7 % of those reporting at the ages of 13 and 14 years, also reported non-consent to coitus. Data confirming forced or coerced sexual debut is provided by Rutenberg et al. (2001) and Jewkes and Abrahams (2002).

The relationship between unintended 'adolescent pregnancy' and sexual coercion has, thus, begun to receive more attention. Jewkes et al. (2001) administered a questionnaire to 191 pregnant teenagers and compared this information with that obtained from 353 (never pregnant) young women of similar background in terms of school and neighborhood. They found that the pregnant young women experienced significantly more violence in their relationship and were more likely to have been forced to have sex for the first time. In addition, the partners of pregnant young women in their sample were more likely to be older, to not be in school, and to have multiple girlfriends than the partners of non-pregnant young women. Dunkle et al. (2004) found in their sample of women attending antenatal clinics in Soweto that over half of the women aged 15–30 had experienced physical and sexual violence or both from male intimate partners, with nearly one-third reporting incidences in the previous 12 months. Another survey, conducted by the Planned Parenthood Association of South Africa in six provinces, found that 20 % of teenage females reported forced sexual encounters or had been sexually assaulted.

The gender dynamics underpinning coercive sex have received attention in recent research. Varga (2000) contends that gender ideology enforces double standards in behavior and inhibits the ability of young women to negotiate with a partner. Constructions of masculinity in part rely on sexual performance, particularly the construction of *isoka*, a dominant and sexually vigorous version of masculinity. The threat of

HIV, however, seems to have diminished this norm, with young men reporting being more cautious than in previous studies. Jewkes and Christofides (2008); Swartz and Bhana (2009) suggest that paternity is so important to masculinity, that some young men might actively seek an opportunity to father a child. On the other hand, Jewkes and Morrell (2012) show how women in their research expressed highly acquiescent femininities, with power surrendered to men.

Programs: Antenatal and Perinatal Care

Where pregnancy does occur, the two sectors most involved in assisting the pregnant teenager are the Departments of Education and Health. In the following, we outline the management of learner pregnancy advocated by the Department of Education, and antenatal and TOP services provided by the Department of Health.

The Management of Learner Pregnancy

In 2007, the Department of Education released its 'Measures for the Prevention and Management of Learner Pregnancy.' In it, a range of both prevention and management procedures are laid out. The principles guiding the management of cases of pregnancy include dealing with cases confidentially, adopting an inclusive approach to education, and safeguarding the educational interests of the learner. The procedures recommended are as follows:

1. A learner should immediately inform a designated educator in the case of pregnancy;
2. Referral should be made to a health clinic or center, with the learner providing to the school a record of attendance on a regular basis;
3. Learners should be sensitized to the fact that medical staff cannot handle the delivery of babies at school. Learners may be required to take a leave of absence from school to address pre- or postnatal health concerns and to carry out initial childcare duties. No predetermined time is given, but it is suggested that a period of absence of up to 2 years may be necessary. No learner may be re-admitted in the same year that she left school due to a pregnancy.
4. Before returning to school, the learner must produce a medical report stating that she is fit to resume schooling; she must also demonstrate that proper childcare arrangements have been made.
5. Parents/guardians should inform the school concerning the health condition of the learner.
6. Parents/guardians should attempt to ensure that the learner receives class tasks and assignments during any period of absence from school.
7. Schools should encourage learners to continue with their education prior to and after delivery.
8. Schools should put into place mechanisms to deal with complaints by pregnant learners of unfair discrimination, hate speech, or harassment.
9. Schools should offer childbearing learners advice and counseling on motherhood and child rearing, should assist the learner in registering for CSGs, and should refer them to appropriate social support services (Department of Education 2007b, non-paginated).

Most of these guidelines promote a supportive, rights-based, and inclusive approach to the issue of 'adolescent pregnancy.' However, points 3, 4, and 5 above seem to give permission to schools to place obstacles in the way of learners' attendance at school throughout and after pregnancy and seem to stand in contradiction to stipulation 7 and, possibly, the Schools Act. None of the stipulations suggested in points 3, 4, and 5—a possible absence of 2 years, no re-admission in the same year, proof of health, and proof of proper childcare arrangements—are required from women who are employed and need to take maternity leave. These stipulations have led to some controversy with calls being made for their revision (Panday et al. 2009).

Antenatal Care

Data emerging from the 2003 SADHS points to less than adequate antenatal care for young pregnant women. Compared to pregnant women 20–34 years old, pregnant women under the age of 20 are more likely to receive care from a nurse or midwife than from a doctor and are more likely not to receive care at all. The components of antenatal care also reflect less adequate antenatal care for younger women compared to women in the age category of 20–34 years. They are less likely to be informed of the signs of pregnancy complications, to have their weight, height, and blood pressure measured, to have urine and blood samples taken or to receive iron supplements.

Many young women report for antenatal testing only in their second or third trimester. This should be seen in light of the finding that late presentation for pregnancy care is a general and persistent problem in South Africa (Myer and Harrison 2003). In addition, taboos associated with teenage sexual activity, denial of paternity by a male partner, and lack of knowledge regarding the importance of antenatal consultations may be reasons for late attendance (Phafoli et al. 2007).

Women who have accessed urine pregnancy testing tend to seek care up to 4 weeks earlier than those who have not. Barriers to young women accessing urine pregnancy testing within the public health sector include ignorance of protocols on the part of service providers and a negative attitude to providing pregnancy tests for teenagers on the basis that this encourages them to be sexually active (Morroni and Moodley 2006).

Termination of Pregnancy Services

The introduction of the CTOP Act has had a significant impact on abortion-related mortality and morbidity in general and particularly for teenagers. Prior to the introduction of the Act teenagers were most at risk for unsafe abortion with one-fifth being in the high-severity category. By 2000, they were likely to be in the low-severity category (Jewkes et al. 2005).

There have nevertheless been challenges in terms of the implementation of the Act. The Department of Health's (2000) review of the implementation of the CTOP Act revealed that only 32 % of the 292 service sites were functioning at the time. There were, according to the report, large parts of the country that did not have access to services at all, in particular rural areas. This improved dramatically with the Department of Health's (2003) review showing that 62 % of sites were functioning. Negative perceptions of TOP services by the health care providers themselves are most frequently cited as the reason for the failure to provide services at all designated sites (Wood and Jewkes 2006). Attitudes and perception are especially relevant in this context because the choice of nurses not to work in TOP clinics is enshrined by policy and legislation. The fact that minors may obtain a TOP without parental consent and that there is no limit to the number of *TOPs* that women may request are some of the issues causing concern among some service providers (Macleod and Luwaca 2005).

Cooper et al. (2005) compared women attending one rural and two urban TOP clinics. At the rural site, 31 % of the women were teenagers compared with 18 % at the urban sites. In general, the women seeking TOP were younger and better educated than the general population of reproductive females. These data suggests that younger women who are well educated are in general more willing and able to make use of TOP services.

Research

A number of shifts in focus with regard to South African research on 'adolescent pregnancy' are evident, as comparison of Macleod (1999a, b) and Macleod and Tracey (2010) indicate. Researchers no longer pontificate about the obstetric outcomes of teenage pregnancy, but rather concentrate on the services that are provided to young women. The mothering capabilities of young women do

not feature as a research question, although (contradictory) data on infant and child mortality rates are available in the 2003 SADHS (these are not reported on here as the data presented are contradictory and hence unreliable). Relationship difficulties with family of origin and partner, which were reported on in Macleod (1999a), are no longer really an issue. Demographical concerns have disappeared from the radar screen, but welfare concerns have emerged with the introduction of the CSG. Disruption of schooling remains a topic of debate with respect to the outcomes of early pregnancy. Reproductive knowledge, the source of knowledge, sexual debut, and the use of contraceptives remain as central points of focus. Researchers seem to have lost interest in expounding early menarche, psychological problems, family structure, and peer influence as contributory factors, all factors that featured in the research reported in Macleod (1999b). Coercive sex and cultural issues remain of interest to researchers, although more nuances are evident in the former and less in the latter. The level of health service provision, as a contributory factor, continues to be an important area of focus.

In general, the quality, depth, and breadth of the research have improved over the last 10 years. This is as a result of (1) the nationally representative as well as localized health surveys being conducted; (2) researchers' teasing out of the nuances surrounding particular issues (such as school return, CSG, interactions between young people and elders around sexual issues, condom usage, and coercive sex); and (3) increased levels of theorizing around particular issues. The data that we have access to and the engagement of researchers with the complexities of issues arguably provide a much better basis for thinking through, planning, and implementing interventions.

Conclusion

The rights-based approach adopted by the South African government to sexual and reproductive health enshrines a young woman's right to prevent an unwanted pregnancy, to plan a pregnancy with her partner should they wish, to make an independent decision concerning the outcome of a pregnancy, to terminate that pregnancy safely should she wish, and to access non-discriminatory prenatal and postnatal care should she take the pregnancy to term. It also means that young women should not be penalized in their vocational, economic, and social roles because of their reproductive status. It is arguably this right-based approach has contributed to the sustained decrease in teenage pregnancy rates. While there are still many obstacles and challenges associated with the issues of 'adolescent pregnancy,' it is important to remember the success represented by, and that arises from, this rights-based legislation.

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Silent Cry: Adolescent Pregnancy in South Korea

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Keywords

Abortion • Adolescent pregnancy • Adolescent sexual behavior • Fertility rates • Maternal care and child care • Public stigma • Sexual debut • Sexual education • Risk factors • Virginity education

Introduction

The rate of sexual intercourse among South Korean adolescents was around 5 % during 2005–2009. This was about one-tenth of that reported by adolescents in the United States and among the lowest when compared to other Asian countries. Throughout the same period, South Korean boys as is typical for most countries worldwide reported relatively higher rates of sexual experiences than girls (Korea Centers for Disease Control & Prevention & Soon Chun Hyang University 2007). As well, during this period (2005–2009), 3–4 adolescent girls out of 1,000 reported becoming pregnant each year (Korea Centers for Disease Control & Prevention, Ministry of Education, Science and Technology & Ministry for Health & Welfare 2010). These self-report numbers, however, appear to be a bit low (probably due to social desirability) because actual fertility rates among adolescent girls during 2005–2008 varied from 3.8 to 5.5 per 1,000 girls. In 2008, for example, the South Korean girl's fertility rate of 5.5 out of 1,000 girls was 1.9 higher than that of the pregnancy rate. Although the adolescent fertility rate in South Korea is relatively small, sixth lowest among 39 OECD countries reported in 2008 (World Bank 2013), the significance of adolescent pregnancy or becoming an adolescent mother for a Korean girl is not as harmless as the numbers might suggest. It is common in South Korea for pregnant adolescents and teen mothers to be stigmatized by other adolescents and adults as well. Moreover, pregnant adolescents who are attending school are covertly and, even at time, overtly forced to quit school or transfer to another school (Kim 2010).

Given these realities, over the last few years, many efforts have been made in South Korea to protect pregnant adolescent girls and adolescent mothers and to provide the necessary services to them and their children. In 2010, for example, the National Human Rights Commission of South Korea issued a policy recommendation to three key government departments responsible for various issues related to adolescent mothers regarding their responsibility to protect the adolescent mother's educational rights (National Human

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Rights Commission of Korea 2010b). Following this recommendation, the Ministry of Education, Science and Technology, advised schools to modify all rules and regulations that hindered adolescent mothers from finishing their education (National Human Rights Commission of Korea 2010a). Additionally, the Ministry of Health and Welfare created a provision that covers the medical expenses of the cost of necessary prenatal care and other medical services for pregnant adolescents and adolescent mothers (National Human Rights Commission of Korea 2010a).

A Korean Perspective on Adolescent Pregnancy

Vignette: "I just want to stay in school and to be a mom as well!"

In April 2009, Y who was a senior in high school and who hoped to become a professional accountant got pregnant. Y and her boyfriend, the baby's father who was 26 years old, had been dating with the approval of her and her boyfriend's parents. They planned to marry after Y graduated from high school. Things became complicated when her pregnancy was disclosed to her teachers by the school nurse. Her teachers then called on Y's mother and told the mother that Y was not allowed to go to school while pregnant. The teachers firmly advised Y's mother that Y needed to voluntary drop out of school and even told Y's mother that Y would be expelled from the school once the principal knew of Y's pregnancy. And, if Y was expelled from high school, Y would not be eligible for reenrollment consideration, and Y would not be able to take a school qualification exam (Equivalent to GED in the US) to get into a college. Y and her boyfriend appealed to the school officials, but the appeal failed to change their minds. Moreover, school officials escalated their treats. It was suggested that because Y was a minor and her boyfriend was responsible for Y's pregnancy, he could face criminal charges. Eventually, Y and her mother had to admit that Y had no choice but to "voluntarily" drop out of school. Y dropped out of school in her senior year in high school, but decided to file a petition to the National Human Rights Commission of Korea regarding her case.

Social Views and Customs

Tradition is based on the influence of Confucianism; as such, people in Korea have been characterized by their conservative attitude toward sexual behaviors both among adolescents and adults. An old adage that describes the strict norms about the relationship between boys and girls of the older generation is that "Boys and girls over the age seven may not sit side by side." These customs were thought to restrain adolescents' sexual interest (Youn 1996). Consequently, there have been rather firm social and cultural sanctions prohibiting dating among adolescents.

These sexual norms and attitudes although strict do not apply equally to both boys and girls. Girls in Korea face more restrictions on their activities in relationships to boys and are expected to be chaste while boys' sexual experiences are widely considered "acceptable" (Youn 1996). Typical South Korean parents, who hold more conservative views and attitudes about relationships between boys and girls, place more emphasis on keeping virginity of their daughters until marriage than they do for their sons. It is sometimes even considered a disgrace of the family for a girl in the family to be pregnant or become a mother before marriage. When an adolescent girl becomes pregnant or gives birth, it is the girl who is blamed for the consequences regardless of who the boyfriend or his partners are (Choi 2003; Yoon 1998). Even in case where the pregnancy resulted from sexual violence or rape, it is often the victim who is considered to be at fault, at least partly.

These traditional South Korean views about the relationship between adolescent boys and girls are changing, especially among the younger generation. Western culture, imported through popular mass media (films, songs, books, and TV shows), which is rather liberal by comparison, have influenced ideas about dating and relationships even for youngsters.

Adolescents today are far more liberal in their ideas and attitudes than those of the older generations. A national study of adolescent in 2008 showed that over a quarter of the adolescents answered that having sex before marriage is acceptable among loving couples (Ministry for Health, Welfare, & Family Affairs 2008). The survey also found gender differences; girls seemed to be more conservative than boys. Only 19 % of girls, compared to 34 % of boys, answered positively on question of having sex before marriage.

Regarding sexual relationships during their teenage years, adolescents in South Korea appear to apply different norms by gender or apply more restrictive norms to girls than to boys. In the 2008 survey, 66 % of Korean adolescents answered that girls should keep their virginity until marriage while 56 % answered that boys should do the same (Ministry for Health, Welfare, & Family Affairs 2008).

Nonetheless, the public norms and attitude toward adolescent pregnancy and adolescents becoming a mother continue to be quite negative in South Korea (Sung 1992). This remains true even though people's attitude toward sex in general has changed quite a lot of in recent years. As a result of this negative public attitude toward adolescent pregnancy, adolescent mothers and even toward their babies results in many adverse consequences for the teen and her child if she carries to term. For example, in the 2008 survey, among adolescent girls who answered that they had become pregnant at least once, 88 % reported that they had aborted their babies by medical surgery at least once in their lifetime. This percentage is equal to 2.4 girls out of every 1,000 girls in South Korea who aborted a pregnancy (Korea Centers for Disease Control & Prevention, Ministry of Education, & Ministry for Health & Welfare 2009).

Overview of Adolescent Pregnancy

Sexual Debut

In 2009, it was reported by the Korea Centers for Disease Control & Prevention that 15 adolescent males per 1,000 and six adolescent girls per 1,000 reported their first sexual debut occurred before they entered middle school, or the age of 13. Based on this national study using self-report by adolescents enrolled in school, the average age of sexual debut among those who experienced sexual intercourse was 14 years of age with boys slightly younger (13.8 years) than girls (14.3 years). Numbers reported here may be underestimation of actual ages at the first experience of sexual intercourse because, in the original study, this specific question was asked to respondents from age 13–18, and the calculation of the average age of first sexual intercourse was based only on those who experienced sexual debut. We simply do not know when those who have not yet experienced sexual debut would do. In other words, adolescents who did not yet experience the first sexual debut were not included in the calculation, which should result in underestimation of actual age of the first sexual intercourse.

These numbers have not changed much. Over the last five years, study data show that girls continue to report that they experience their sexual debut later than boys (Fig. 1). In 2009, 15.2 % of 18-year-old boys and 6.8 % of 18-year-old girls answered that they had experienced sexual intercourse with either same sex or different sex partner. There also seems to be rather a big difference in terms of prevalence of sexual debut among 15- and 16-year-old adolescents as they transition from (what is the equivalent in the U.S.) the last year of middle school to the freshman year in high school (Fig. 2).

Among the adolescents who experienced sexual debut, 42 % reported that they had used some type of contraception and had used contraception either "all the times" or "most of the times" when they had sex. Use of contraception during sexual intercourse among adolescent increased during over the last five years from 28 % in 2005 to 42 % in 2009.

Pregnancy

In 2009, 3.6 out of 1,000 South Korean adolescent girls between 12 and 18 years of age answered

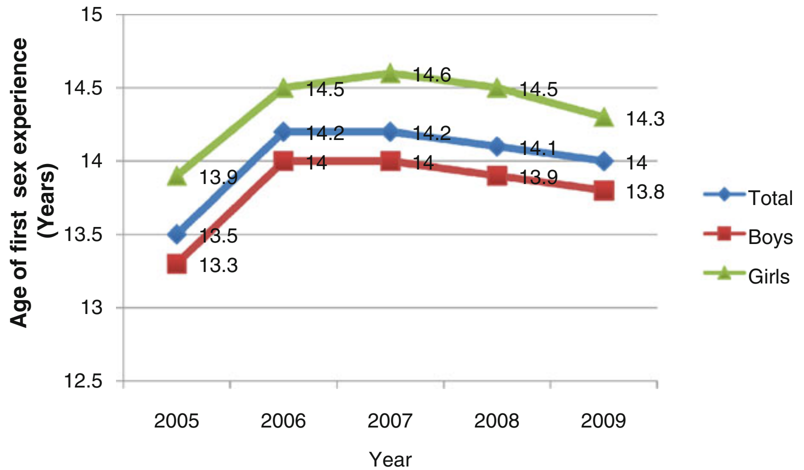

Fig. 1 Age of sexual debut, 2005–2009

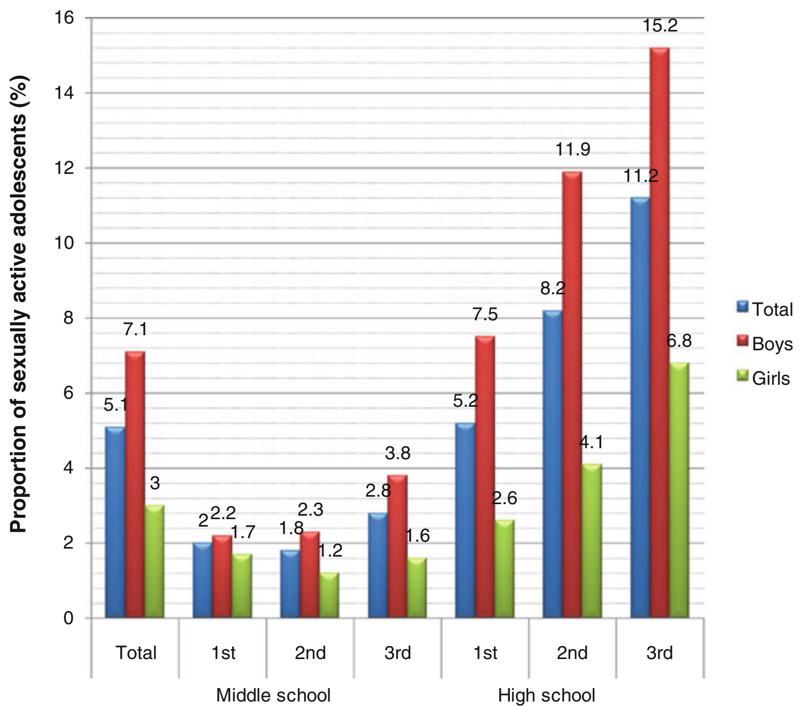

Fig. 2 Proportion of sexually active adolescents by grade (2009)

that they experienced pregnancy at least once in their lifetime. Among 18-year-old girls only, or toward the end of adolescence, this number went up to 5.8 per 1,000. Also, among those who experienced sexual debut, 12.8 % reported pregnancy history during their adolescence. This number has not changed much during the last five years. In 2005–2009, the number of adolescent girls who experienced pregnancy ranged from 2.5 per 1,000 in 2007 to 4.3 in 2006 (Fig. 3).

Abortion

Most of the pregnancies that occur during adolescence in South Korea appear to result in abortion. As mentioned earlier in the vignettes, most pregnant adolescents suffered stigmatization and, consequently, isolation from schools, peers, and even from their own family members. Due to the social environment, many of the adolescent pregnancies result in abortion.

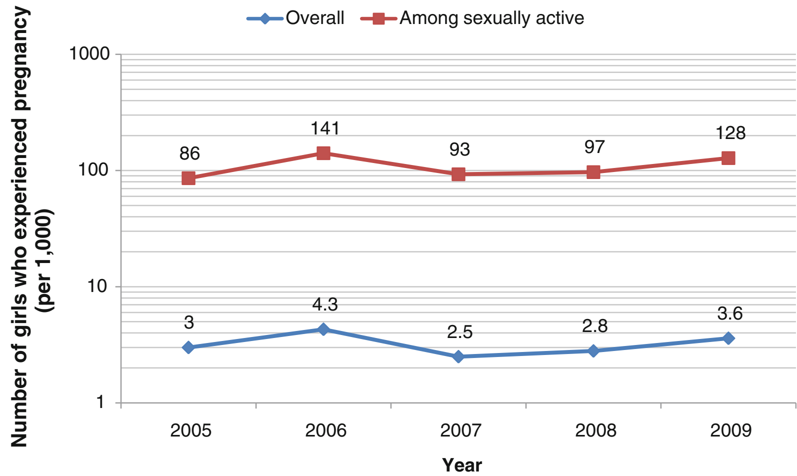

Fig. 3 Trend of pregnancy rate, 2005–2009

Abortion is illegal in South Korea with a few exceptions, such as serious risk to pregnant women or pregnancy as a result of rape or sexual assault. However, based on the analysis of the data from National Online Survey of Adolescent Health Behaviors (Lee et al. 2010), 79 % of girls who experienced pregnancy also reported an experience of abortion. This rate of abortion is equivalent to three out of 1,000 South Korean adolescent girls. It should be noted that in the National Survey of Adolescent Health Behaviors, the abortion question was not linked to specific pregnancies. In other words, the analysis result does not necessarily mean that 79 % of adolescent pregnancies resulted in abortion.

Fertility Rate

Fertility rates reported among females between 15 and 19 years of age were 13 per 1,000 in 1970 and ten per 1,000 in 1985 (UN 2009). The rate declined rather consistently after peaking in 1970. A period when teen pregnancy was high, for the most part, internationally. During the last decade, adolescent fertility rates remained under three per 1,000 (Fig. 4). Based on the South Korean birth registration records in 2009, girls and young women between 15 and 19 years of age had a fertility rate of 1.7 births per 1,000. This rate is projected to drop to 1.5 in 2010 (Statistics Korea 2011). There were two different sources of statistics on 2008 South Korean adolescent fertility rates available, which were quite different with each other. One was from "2008 United Nations Demographic Yearbook" made available by the Statistics Division of the United Nations Department of Economic and Social Affairs. Based on the statistics from the Demographic Yearbook, South Korean adolescent fertility rate was 1.7 births per 1,000 girls of 14–19 years old, which was consistent with the statistics provided by the South Korean Department of Statistics. The other source was from "World Population Prospect: The 2008 Revision" by the Population Division of the United Nations Department of Economic and Social Affairs. The World Population Prospect reported 5.5 per 1,000 Korean adolescent girls between 15 and 19 years, which were over three times as high as the same statistics from the Demographic Yearbook. We confirmed with the South Korean Department of Statistics that the adolescent fertility rates reported in the Demographic Yearbook were based on the data provided by the Korean Department of Statistics. Thus, we employed the numbers from the Demographic Yearbook regarding Korean adolescent fertility rates. We have yet to figure out from which data source the World Population Prospect employed in the report and why they are different from each other.

Adolescent fertility rate in South Korea is relatively low compared with the U.S., European

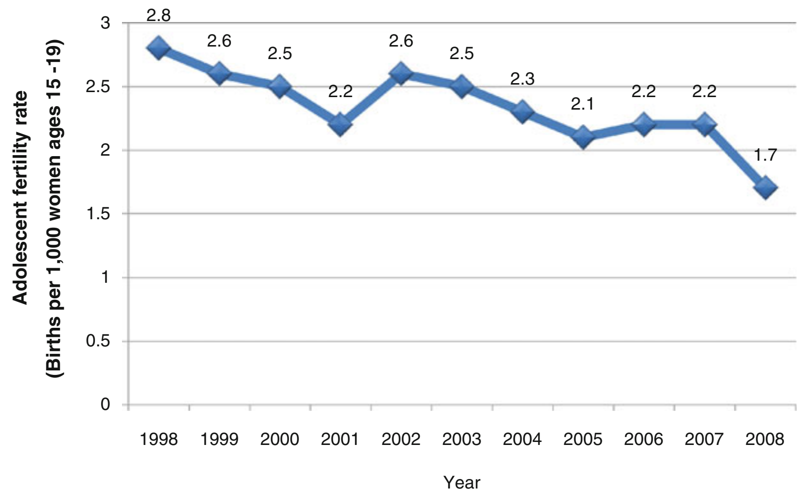

Fig. 4 Adolescent fertility rate, 1998–2008

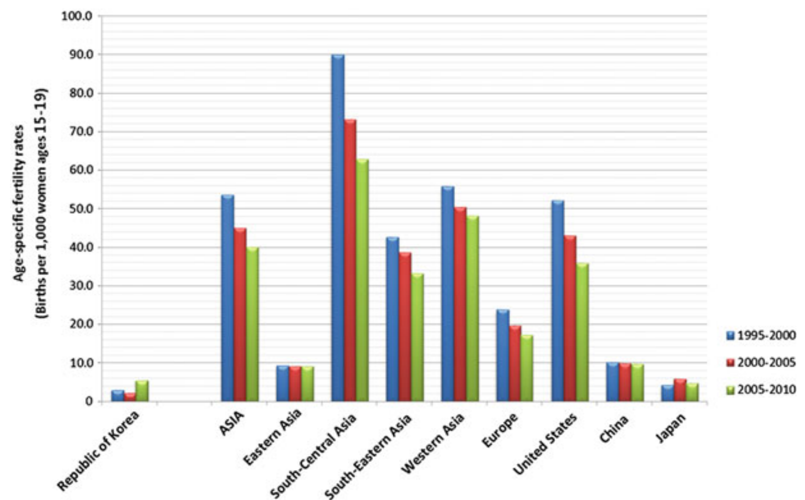

Fig. 5 Adolescent fertility rate by region and country

countries, and other Asian countries. Figure 5 summarizes average adolescent fertility rates of Europe, America, and other areas of Asia. It shows that the fertility rates for South Korean adolescents were lower than any other areas including Japan and China during the last 15 years.

Many of these babies born to adolescent mothers are not raised by their mothers. They are referred to adoption agencies for couples who want to adopt infants. Even though increasing number of adolescent mothers are deciding to keep their babies, about 80 % of unmarried adolescent mothers, voluntarily or involuntarily, chose adoption for their new born babies (Choi 2003)

Understanding Adolescent Pregnancy in South Korea

Until the early 1990s, there were few studies examining adolescent pregnancy or other sexual behaviors in South Korea. As a result, little was known about the topic including the prevalence of adolescent sexual involvement (Sung 1992). Over the last two decades, however, awareness about the grave impact of adolescent pregnancy on the individual adolescent, family members, the girl's health, and her social and psychological functioning has prompted a number of surveys and studies. These efforts by both the

government and academics to better understand the causes and consequences of adolescent sexual behaviors and pregnancy have provided valuable information for planning health and psychosocial interventions and services. Two studies on nationally representative samples of adolescents, the National Online Survey of Adolescent Health Behaviors, and the National Study on Adolescents' Exposure to Risky Environment have been conducted since 2005 and included a rather comprehensive questionnaire probing respondents' sexual behaviors and other related factors including sexual intercourse, pregnancy, contraception, sexually transmitted disease, and sex education. These studies inform our understanding and assumptions about the nature of adolescent sexual development in South Korea.

In these studies, risk factors associated with AP were found to be related to the family structure, specifically growing up in a single-parent household (Bae 2001; Hong and Moon 2009). The association between family structure and an increased risk for adolescent pregnancy is familiar to many countries who have studied adolescent pregnancy (Miller 2002; Woodward et al. 2001). Based on the data from the National Online Survey of Adolescent Health Behaviors, Hong (2009) found that two per 1,000 girls living with both parents reported pregnancy experience while six and 22 girls living with only a parent or no parent, respectively, reported the same.

While most Korean studies of adolescent sexual behavior reported low socioeconomic status as a risk factor of adolescent pregnancy (Bae 2001; Hong and Moon 2009; Lee 2005), there are some inconsistencies in the findings. Kim (2002) studied 136 adolescent mothers from six shelters nationwide for unmarried mothers and found that 81 % of the mothers reported their economic status as middle class or above. In the same study, however, their parents' education level appeared low, which seems inconsistent with the reported economic status. Only 8 % of fathers and 7 % of mothers were college graduate or higher (Kim 2002).

Another study stressed that there were about 38 % of adolescent mothers in their sample above middle class based on their reported household income (Yoon and Lee 2002). Overall, although a substantial proportion of adolescent mothers were from middle-class families, low socioeconomic status seemed to increase the risk of adolescent pregnancy in South Korea.

A characteristic often associated in the literature with adolescent pregnancy is a history of child abuse. In the South Korean studies, however, there is little support for the association between child maltreatment and an increase risk of adolescent pregnancy. Although one study, limited by the sample, found that among a population of unmarried adolescent mothers from eight shelters throughout South Korea, adolescent mothers with a child abuse history experienced their first pregnancy earlier than the adolescent mothers without a child abuse history (Kim 2002). Another study reported an increased risk of sexual relationship experience, not pregnancy, among high-school girls who had experienced psychological abuse in their childhood compared to those who had not (Lee 2005). In sum, however, because both of these studies have major limitations in terms of generalizability, the association between child abuse experience and risk of adolescent pregnancy is not evident from these studies.

In these South Korean studies, peer-related variables were also identified as factors that increase the risk of adolescent pregnancy (Kim 2002; Lee 2005; Ryu et al. 2004). In one study, Kim (2002) found a significant bivariate relationship between attitude of peers about sex before marriage and age of adolescent first pregnancy. This correlation was not significant, however, when adjusted for the effects of other variables such as school dropout and child abuse experience. In another study, data were collected from 1,548 high-school students and 61 adolescent mothers in shelters. In this study, Lee (2005) found that sex experience and pregnancy experience of peers were associated with increased odds of pregnancy in adolescence even after controlling for other risk factors.

Other risk factors found in similar studies such as enrollment in a vocational school (Kwon et al. 2006; Ryu et al. 2004), school dropout (Kim 2002; Yoon and Lee2002), alcohol use (Hong and Moon 2009; Sohn 2010; Sohn et al. 2002), smoking (Hong and Moon 2009; Kim and Jeon 2007; Ryu et al. 2004; Sohn 2010; Sohn et al. 2002), drug use (Hong and Moon 2009), and sex under the influence of alcohol (Hong and Moon 2009) were also associated with adolescent pregnancy. Kim (2002) and Kim and Kim (2002) also found that adolescent girls who dropped out of school experienced their first pregnancy younger than those girls who stayed in or finished school. In a study using a nationally representative sample of South Korean adolescents enrolled in junior high and high schools, risk factors for increased odds of adolescent pregnancy were identified as drinking alcohol, smoking, using drugs, sex under the influence of alcohol, and employment in a job outside school (Hong and Moon 2009).

As informative as these studies are, the issues related to the sample warrants special attention and explanation. First, many of these studies only included adolescent mothers from shelters (e.g., Bae 2002; Cheon et al. 2002; Kim 2002; Kim and Kim 2002). This is problematic because no comparison can be made between girls who have experienced pregnancy and those who have not. As a result, although the findings can be used to describe South Korean adolescent girls who become pregnant, the studies cannot be used to determine risk factors that predict adolescent pregnancy. Second, many of the studies that have been conducted use regional samples (e.g., Kim and Jeon 2007; Sohn et al. 2002), which makes generalizability of the findings to all of South Korea debatable at best. There are two studies that used nationwide probability sample of community adolescents (Korea Centers for Disease Control & Prevention et al. 2010; Ministry of Gender Equality and Family 2010). These are relatively recent efforts by the South Korean government and academia but their success is expected to promote additional studies that will not be as limited to scope and sample as previous studies.

Prevention: Sex Education

The concept of sex education was first introduced to South Korea in 1947 and referred to as "Virginity Education" (Lee and Kim 2001). As the name implies, the main purpose of sex education at the beginning was placed on abstinence, or keeping virginity, of adolescents especially for girls until marriage. In 1983, the Department of Education of Korea published "Teacher's guide for sex education," which introduced sex education to the South Korean education system (Lee and Kim 2001). Influenced by western sex education, which was considered more liberal than "virginity education," this guide was the first attempt to define sex education in rather realistic terms (Lee and Kim 2001).

Sex education in South Korean schools starts in the first year in elementary school. The current version of sex education (the 7th revision of the sex education curriculum) in South Korea requires schools to provide at least 10 h of sex education per year is taught by a teacher who specializes in sex education (Ministry of Education and Busan Metropolitan city Office of Education 2008). More recently, the hours of sex education in elementary school and middle and high schools have been increased from 10 to 17 h. In high school, schools may opt to select "Health" as one of the elective courses, which includes sex education as a part of the regular curriculum.

The sex education curriculum is comprised of four parts: human relationship and sexual psychology; human body development and sexual health; social environment and gender equality; and marriage and healthy family. All of these sections are embedded in the curriculum and designed to be school grade appropriate (Ministry of Education and Busan Metropolitan city Office of Education 2008).

Overall, the current content of sex education programming in South Korea emphasizes enhancing adolescents' knowledge about sex with the primary focus on "safe sex" rather than "abstinence only or keeping virginity" (Moon 2010). Specifically, the sex education in middle school teaches prevention of sexually

Table 1 Facilities for single parents (as of 12-17-2010)

• Type of facility	Number of facilities	Eligibility	Maximum length of stay (Extension)	Number of slots
• Mother–child residential shelter	• 41	• Child under 18 years; mother–child of low-income without house	3 years (2 years)	1,052 households
• Father–child residential shelter	• 1	Child under 18 years; father–child of low-income without house	3 years (2 years)	20 households
• Mother–Child self-reliance support facility	• 3	Child under 18 years; mother–child of low-income without house; seeking self-reliance support	3 years (2 years)	41 households
• Unmarried mother–child residential facility	• 32	• Unmarried pregnant women or mother with infant (<6 months of age)	1 year (6 months)	767 women
• Group home for unmarried mother–child	• 24	• Unmarried mother with infant of 2 years or younger	2 years (1 year)	205 households
• Group home for unmarried mother	• 1	• Unmarried mothers after delivery who do not raise babies	2 years (6 months)	10 women
• Group home for father–child households	• 1	• Father–child households having difficulty in self-reliable lives	2 years (1 year)	15 households

Source: http://withmom.mogef.go.kr/welfare/facilitiesInformation.do

transmitted disease, contraception, pregnancy, sex and dating, masturbation, and controlling sexual desire, etc (Ministry of Education and Busan Metropolitan city Office of Education 2008). Based on the data from the National Study on Adolescents' Exposure to Risky Environment, over 50 % of adolescents reported their first sex education occurred between fourth and sixth grade in elementary school.

Parents are also one common source of sex education. Using a regional sample of high-school students, Kim and Lee (2005) reported that about 27 % of adolescents reported they had received their sex education from their parents. Kim and Lee also reported that parental sex education decreased adolescent sexual behaviors for boys but not for girls. However, in an earlier study, it was reported that parental discussions about sex with their children (not necessarily with the purpose of sex education) decreased the risk of sexual activities among middle- and high-school girls (Yoon 2002).

Programming: Maternal Care and Child Care

There are 118 resident facilities across the country of South Korea that provides housing and other services for low-income single parents without a place to stay. Most of the facilities are available for adolescent single mothers except for two that are exclusively available for single fathers with a child. Table 1 summarizes the basic information about these facilities.

These facilities are funded by local government and operated by foundations or other agencies. Residents of these facilities receive housing support, counseling and treatment services for psychological and emotional conditions, parenting education, and vocational programs to promote self-reliance. Depending on income level, the residents are also granted some funds for living expenses, childcare, and tuition for their child's education.

There are some medical provisions available for unmarried pregnant adolescents. For those who stay in unmarried mother–child residential facilities, public community medical centers or hospitals are responsible for each mother where she will receive necessary medical care including prenatal care and delivery for teens with special needs. In cases where the babies of adolescent mothers are born premature, the government supports the medical cost for the babies.

Besides the efforts driven by public sectors, there are a variety of small size programs supported by private community agencies. Samsung Welfare Foundation and Community Chests across South Korea are leading contributors supporting these efforts by local community agencies.

Education for pregnant adolescents and adolescent mothers has been a controversial issue in South Korea. Once a student's pregnancy is revealed, the student faces disgrace and rejection from peers, teachers, and even her own families. In some cases, the parents of other students protest the decision to allow the pregnant adolescent to attend school fearing the possible negative influence of the pregnant student on their own children. Until recently, most schools have had rules and regulations against pregnant students or students with babies attending school. Schools and teachers, overtly and covertly have forced pregnant students to leave schools voluntarily, or they have expelled them. Consequently, many pregnant adolescents have left schools against their will.

A breakthrough has recently been made to secure pregnant adolescents and adolescent mothers educational rights in South Korea. As a result of a pregnant student's appeal to the National Human Rights Commission of Korea, the commission investigated the case and issued an advisory statement for the Ministry of Education, Science and Technology, to implement any necessary actions to prevent pregnant adolescents or adolescent mothers from being forced out of the educational system. The Ministry of Education, Science and Technology responded to the statement by developing a number of new policies. First, the ministry advised local school districts and schools to revise the rules and regulations that punish a student's pregnancy. Second, the residential shelters and facilities for pregnant adolescents were authorized by the Ministry to perform an educational function during the adolescents' stay. Further, the education received from the shelters and residential facilities were recognized equivalent to the regular school education. As of March 2011, there are seven facilities across the country, which are authorized by the ministry to provide alternative residential schooling services. Lastly, the ministry would develop educational programs for students to prevent adolescent pregnancy. Also, teachers would be provided with training programs designed to turn their perspective on pregnant adolescents from punishment to protection of becoming mothers and to increase their awareness about adolescent pregnancy.

A Korean Perspective on the Future of Adolescent Pregnancy

Traditionally, an open discussion about adolescent sexual behavior and pregnancy was taboo in Korea. Pregnant adolescents were publicly stigmatized and ostracized by their peers, teachers, and, sometimes, even by family members. Given this social reality, pregnant adolescents in South Korea have been left alone outside any support system and had to cry silently.

South Korean society has been experiencing a rapid change in general. Among those changes were progressive policy provisions to promote the education and health of pregnant adolescents, adolescent mothers, and their offspring. Especially, after the advisory statement from the National Human Rights Commission of South Korea in 2010 (National Human Rights Commission of South Korea 2010b), the South Korean government and the education system have been working together to secure pregnant adolescents' access to education, medical, and other crucial services. As well, these government agencies have been making significant efforts to

enhance the public awareness about adolescent sexual activities and pregnancy via educational programs within and outside of schools.

Yet, what effect the implementation of policy provisions and other efforts will make in the lives of pregnant and parenting adolescents. Hopefully, public attitudes and perceptions about pregnant adolescents and adolescent mothers will eventually change as a result of these efforts. However, it is hard to imagine that significant changes in public awareness and attitude will change in the near future.

In order to stop the "silent cry" of adolescent mothers and their babies in South Korea, there are a few recommendations warranting special attention based on this review. First, a primary prevention effort regarding adolescent pregnancy in public sectors including the school system should be accompanied by the same efforts at family level. As the studies of sexual education showed, many adolescents reported the primary source of knowledge about sex was their own parents. Further, these South Korean studies suggest a positive influence of parental sexual education and even parent–child conversation about sex on reducing risky sexual behaviors of South Korean adolescents. A significant effort should be directed to the education of parents and other family members to increase the positive effect of sex education within rather than proximal in the family system.

Second, the ongoing efforts to enhance public awareness about pregnant adolescents and adolescent mothers should be continued. While there has been some public outcry, especially in the media regarding the punitive environment that pregnant adolescents must deal with, overall public attitude and perception about pregnant adolescents have been slow to change. The hostile atmosphere that pregnant adolescents face far too often results in abortion, giving up motherhood and putting their child up for adoption, or sadly, abandonment of the newborn baby, which often results in the death of the baby.

Lastly, much more attention should be directed to meet pregnant adolescents' medical needs and welfare of their babies because most pregnant adolescents are typically not financially self-sufficient and often lack a support system. Given these circumstances, it is likely that many pregnant adolescents do not get much needed prenatal care and other crucial services that any prospective mother should expect. Having few alternatives because of the lack of financial and emotional support, far too many unmarried adolescent girls are forced to give their babies up for adoption. Given these circumstances, far more public and foundation resources should be allocated to enable adolescent mothers, if they wish to keep their babies and fulfill their maternal rights.

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Teenage Pregnancy in Spain

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Keywords

Spain: abortion · Abortion law · Contraception methods · Free union · First sexual intercourse · HIV · Sex education · STIs · Transition to adulthood · Unintended pregnancy

Introduction

In Spain, health and social policy makers and ministers are concerned about teenage sexuality because of the medical and emotional problems associated with adolescent pregnancy and motherhood. This is not misplaced concern. While research shows that there has been an increase in the use of condoms among Spain's adolescent girls and young women, research also shows that abortions have continued to rise among girls and young between 15 and 24 years of age. The increase in the rate of abortion indicates unsafe sexual practices. Furthermore, the practice of unsafe sex is a cause for the transmission of STIs, including HIV, especially among the 15–24-year-old age group (Monascha and Mahyb 2006; Pettifor et al. 2005).

To move beyond easy answers that never quite work, adolescent pregnancy can only be understood as the result of the sequelae of adolescent development within harsh and unforgiving cultures. To move beyond the perception of values and customs in our understanding of adolescent pregnancy, the transition to adulthood must include a *sexual expression* phase. Currently, the transition to adulthood can be described and has been normalized as various events such as the beginning of sexual expression, completion of studies, and emancipation from the original household. The period of the maturation process that has not been normalized or given due consideration, especially when it comes to girls, is the beginning of sexual experimentation and expression. This lack of normalization leaves a void that impairs our understanding and appropriate reaction to sexual expression as a normal part of an adolescent girl's development. It is extremely problematic. The pressure on young girls to abstain from sex

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is only comparable to the pressure from society for her to express her sexuality.

The beginning of sexual activity is often the prelude to other transitions that usually start with the entry into the labor market, followed by emancipation, establishing a domestic partnership, and the arrival of children. However, the chronology does not always follow this sequence. The process is influenced by geographic, demographic, and conjectural circumstances, as seen when economic conditions change behavioral patterns and hampers, for example, emancipation (Baizán et al. 2003).

In earlier times, the main purpose of this sequence was reproduction. Today, this sequence of transitions is not intended as a mean to procreate, and increasingly, these vital milestones are more independent. So, living with a partner may not follow emancipation or the arrival of the children. It is becoming increasingly common, especially among the younger generations that these vital processes are independent of each other (March and Pérez 2011). These processes may no longer occur in sequence, or they may be culturally bound.

When the traditional sequence of events in the process of making a family is examined by culture, what one does observe is that the only thing different cultures have in common across the board is the outcome of the sequential process—making of a family. An example of this type of difference can be observed in Europe. In many European countries, especially in the north, emancipation precedes the domestic partnership, which is often a precursor to the family formation phase. In southern European countries, however, consensual unions are less widespread and less permanent, as they are frequently an intermediate step toward marriage. This difference makes it almost impossible to describe a sequence of events that end in the family unit.

By any measure, this sequence of events that occur in the transition into adulthood has undergone remarkable changes, even perceptions between close generations, not only in the sequence of the events but also in the time lapse between them. Generally, in Europe and particularly Spain, the age of the first sexual encounter has decreased significantly while the age of marriage has continuously increased over the last few decades (INE 2013).

Initiation of Sexual Activity

Among women who were teenage mothers, one of the characteristics that stand out is an earlier average age of the onset of sexual intercourse than women who were not teen moms. This holds true in most of the studies of developed and developing countries. The Survey of Health and Sexual Habits of 2003, conducted among a Spanish population between 18 and 49 years of age, reveals that the average age of the first sexual intercourse is 18.6 years (18.1 years of age for men and 19.1 years of age for women) (March and Pérez 2011). This average age of the onset of sexual intercourse for this sample of Spaniards is older than in most other European countries and the USA (Santelli et al. 2006). In the Spanish case, among young people aged 18–29, first intercourse happened on average at the age of 17.8 years (17.5 years of age for males and 18.2 years of age for women). This subgroup was selected because by the nature of their age they would better reflect the behavior teenagers in the current context. Of this subgroup, 11.4 % of women and 18.4 % of men reported to have had their first intercourse before they were 16 years of age. Education or the expectation of continuing one's education seems to have modified the average age of the first sexual intercourse among these young people. The percentage of girls having intercourse before the age of 16 was lower among those who attended and studied at a university.

Family Formation

In Spain, establishing a household or becoming a "couple" is a major step that many adolescents go through as they transition into adulthood. Although, there are numerous arrangements that constitute or define two people as a couple in

Table 1 Age of marriage in Spain (National Statistics Institute)

Year	Average age of women at marriage (years)
2010	32.5
2000	29.2
1990	26.1
1980	24.1

addition to marriage, this also has been evolving as an institution. Over the 30 year period between 1980 and 2010, the average age at which women married increased by 8.4 years of age. As shown in Table 1, this has been a steady increase over the years.

Age of first intercourse and first marriage is of interest for what it tells us about the sexual behavior among young women in Spain. The difference between the onset of intercourse and first marriage among these young people is 14 years. Under these conditions, when young women marry later in life, their exposure to the risk of pregnancy outside of marriage is greater. However, in contrast to this logical expectation, birth rates declined significantly in most European countries and in Spain. The declining birthrate, as seen in Table 2, is an indication that girls and young women are using effective contraception methods reduced the expected number of births as a result of these changes (Table 2).

Table 2 Birth rate in Spain (National Statistics Institute) (Ministry of Health 2013)

Year	Birth rate/1000 inhabitants
2010	10.5
2000	9.85
1990	10.32
1980	15.20
1975	18.73

Unintended Adolescent Pregnancies

In a modern world, girls and young women must have the right to choose the number of children they will bear, and they must be able to control when they will start their family. Abortion is an option that adolescent girls and young women need as a last resource for help with an unintended pregnancy. Adolescent pregnancy occurs globally. Sometimes the teens are wives, other times they are unmarried and not in a free union. In most cultures, adolescent pregnancy is considered a problem, particularly when a very young girl becomes pregnant. Not only because of concern for the physical risk the girl may be facing but for disobeying a moral standard. The issue that juxtapositions society's moral belief against reality is the adolescent pregnancies that are unwanted.

Unwanted pregnancies, by definition, are difficult to quantify because while they may initially be unwanted, and they may ultimately be accepted. It is also unlikely that a woman who has borne a child will refer to that child as unwanted.

To better understand the circumstances related to unwanted adolescent pregnancy, there are both qualitative and quantitative data available on abortions among Spanish adolescents. An indirect quantitative measure of the prevalence of unwanted pregnancies is captured in the number of reported voluntary adolescent abortions in Spain. Qualitative data based on individual interviews are useful, even though participant interviews often suffer from biases given that the answers can be influenced by social conventions. In this examination, the qualitative data came from records and reports of voluntary abortion collected by the Ministry of Heath.

In Spain, the total reported voluntary abortions reached its highest yearly number (118,359 reported abortions) in 2011, which is the latest data available. Since 2007, the number averages about 114,000 abortions reported per year. At 21.4 of abortions per 1,000 women, the highest rate of voluntary abortion among young women is between the ages of 20 and 24 (see Table 3). This group has consistently reported the largest number of abortions between 2002 and 2011.

Table 3 Reported voluntary abortions by age groups (Ministry of Health, Spain, Statistics IVE)

Year	19 and younger	20–24 years	25–29 years	30–34 years	35–39 years	40 and more years
2011	13.67	21.34	17.72	13.36	9.23	3.86
2010	12.71	19.82	16.34	12.09	8.27	3.50
2009	12.74	20.08	16.02	11.63	8.05	3.36
2008	13.48	21.05	16.49	11.63	7.97	3.30
2002	9.28	14.37	10.72	8.10	5.84	2.72

Spain's Abortion Laws

Article 417 of the penal code states that abortion is not a punishable offense if carried out by a medical practitioner in a public or private clinic with the express consent of the pregnant woman under the following circumstances:

1. To avoid physical or mental harm to the mother (in this case two specialists must consent to the abortion going ahead).
2. If the pregnancy is the result of rape or an act of incest that has been declared to the police. The abortion must, however, be carried out within the first 12 weeks.
3. If the baby is severely physically or mentally handicapped. The abortion must again take place within the first 22 weeks. In this instance, two specialists from an approved health center plus the doctor in charge must certify that the fetus will suffer from severe defects if allowed to be born.
4. In the case of an emergency that puts the life of the mother at risk, the abortion may be carried out without the express consent of the doctor and without that of the mother.

If the case does not fit into one of the four categories mentioned above, the Spanish National Health Service would not cover the abortion, although those with very limited resources can apply to their local family planning center for emergency financial assistance. Most abortions take place in private clinics in Spain. The revised 2010 abortion law allows abortion without restrictions up to 14 weeks and up to 22 weeks under certain conditions.

Adolescent Abortion Spain

The rate of voluntary abortions among girls aged 15–19 in Spain in 2010 was 12.7 per 1,000 adolescent girls in the same age group. Germany had the fewest voluntary abortions among girls aged 15–19 in 2010, 5.5 per 1,000 adolescent girls in the same age group. While the United Kingdom had the highest rate of abortion among that age group in 2010, 21.8 per 1,000 adolescent girls in the same age group sought an abortion (Sedgh et al. 2013).

Abortions among adolescents 14 years of age and younger are also reported. As a percentage of the total number of abortions in Spain 112,000 abortions in 2007, abortions among girls 14 years of age and younger are quite small. In 2007, there were 500 abortions reported in this age group. That is, 0.0045 of one percent of all abortions reported in Spain. In terms of total adolescent voluntary abortions, girls 14 years of age and younger made up 3.3 % of all the reported voluntary adolescent abortions in 2007 (females 19 years of age and younger accounted for 15,407 abortions). In 2007, all adolescent abortions accounted for 14 % of all reported abortions in Spain (see Table 4).

The number of abortions is far higher than many other European countries, which suggest systemic issues that contribute to these high numbers as seen in Table 4. The conclusion that can be drawn from this finding for this age group is that there is a lack of effective birth control being used by adolescents and young women.

Table 4 Abortions among teenagers in Spain (National Statistics Institute)

Year	Number of abortions	
	15–19 years	Less than 15 years
2007	14,807	500
2002	10,385	274
2000	9,047	157

Table 5 Percentage and type of contraceptive use among adolescents and the general population (Daphne 2011)

	15–19-year-olds (%)	General Pop. (%)
Condom	46.1	35.6
Pill	11.4	16.3
Double method	3.2	1.3
IUD	0	5.2
Vasectomy	0	5.7
Tubal ligation	3.7	3.3
Other hormonal methods	0	2.2
Coitus interruptus	0	0.3
None	35.6	24.8
Total	100	100

Supporting this conclusion is data from the VII Spanish Contraception Survey of 2011. The study found that among 2,096 Spanish women 5 years of age or older 24.8 % did not use any contraceptive method. Among adolescents, the percentage was much higher, 35.6 % of the 15–19-year-old girls did not use any contraceptive method (see Table 5) (Delgado 2007).

Contraception Use

Although a sizable percentage of Spanish girls and women do not use contraception of any type, among those that do use birth control, the methods most often used by adolescents and the general population are presented in Table 5. As can be seen in the table, the method of choice or at least the method of birth control that is most widely used is the condom. In the 15–19-year-old group, 46.1 % use a condom (see Table 5).

Physical Consequences

Teenage pregnancy carries greater physical and emotional risks of harm than pregnancy does for adult women in general. Perinatal outcomes are worse among adolescents than in older women (Daphne 2011; Klein 2005). This risk includes a higher mortality rates (Black et al. 2012). Especially, at risk are young adolescents, those 14 and younger. Some of these consequences will be apparent at the time of the pregnancy, but others will have a long-term effect. It will change the course of the girl's life by limiting her to less favorable situations and opportunity than those experienced by their peers who were not teenage mothers (Conde-Agudelo et al. 2005). But, this does not need to be the reality for adolescents. Comprehensive sex education can reduce the number of unintended pregnancies among adolescent girls and young women.

Sex Education

In Spanish schools, teaching sex education is within the purview of school administrators. There is no training requirement to teach a course on sexuality other than training as an educator; however, much of the material are presented in biology classes. Some schools provide specific courses on sexuality for students and parents (de Irala et al. 2008). Perhaps not ideal in terms of educating generations of young people going through the transition to adulthood, sex education in school has contributed to a positive change in adolescent sexual behavior. Yet, while condom use is higher among adolescents than in the past years, which suggest information about contraction has reached its target population, there has also been a paradoxical increase in heterosexual transmission of HIV, other STI, and adolescent voluntary abortions. Even among girls who became pregnant, research shows that the majority had received sexual counseling and contraceptive information from a health care professional during the year pervious to becoming pregnant

(Churchill et al. 2002). Thus, information is being disseminated and utilized. As well, the incongruence does not appear to be related to a lack of available contraception. A national survey of youth and their sexual behaviors showed that 81 % of adolescents reported no difficulty in accessing contraceptives (Lopez Blasco et al. 2005).

Consequently, while adolescents receive more information on contraception and contraceptive use and are using more contraceptive methods, more often, the incidence of contraceptive failure puts the girl at risk for STIs and unintended pregnancy (Free and Ogden 2004; Marston and King 2006).

While the cause for this paradox continues to challenge researchers and health care providers, there is a growing concern over the school-based sex education programs. When these programs are evaluated for their effectiveness in delaying adolescent sexual activity, promoting better contraceptive use, and reducing the incidence of teen pregnancy, sex education programs are found ineffective. In a meta-analysis of 22 journal articles that reported an evaluation of a school-based sex education program, DiCenso and associates (2002) concluded that programs based on the sex education policies developed since the 1970s have for the most part failed to reduce early sexual activity, failed to increase effective contraceptive use, nor did it reduce the number of unintended pregnancies.

In a content analysis of textbooks used in Spanish schools, de Irala et al. (2008) reported that the information provided by the textbooks lacked accurate and reliable scientific information and did not discuss the risks involved in being sexually active. They conclude that using these textbooks, students learned that condoms are highly effective in preventing HIV, STIs, and pregnancy. The subliminal message, however, is that if a condom is used during sexual intercourse, there is little risk in sexual relationships. Thus, they concluded that the unanticipated consequence of both the intended and unintended lessons has the effect of putting pressure on adolescents to engage in sexual behavior (de Irala et al. 2008).

An outcome of sex education, where adolescents are more apt to use condoms, but tend to engage in earlier sexual behavior is problematic because of the risk of HIV and STI's. Research has shown that the earlier one begins sexual experimentation, the greater the number of lifetime sexual partners, which puts one at greater risk of contacting HIV and STI's (DiClemente et al. 2005). Given this association (between early initiation and risk of STI's), the consensus of a panel of international experts that was published in Lancet in 2004 states simply: for adolescents "who have not started sexual activity the first priority should be to encourage abstinence or delay the sexual onset." Abstinence and a delayed debut are risk avoidance approaches to the prevention of STIs and unintended pregnancies. They also proposed that: "after sexual debut, returning to abstinence or being mutually faithful with an uninfected partner are the most effective ways of avoiding infection" (Halperin et al. 2004)

Prevention programs that promote healthy adolescent sexual behavior are being developed. One such program that has both supporters and detractors is a strategy called the ABC approach (Abstain, Be faithful/reduce partners, use Condoms) (Shelton et al. 2004). A vision of the abstinence-only approach, the ABC model combines "risk avoidance" and "harm reduction" philosophies. Prevention strategies include education on the advantage of having safe sex with fewer sexual partners and contraceptive education (Hearst and Chen 2004). Although limited research is available, at least one study from Uganda reported that the ABC approach to preventing HIV infection was 80 % effective (Stoneburner and Low-Beer 2004).

In Spain, researchers have found that the most common reasons adolescents use the "morning-after pill" is that the condoms they were using ruptured, there was vaginal retention, or there was slippage of the condom (Ruiz et al. 2002). Exasperatingly, researchers also find that adolescent girls who had a voluntary abortion had used a birth control method before the pregnancy (Churchill et al. 2000; Truong et al. 2006).

Given the individual and public health concerns, school-based sex education programs are essential for educating adolescents about the physical and emotional changes they may experience during their transition to adulthood. Although the effectiveness of school-based sex education programs has come under fire for their limited effectiveness, this can be changed. Models can be developed that are grounded in science and evaluated empirically. Models that can increase a healthier sexual lifestyle among adolescents and reduce the consequences of adolescent sexual experimentation and behavior, and models that can provide a sex education that will better serve adolescents coming of age in a modern and connected society.

Educational Attainment

A lack of educational attainment is another common characteristic among adolescent mothers in Spain. At age 20, women with children have a higher incidence of school dropout than women without children. This pattern persists throughout life, indicating that early pregnancy tends to impede educational attainment. The shortening of the educational period of life is one of the main characteristics that distinguish teenage mothers. In short, women who were teenage mothers present as being educationally disadvantaged when compared to their peers.

Labor Outcomes

Another concern is that teenage mothers do not have other experiences typically involved in the transitions into adulthood that are deemed important before motherhood is obtaining a job and in most cases having a partner. This lack of these experiences has several implications for the future.

Among the main aspects that influence early motherhood is the time of entry into the labor market. Upon reaching age 20, women who were teenage mothers had experienced work to a lesser degree than their peers with no children. This trend is even sharper over time (analysis at 25 years). These differences are only attenuated after 30 years. Additionally, there are differences in job quality as women who were teenage mothers had lower rates of stable jobs than their peers with later pregnancies.

Motherhood in Adolescence

In Europe, there has been a widespread shift in patterns of behavior regarding sexual activity. The most striking shift has been the decline of age of first intercourse. In Spain, according to an epidemiological survey that included 9,737 women aged 15 or older (Olausson et al. 2001), it was found that among cohorts born in the 1970s, there has been a convergence to common European patterns regarding both the beginning of sexual activity and the use of contraception. Older cohorts showed more difficulty adopting contraception since there were restrictions on the access to oral contraceptives until the late 1970s.

In Spain, the increased prevalence of teenage pregnancies coincided with a time of great sociopolitical changes in the 1970s. These changes were associated with the liberation of sexual behavior, a situation that had happened earlier in other European countries. Additionally, the availability of contraceptive methods was not as fast (in Spain contraceptives were not decriminalized until 1978), and there was, therefore, an increased fertility rate during this period, especially among the youngest age groups.

The age of first sexual intercourse clearly relates to the time of birth. In generations born prior to the 1940s, less than 25 % had sexual relations before the age of 20 while this percentage is 80 % among those born in the decades of the 1970s and 1980s.

The number of women who were sexually active before the age of 20 (and therefore at risk of pregnancy in adolescence) has increased consistently from the oldest cohorts to the most recent. However, teenage pregnancy has

decreased proportionally among the same group, which is justified by the widespread and earlier adoption of contraceptive measures (Free et al. 2005).

In Spain, foreign and national populations show different patterns in the transition to adulthood in terms of teenage pregnancies. In recent years, foreign girls and women have requested a high percentage of the abortions performed in Spain (Delgado et al. 2011). Whether this situation is due to a real desire to be a mother in adolescence (possibly associated with culture) or a consequence of more restricted access to and use of effective contraception methods is a question that remains still to be answered. The reality is that voluntary abortions are more prevalent among foreign girls and women. In the Community of Madrid, for example, foreign girls and women requested some 50 % of abortions. This represents only 11.7 % of fertile women in Madrid (Orjuela et al. 2009).

The Experience of Teen Mother's in Spain

Understanding adolescent motherhood from the perspective of the teen is important in the effort to prevent unintended teen pregnancy. An analysis of the characteristics of women who were teen mothers can be very informative. Research indicated that girls who became teen mothers suggest and indicate that these girls more often come from households with a higher number of children than those women who were not pregnant as teenagers. Also, despite the general decline in the number of children per family in Spain, this pattern does not present itself in the original households of adolescent mothers. This has been a stable trend over several of the last few decades.

In general, women who became mothers in their teenage years in Spain were unmarried, not emancipated (living at home with their parents) and not living with their partner or spouse at the time of conception of their first child. In contrast, women who gave birth after their teenage years frequently had been emancipated and lived in a union (marriage in the oldest cohorts) at time of conception. The differences in the sequence of events and the age of first conception are the elements that distinguish one group of women from the other. A certain lack of "foresight" in one group while "planning" stands out in the other group.

Contraception and First Sexual Intercourse

Over time, there has been dissociation between sex and procreation largely linked to the use of contraceptives although sexual initiation is not always accompanied by the beginning of the use of contraceptive methods. On the contrary, many girls and young women did not use a contraceptive method in their first sexual encounter. However, in the younger generations, the use of contraception during the first sexual intercourse has increased, both among those women who have been teenage mothers and those with later conceptions.

In contraceptive use, however, there are major differences between teenage mothers and mothers who had children after their teenage years. Teenage mothers were less consistent when using contraceptive methods and used less effective methods than their peers. Data show that only 37.8 % of women who became pregnant used contraception in their first sexual encounter compared to 80.8 % of mothers who had children after their teenage years.

Fragility of Free Unions

Another disadvantage of early childbearing is related to the fragility of unions formed by adolescent mothers who enter into a union because of the pregnancy. These unions are not typically the product of a plan but rather a consequence of an unintended pregnancy. Data show that women who were teenage mothers present two to three times the separations than the girls who became mothers after their teenage

years. Furthermore, the average length of unions is shorter in women who were teenage mothers compared to their peers who did not become teenage mothers.

Finally, the timeline of life experiences that includes adolescent pregnancy is a timeline that is accelerated and shortened. It is estimated that teen moms go through, in 4 years, the onset of sexual activity, contraception use, school completion, first job, emancipation from the parental home, first cohabitation, marriage, and giving birth to her first child. While among their peers who became mothers in their 20s, this same period extends to almost 10 years. This additional 10 years provides time for the girl to learn and plan her life, so that she can take advantage of educational and work opportunities.

Conclusion

Adolescence is a period of transition to adulthood marked by significant physical and psychosocial changes overtime. This chronological pattern of transition, however, does not always follow the same sequence of events. Moreover, events can be hampered by and is influenced by geographic, demographic, economic, and political circumstances. A weak or poorly functioning economy that hinders adolescent movement into the world of work can change behavioral patterns and delay, for example, emancipation.

Adolescent pregnancy and motherhood is another condition that can hinder or truncate the pattern of an adolescent's transition into adulthood. Consequently, teenage mothers present characteristics that compose a fairly specific profile. The disadvantages of teenage pregnancy go beyond negative perinatal and postnatal outcomes. It can negatively impact the girl's education and employment opportunities, a negative impact that will have a long-term effect on the girl's life, even as an adult, and the life of her child.

Given, the medical risks due to the physical and emotional immaturity adolescent girl, especially among very young pregnant adolescents, educational and health care initiatives should focus on providing age-appropriate services to reduce the risk and increase protective factors. In addition to the physical risks to the adolescent and her fetus, there are social risks and consequences that are the product of Spanish society's values and morals. Risks that result from the social context can and should be modulated by policy and interventions.

The focus, however, must continue to be on prevention of STI's and pregnancy. This requires accurate and comprehensives sex education for all children and adolescents. A major accomplishment in reducing the risk of unintended pregnancy was making available the "morning-after pill." Easily obtained contraception needs to be supported by comprehensive sex educational programs that provide reliable, age-appropriate scientific information about sexual development, sexual behavior, and sexual relations. Without accurate and reliable information about one's sexuality, adolescent girls and young woman cannot make informed decisions about childbirth, or exert control over their reproductive lives.

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Adolescent Pregnancy in Sweden

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Keywords

Sweden: adolescent pregnancy · Adolescent sexuality · Alcohol and other drugs · Comprehensive sex education · Contraceptive services · Family supports/child stipends · Rationalistic approach to sexuality · Risky sexual behaviors · Sexually transmitted infections · Social marginalization

Introduction

Few adolescents in Sweden become parents and there is little debate or discussion about adolescent pregnancy as an urgent social problem. Instead, adolescent pregnancy and parenting are approached as aspects of youth development and sexual health more generally. Thus, adolescent sexuality is treated as a normal part of adolescent life; as a result, there is no official effort to suppress it. Public involvement in adolescent sexuality is almost exclusively devoted to making sure that adolescent sex is safe, healthy, and devoid of coercion. Due to the persistence of gender inequity, the safety of adolescent girls is of particular concern, but the official approach—in schools, information materials, adolescent centers, data gathering, etc.—encompasses boys' sexuality as well.

From a historical perspective, there are two paths leading to the current approach to adolescent pregnancy. The first reveals a longstanding cultural acceptance of sexual relationships between young men and women destined to marry (Persson 1972; Löfgren 1969). In many rural regions, especially in the north, the rituals of adolescent courtship included nightly visits during which boys and girls talked and shared a bed together. While this practice did not overtly or explicitly sanction pre-marital sexual intercourse, it accommodated it, provided that the union was eventually formalized in marriage. The notion of "engagement children" captures the general acceptance of consummating sexually a relationship prior to marriage. As a result, a significant number of children were conceived, and sometimes born, outside of marriage without community uproar (Linders 2001). In cases when marriage did not follow, however, the burden of the moral transgression fell almost exclusively on the young woman.

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The second path leading to the current approach and perspective related to adolescent pregnancy reveals a formal punitive approach to most forms of sexual expressions outside of marriage (e.g., adultery, bestiality). Grounded in the stern morality of the Protestant church, the state's concern with extra-marital sexual matters, and sexual transgressions more generally, increased greatly during the eighteenth century, when both abortion and bestiality were capital crimes. Not surprisingly, it was women who bore most of the moral burden of this harsh legal climate, thereby providing a strong motive for the clandestine and unsafe illegal abortions that rapidly increased among unmarried women during the nineteenth century. As the church's influence on policy making waned, the harshly punitive environment surrounding sexuality began to erode.

Beginning in the 1930s and continuing over the next few decades, the legal approach was loosened when the state, as part of the larger social democratic reorganization of society, started to become actively involved in reproductive practices. It did so in two distinct ways: by *promoting* childbearing among those suitable to become parents (e.g., cash allowances, parental insurance, and day care), and by making it possible for those deemed unsuitable to *prevent* childbearing (e.g., sex education, contraceptive services, limited abortion opportunities). The implementation of these goals, then, constituted a retreat from the harsh moral climate that had long surrounded women's sexuality. Instead, the state emerged as the steward of the citizens' reproductive lives, taking responsibility for providing a social and economic environment that fostered childbearing and general wellbeing. Initially formulated in response to the "population crisis" in the 1930s, when birth rates as well as marriage rates declined, The transformation of the Swedish approach to reproductive and sexual practices was designed to both secure and improve the Swedish population (Carlson 1990; Hirdman 1989; Linders 1998).

Taken together, these two policy approaches signaled an ambition to facilitate the birth of wanted children while also making it possible for women to prevent unwanted pregnancies. In terms of policy innovation, these ambitions produced a policy package—to be further elaborated on over the next few decades—that simultaneously encouraged and discouraged childbearing. Encouragements included various social, legal, and economic supports for pregnant women and new mothers whereas discouragements included improved access to contraceptives and the possibility of obtaining an abortion under some select circumstances (the abortion law was modified several times from 1938 till the adoption of free abortion in 1974).

While not directly designed to monitor adolescents' sexuality, these kinds of reforms nonetheless had an impact on the responses to and consequences of adolescent sexuality, especially for girls who were given a modicum of security should they become pregnant. It was not until the 1970s, however, that adolescent girls' sexuality, as part of the so-called sexual revolution, was liberated to the point where they could take charge of their own sexual and reproductive lives. This is not to suggest that these changes suddenly placed young women on an equal footing with men in matters of sexuality—it is after all women who get pregnant—but they did give women more opportunities for self-determination.

Overview of Adolescent Pregnancy

Although adolescent pregnancy is not approached as a single, freestanding issue in Sweden, statistics are routinely collected as part of population statistics more generally, and patterns over time are carefully monitored. This monitoring is linked to the general mapping and tracking of sexuality, reproductive practices, and the support system focusing on child development and youth adjustment.

Table 1 The adolescent birth rate (per 1,000 women) in Sweden for 15–19-year olds, and the total birth rate, 1975–2010

	Mother's age*					Total**
Year	15	16	17	18	19	15–44
1975	0.7	4.7	14.2	31.0	54.6	64.3
1980	0.5	1.7	6.9	16.4	32.7	57.0
1985	0.3	0.9	3.8	9.4	21.2	56.0
1990	0.5	1.5	5.4	12.9	27.5	69.0
1995	0.4	1.2	3.5	7.9	16.7	58.0
2000	0.3	0.8	3.8	6.7	13.5	52.2
2005	0.3	1.1	2.7	5.6	12.3	57.4
2010	0.2	1.0	2.6	5.1	11.1	60.0

Source Statistics Sweden, *Statistiska Centralbyrån*

* Mother's age refers to her age at the end of the year in which the birth took place

** This rate does not include births to women below 15 years old and over 44 years old

After abortion was legalized in the mid-1970s, the adolescent birth rate was cut almost in half, from 29 per 1,000 in 1975 to 16 in 1980. Since then, the rate has declined fairly steadily to the current rate of about 6 per 1,000 in 2009 (Table 1). As is evident from Table 1, the decline is especially noteworthy for the older adolescents; in 1980, the birth rate for 19-year-old women was about 33 per 1,000, whereas it was no more than 11 in 2010. At the same time as the adolescent birth rate has declined, the age at which both women and men have their first child has gone up. In 2007, the average age of women having their first child was 28.6 years, which is an increase from 24.4 years in 1975. For men, the average age has increased from 27 to 31.1 during the same period (Folkhälsorapport 2009). Viewed as a proportion of all children born in Sweden, those born by adolescent mothers currently account for less than 2 % (Socialstyrelsen 2009).

When it comes to adolescent *pregnancy*, however, the rates are considerably higher. This is so because most adolescent pregnancies end in abortion. See Table 2. Generally speaking, the rates of births and abortions covary in such a way that when the birth rate goes up, so does the abortion rate. In 2006, 96 % of all pregnancies of 15–17-year-old women and 79 % of pregnancies of 18–19-year-old women ended in abortion (Folkhälsorapport 2009). After a steady two-decade decline, the Swedish adolescent pregnancy rate (births + abortion) increased somewhat during the last decade, from about 25 in 1996 to about 31 in 2006 (McKay and Barrett 2010). More recently, however, the adolescent abortion rate has declined again and is currently about 21 per 1,000 women (Socialstyrelsen 2010).

A low adolescent birth rate is generally viewed as a good and desirable development. This is so not primarily because adolescent sexuality is frowned upon; the official view in Sweden is that sexuality promotes the health and wellbeing of adolescents and therefore ought not to be subject to feelings of shame and guilt. Rather, it is because of the pervasive assumption that adolescents are not ready to become parents, either emotionally or financially. The official overarching goal for pregnancy and childbirth is that all "children who are born should be wanted" (Folkhälsorapport 2009: 283). To facilitate this goal, the state has taken on the responsibility to provide the knowledge and resources that make it possible for people to avoid unwanted pregnancies, plan their childbearing, and provide for the children they have.

Looking at adolescents specifically, most resources and programs are designed to foster the kinds of sexual practices and attitudes that are the least likely to lead to unwanted pregnancies. Thus, although adolescent sexuality is

Table 2 Number of pregnancies, abortions, and births per 1,000 for women age 15–19, 1970–2003

	Pregnancy	Abortion	Birth
1970	55.3	12.3	43.0
1975	58.2	29.8	28.4
1980	38.4	21.8	16.6
1985	28.8	18.2	10.6
1990	38.4	24.6	13.8
1995	25.6	17.0	8.6
2000	28.2	21.1	7.1
2003	30.4	24.4	6.0

Source Forsberg (2006)

accepted, it does not mean that all expressions of sexuality are celebrated and encouraged. Sexuality, in brief, is something that young people "ought to feel protective of and take responsibility for" and hence not practice in unsafe and risky ways (Folkhälsoinstitut 2010: 15). The fact that the adolescent birth rate is very low and the adolescent pregnancy rate fairly low (compared with the United States, for example), while sexual activity is widespread, indicates that, at least to some extent, adolescents do take responsibility for their sexuality. The extent to which adolescents' sexual practices beyond pregnancy are as safe as they might be, however, is subject to extensive debate.

Medical and Health Issues

Pregnancy and childbearing in Sweden are generally safe experiences for women. For example, few women die in connection with pregnancy and childbirth (no more than 2–4 per year during the first decade of the 21st century), and the infant mortality rate is one of the lowest in the world. This is so in part at least because of a well-developed system of medical care and resources for pregnant women and new mothers. These services now reach almost all expectant mothers (Folkhälsorapport 2009). Moreover, for women who choose to terminate their pregnancies, abortion is a safe alternative. Since the legalization of abortion in 1974, most (about 93 %) abortions are done before the 12th week of pregnancy, and less than 1 % of abortions are done after the 18th week, when the health risks are much greater (Folkhälsorapport 2009).

Nonetheless, as part of a more general emphasis on prevention and public health, women's and girls' reproductive lives are monitored carefully. Since 2003, the following two goals guide public health policy in the area of sexual and reproductive health: (1) good protection against sexually transmitted infections; (2) safe and secure sexuality and good reproductive health (Folkhälsorapport 2009). These goals are not directed at adolescents specifically, but adolescents play a significant and prominent role in public health initiatives to improve reproductive health more generally. This is so because practices learned and habits developed during the adolescent years impact adult sexuality as well. Given this, recent evidence that adolescents' sexual practices have become more "risky" since the late 1990s is cause for concern (Edgardh 2002).

When it comes to sexually transmitted infections, the rise in the number of people with Chlamydia has been of particular concern during the last decade. The Chlamydia rate has tripled during the last decade and the rise has been particularly dramatic among adolescents and young adults (Folkhälsorapport 2009). Chlamydia, alongside gonorrhea, syphilis, and HIV/AIDS are classified as a public health threat, which means that both testing and treatment are free of cost. The susceptibility of young people in particular to this infection has prompted a renewed concern for unsafe sexual practices among the young. Other serious sexually

Table 3 The proportion (percent) of adolescents who have had intercourse "the first night" they met someone, sometime during the last 12 months

	Women		Men	
Year	16–17 years	18–19 years	16–17 years	18–19 years
1989	12	15	16	25
1994	14	16	14	28
1997	19	24	17	26
2000	14	25	20	24
2003	21	26	23	28
2007	37	35	35	36

Source Folkhälsorapport (2009), Forsberg (2006)

transmitted infections are also monitored and of concern (although rates are low), but none impact young people the way Chlamydia does.

Additional concerns related to women's physical health during pregnancy include smoking, and, more recently, obesity. Except for smoking, most of these concerns are not directed primarily at adolescents. While smoking during pregnancy is generally on the decline, adolescents are more likely to smoke. In 2005, 28 % of pregnant adolescents smoked, compared to 9 % of all pregnant women. With alcohol use among adolescents, the concern is primarily is that it increases risk-taking behavior, including sexual behavior. For instance, alcohol use among adolescents has been linked to both the spread of sexually transmitted infections and to an increased likelihood of regret with sexual encounters.

For the goal of making people's sexual practices safe and secure, adolescents play a particularly prominent role. The primary concerns are issues and practices deemed "risky" and that might impact health and well-being more generally. The increased tendency for adolescents to have intercourse the first night they meet someone, for example, is not primarily a moral concern, but insofar as "first night" sex is associated with more risk behavior (e.g., alcohol use, no contraception), it becomes a public health concern. As Table 3 shows, the proportion of adolescents who have intercourse the "first night" has increased markedly during the 2000s.

The number of sexual partners has also increased for adolescents, especially for the younger ones. As Table 4 shows, in 2007, 17 % of 16–17-year-old women reported that they had at least three different sexual partners the past year; this is an increase from 8 % in 2000.

These changes in the direction of more casual approach to sex are also reflected in attitudinal studies. For example, the proportion of adolescents who agree that sex belongs in stable relationships has declined steadily since the late 1980s; in 2003 only 28 % of boys age 16–17 agreed, compared to 62 % in 1989; among girls the same age, 43 % agreed, down from 76 % in 1989 (Forsberg 2006).

None of these changes reflect a lowering of the age of first sexual intercourse. The average age of first intercourse has remained fairly stable at 16–17 years since the late 1960s. That does not mean, of course, that *all* adolescents start having sex at that age, but most studies show that somewhere between 60 and 80 % of adolescents have had intercourse before they turn 18 (Forsberg 2006).

Given the high rates of sexual activity among adolescents, contraceptives are heavily promoted, both as a means to prevent pregnancy and to protect against sexually transmitted infections. Despite the extensive availability of contraceptives at no cost, for both boys and girls, there is some evidence that the efforts to promote safe sex have reached a plateau and perhaps even have been reversed a bit. This is so especially in connection with "first night" sex,

Table 4 Proportion (percent) of adolescents who have had three or more sexual partners during the last 12 months, 2000–2007

	Women		Men	
Year	16–17 years	18–19 years	16–17 years	18–19 years
2000	8	23	7	17
2007	17	25	11	23

Source Folkhälsorapport (2009)

where condom use has decreased over the last two decades. For girls, the proportion of "first night" sex without a condom increased from about 10 % in 1989 to almost 25 % in 2007. When it comes to the sexual debut, similarly, somewhere between 60 and 70 % of adolescents use a condom the first time they have sex. These numbers are generally considered too low.

Poverty, Family Supports, and Structure

Because so few adolescents have children, the financial hardships that are associated with adolescent parenting are not a primary concern in Sweden. And yet, one prominent reason to prevent adolescent parenting is precisely that the children of adolescents are more likely to suffer from social and economic problems. Therefore, the overarching goal that "all children should be wanted" requires not only opportunities to prevent or terminate unwanted pregnancies, but also to provide for wanted children. Both of these issues will be discussed in more detail below, but it is important to recognize that prevention efforts are part of the same goal as efforts to facilitate parenthood among those who want children. Despite such efforts, however, the patterns of childbearing and family formation remain linked to social location.

Although hardships associated with single parenting are recognized, especially since the poverty rate among single mothers have increased over the past decade, from about 10 % in the early 2000s to about 25 % in 2010 (Wahlgren 2010), these are not hardships specifically identified with adolescents. Or rather, the proportion of single mothers who are adolescents is so low that the problem of single parenting is not viewed as inexorably linked to adolescent parenting. For example, a comprehensive review of research on Youth and Sexuality published in 2006 includes no reference to adolescent parenthood, single or otherwise (Forsberg 2006), and the chapter on reproductive health in a comprehensive public health report published by the National Board of Health and Welfare in 2009 does not mention single adolescent parents.

And yet, there is no doubt that adolescents who become parents face financial and other kinds of hardships, regardless of partnership status, which adolescents themselves are evidently aware of. A study about why women choose to terminate their pregnancies provides insights into how adolescents think about parenting (Larsson et al. 2002). As Table 5 shows, the three top reasons why young women choose an abortion point to different aspects of the hardships that adolescent parents can expect. Almost 84 % of 14–19-year olds think they are "too young" to become parents, 63 % wants to finish school before they have children, and 63 % say that their financial situation is too uncertain. In this context, it is noteworthy that only about 15 % say that being single is a reason for abortion. It is also noteworthy that adolescents think of their own pregnancies in ways that correspond fairly closely with the official view of adolescent pregnancy, which holds that adolescents for the most part are not ready to become parents.

While financial considerations are part of the question of readiness, it is not primarily a short-term concern for the ability of adolescent parents to provide adequately for their children—welfare support makes sure that they can. Rather, it is a concern about the long-term consequences

Table 5 Reasons why adolescent girls (14–19 years) choose abortion, compared to other age groups, for year 2000. Because women gave multiple reasons, percent add up to more than 100

Reason	14–19 years	20–29 years	30 years	Total
Too young	83.6	22.9	0.0	25.1
Poor finances	63.0	36.3	15.9	32.3
Want to finish education	63.0	28.6	6.7	25.1
Too early in relationship	26.0	26.9	11.3	20.8
Want to work first	19.2	24.9	12.8	19.5
Uncertain about relationship	17.8	23.3	14.9	19.3
Do not want children	17.8	9.8	8.7	10.5
Unsuitable living situation	17.8	13.5	2.6	9.9
Single	15.1	15.9	9.2	13.4
Health problems/fetus	12.3	4.5	6.7	6.4
Partner wanted abortion	11.0	11.4	9.7	10.7
Do not want to bring children into this world	11.0	4.1	1.0	4.1
Afraid of delivery	9.6	6.9	2.2	5.4
Want to marry first	8.2	6.1	2.1	4.9

Source Larsson et al. (2002), reported in Forsberg (2006)

of early parenthood. Adolescent parents are less likely to finish school, less likely to pursue higher education, and less likely to end up in high-paying jobs. This also means that the children of young parents are disadvantaged in relation to other children. These patterns are even more pronounced for single parents.

The marital status of parents, however, is not an issue in this context because the typical trajectory for Swedish couples is to first live together, then have children, and then get married. That is, most first-time parents are not (yet) married, even though many end up marrying some years later. Thus, while currently about 56 % of all children in Sweden are born to unmarried women, only about 21 % grow up in single-parent families (Popenoe 2009).

While adolescent pregnancy in itself is not an issue that is clearly implicated in poverty and/or social marginalization, several other aspects of adolescent sexuality are. Several studies have shown that the kinds of sexual behaviors that are deemed "risky" (e.g., early sexual debut, unprotected sex, and more sexual partners) are more prevalent among the least privileged, and these are also the populations that are the least reachable by various programs and initiatives (Folkhälsoinstitut 2010). Moreover, there is mounting evidence that adolescents from immigrant backgrounds both think about and practice sexuality somewhat differently (e.g., guided by more traditional gender norms) than adolescents with a Swedish background (Folkhälsorapport 2009; Folkhälsoinstitut 2010). This also means that these adolescents may be underserved by available resources, especially considering the official emphasis on delayed childbearing, coupled with a rationalistic approach to adolescent sexuality.

The Cost of Adolescent Pregnancy

The state's involvement in people's reproductive lives also includes financial support at multiple levels, including medical care during pregnancy, childbirth, abortion, parental leave, child medical care, social welfare assistance to unemployed/young parents, child care assistance, and various other forms of support. This support system does not generally distinguish adolescents from other women/parents and does not approach adolescent pregnancy as a distinct and identifiable expense. Contraceptive counseling and services (to help girls prevent unintended pregnancy) are available free of charge to

adolescents. Although there are no efforts to calculate the social costs of adolescent pregnancy, there is a generally agreed upon assumption that the costs involved in the prevention of adolescent pregnancy are cost-effective in the long run, from the perspective of both the state and adolescents themselves.

Public Policy

In general, the state takes an active role in the reproductive lives of its citizens. The different policy packages that guide and are linked to adolescents' sexual practices are firmly entrenched, which means that new policy initiatives for the most part are designed to improve and/or expand current policies rather than completely reformulating them. For example, the persistence of practices like abortion, unsafe and/or unprotected sex, coercion, and sexual abuse serve as reminders that the current policy efforts to educate young people in healthy sexuality and to encourage them to behave responsibly in sexual interactions are inadequate. And yet, the confidence in and commitment to the current policy approach remain strong and are reinforced by a conviction that without the massive policy apparatus, conditions would be worse.

Prevention: Educational Programs, Sex Education, and Birth Control

The dominant strategy for meeting the official goal that "all children should be wanted" is prevention. While not exclusive to adolescents, the efforts to prevent unwanted pregnancies are particularly pronounced with adolescents. Comprehensive sex education is a component of the national school curriculum, contraceptives are offered free of charge to adolescents, and most communities have clinics especially for youth. Moreover, there are various information campaigns, inside and outside the school system, designed to promote healthy sexuality. Healthy sexuality means a general sense of "sexual wellbeing" and "sexuality free of negative consequences, prejudice, discrimination, coercion, and violence" (Livsstilsrapport 2008: 48).

Schools play a particularly important role in the prevention of unsafe sex and reduction in unwanted pregnancies. Comprehensive education in sexuality and in intimate relations has been compulsory in Sweden since 1956, even though the content of the sex education curriculum has changed quite drastically during this half-century. During the first few decades of sex education, the focus was almost exclusively on the biological elements of reproduction (Trost 1985), albeit interlaced with moralistic suppositions about sexual behavior (SOU 1983:31). While guided by the general principle that knowledge about sex and reproduction was an important element in the preparation of adolescents for adult life, the early generation of sex education proponents and practitioners "did not envision a world in which adolescents could (or should) have sex freely and safely" (Linders 2001: 175). Such a vision did not emerge until the 1970s, when the movements for women's rights and sexual liberation overthrew the moralistic and patriarchal view of sexuality that had long guided public policy. Nonetheless, since the 1930s, no serious discussion in Sweden about sexuality, adolescent or otherwise, has been carried out without some reference to contraceptives.

Contemporary sex education has shed much of its moralistic heritage and now approaches adolescent sexuality as a normal and healthy part of growing up (Nilsson 2008). Abstinence, as a result, has all but disappeared as a feasible policy alternative, and with it the notion that adolescent sexuality is inappropriate, problematic, or even unfortunate Linders (2001). Currently, a three-pronged approach guides the schools' education in sex and intimate relations from kindergarten and elementary school through high school. The first part addresses everyday issues and involves answering questions and helping students deal with sex- and intimacy issues as they encounter them. The second part involves scheduled class time to discuss issues like sexuality, love, and equality. The final part touches the overall curriculum and aims to

integrate issues of sex and intimacy into various other substantive topics, such as history, religion, biology, social studies. (Skolverket 2011). As is clear from these general goals, the sex and intimate relations curriculum is not only about the dissemination of knowledge but also about fostering healthy and ethical attitudes toward sexuality and providing tools for children and adolescents to manage their own sexuality and navigate the thorny sexual market place. As such, the Swedish system of sex education, according to Kristin Luker, is the "gold standard of what most American sex educators imagine an ideal comprehensive sex education program looks like" (Luker 2006: 207).

More specifically, and beyond the biological aspects of reproduction, sex education in Swedish schools addresses love and intimacy, sex and pleasure, hetero- and homosexuality, contraceptive methods (as well as discussion about how to negotiate such issues in the heat of the moment), pregnancy, abortion, gender inequality, heteronormativity, etc. (Wester 2009). Moreover, many schools bring classes—typically in the 8th grade—to the local youth centers which support and assist youths with their sexual lives. The school curriculum about sex and intimacy is a comprehensive program that assumes that children are both capable of discussing all aspects of sexuality in a rational manner and also benefit from such discussions.

The following brief examples of how this may look in practice are provided by the Swedish Association for Sexuality Education (RFSU, Riksförbundet för Sexuell Upplysning), which, in addition to developing some of the materials used in schools, also catalogues initiatives at various schools throughout the nation. In Norrtälje, Emma, a high school student, recently initiated a project where high school students taught six-graders about sex and intimacy; they addressed a range of issues, including love, sex, HIV/AIDS, masturbation, condoms, and gender (RFSUa 2010). In another middle school, this one Stallarholmen, the instructor in sex and intimate relations begins the education with word knowledge; he distributes a list with words, including abortion, estrogen, interrupted coitus, lesbian, orgasm, IUD, and transsexual, and then works with the students to figure out what they mean (RFSUb 2010). Finally, in a high school in Stockholm, the instructor engages students in extensive discussions about issues and concern in relation to sex and intimacy, including the sexual debut, how to negotiate condom use, and emotions and embarrassments for girls as well as boys (RFSUc 2010).

Despite the national curriculum and despite the official mandate to provide comprehensive education in sex and intimate relations, there is extensive variation across both districts and teachers in the quality of that education. It is for this reason that there is a current emphasis on improving the education of teachers and also providing continuing education courses for teachers (Folkhälsoinstitute 2010). Moreover, there is an ongoing effort to evaluate the quality of the materials used in sex and intimacy classes (Wester 2009). Such evaluations sometimes provide evidence that available educational materials, even quite progressive materials, have shortcoming by reinforcing traditional gender expressions, for example (Thanem 2010).

In addition to the work in schools to educate and assist youth in sex and intimacy, there is a system of centers (currently about 220 throughout the nation) that provide youth with support and information about sex, intimacy, and contraceptives. Part of the purpose of these centers is to help adolescents and young adults manage their sexuality and to prevent sexually transmitted infections and unwanted pregnancies. In order to do so, the centers offer counseling, STI and HIV tests, contraceptive advice, free condoms, and the "day after" pill. An ongoing concern for those who work at these centers is the gender-imbalance of those seeking services. Girls are much more likely than boys to use the centers, which have prompted a renewed effort to institute programs directed specifically at boys. For example, only a handful of clinics offer counseling for young men around unwanted pregnancies (Folkhälsoinstitut 2010).

Because issues of sex and intimacy are still fraught with tension for many youths, an

initiative was launched in 2008 to provide many of the same informational services offered by the physical youth centers online (http://www.umo.se). Moreover, the site encourages visitors to ask questions and tell stories. There is evidence that this format works especially well for boys, who otherwise may avoid the physical centers out of embarrassment (Folkhälsoinstitut 2010). No doubt to encourage boys to participate, the current start page of the site features an image of a boy and offers information about sperm and erection.

Public Awareness Initiatives

Supplementing the services in schools and in youth centers are various public information campaigns targeting specific issues and/or vulnerable groups. Many of these efforts are coordinated and monitored by the National Board of Health and Welfare and the Swedish National Institute of Public Health. To take a recent example, the rise in Chlamydia, has prompted an extensive campaign to spread information, encourage testing, and facilitate prevention. The initiative involves the active participation of schools, youth centers, nonprofit organizations, and government agencies, and also public announcement campaign in newspapers, radio, TV, and buses, trains, and subways (Folkhälsoinstitut 2010).

Programming: Maternal Care and Child Care

The systems of maternal and child care are longstanding and reach almost all pregnant women and young children (Folkhälsorapport 2009). The mandate of the maternal health care system is to monitor pregnancy, provide follow-up care after birth, provide assistance with nursing, and offer preparatory parental education (Elvin-Nowak 2005). The child health care system is designed to promote children's safe and healthy development, both physically and mentally, and to foster active and engaged parenting. Parental education has been one of the pillars of both the maternal and child care system since 1979 (Elwin-Nowak 2005). Part of the parental education initiative involves recurrent meetings of groups of expectant parents, normally 5–6 times before the birth of the child and another 4 or 5 times after. Practically, all first-time mothers participate. A fair number of fathers also participate in the pre-birth meetings, but not as regularly after birth, perhaps signaling that the efforts to reconstitute maternal care as family care has been less than completely successful. To facilitate the involvement of fathers, many local centers organize "daddy-groups" (Elvin-Nowak 2005). Neither the maternal nor the childcare system distinguishes between adolescent and adult parents, which means that adolescent parents, like other parents, are encouraged to participate, but without receiving support and/or assistance geared specifically toward their age group.

Child Welfare Provisions: National and Private Financial Support

As an advanced welfare state, Sweden has numerous provisions that directly or indirectly support children and their parents, including paid parental leave, national health insurance, child stipends, and subsidized childcare. Many of these benefits are universal, and available to everyone regardless of income and age. Additional benefits are available to poor parents via the social welfare system.

Since the 1930s, when the welfare state was first established, provisions aimed at improving the welfare of children have been guided by two overarching goals: first, that all children should be wanted and second, that all parents who want children should be able to have them. The first of these goals has produced a series of prevention efforts that include abortion, access to contraception, comprehensive sex education in schools, and a host of informational and counseling resources. Considering the dominant

assumption that young people do not (and should not) want to have children, such prevention efforts are directed with particular vigilance at adolescents. From the perspective of this goal, then, the low birth rate among adolescents is evidence of success, even though the adolescent abortion rate is a constant reminder that too many women who do not want children get pregnant.

The second goal has guided a long list of policy initiatives, including the prohibition against the dismissal of pregnant (and engaged and married) women (1939, 1946), a rudimentary maternal leave act (1955), and a modern parental leave act in 1974. The system of paid parental leave is designed not only to enhance the wellbeing of the child but also to facility gender equality. Contrary to other social welfare provisions, the utilization of parental insurance is vigorously promoted and highly desirable; that is, the greater the number who take advantage of it, the better (SOU 2005: 73).

Currently, parents receive 480 days off from work when they have a child. They can divide the days however, they want, with the provision that they must take at least 60 days each; that is, one parent cannot take all 480 days. Although formulated in gender-neutral terms—it is parental leave, not maternal leave—women take the majority of the allotted time. It is for this reason that the 60 days that must go to the other parent are generally referred to as the "daddy months." Payment to parents for the first 390 days is calculated on the basis of their respective income just prior to the birth of the child; the stay-at-home parent receives 80 % of her/his income, unless s/he earns more than the current ceiling. Parents who earn little or no money (including students and the unemployed) receive a base payment of 180 kronor per day (about $28) for 390 days. In addition to the first 390 days, all parents have a right to stay home for an additional 90 days at 180 kronor per day, regardless of income level. According to many observers, this system of parental insurance, which links leave payment to income, is partially responsible for the inching up of the age at which women (and men) have their first child.

Sweden also has a generous leave policy for the care of sick children. Parents are allowed to stay home with a sick child for 120 day per year at a payment rate of 80 % of their income (up to the ceiling). If the child is seriously ill, there is no limit on the number of days. Additional benefits include up to 10 days of leave for fathers in conjunction with the birth of a child (at the 80 % rate).

Another universal benefit, aimed at facilitating parents' ability to provide for their children, is the child stipend. All children born in, or immigrated to, Sweden are eligible to receive (via their parents) a quarterly payment of currently 1,050 kronor (about $165) up till they are 16 years old. Parents with more than two children, in addition to the per-child stipend, also receive an additional "multiple-children" contribution.

A Swedish Perspective on the Future of Adolescent Pregnancy

Sweden's approach to reproductive health, including adolescent pregnancy, is guided and reinforced by an interlocking system of government agencies, research institutes, schools, organizations, youth centers, and professionals. Given that the current approach has wide backing from experts, politicians, and a large spectrum of interest groups, there are no reasons to assume that the approach will change in the foreseeable future. It is an approach that weaves together public health concerns (e.g., sexually transmitted infections), youth concerns, gender and other inequity concerns, and concerns for individual development and wellbeing. For adolescents in particular, it is an approach that coaxes them in the direction of "safe and healthy" sex, and away from "hasty and irresponsible" decision making with regards to sexual behavior. From this perspective, it is not an exaggeration to conclude that the State is engaged and invested in the sexual practices of adolescents.

The monitoring of the sexual practices of adolescents and young adults is part of this approach. The monitoring process produces a string of statistics and research findings that point to areas that need more work. Based on current research and policy initiatives, areas that are likely to receive, and/or keep receiving, attention in the future include sexually transmitted diseases, the practice of unsafe sex, and gender inequality in sex and intimate relations. This work could also benefit from a greater understanding of the factors associated with good decision making among adolescents, instead of the almost exclusive current focus on bad decision making (Folkhälsoinstitut 2010). Moreover, the fairly recent recognition of diverse needs in different populations is likely to invigorate research and program interventions geared at groups deemed particularly vulnerable and/or under-served, including immigrants, gays and lesbians, and those living with various disabilities. Furthermore, the very complexity of the organizational and institutional networks that monitor adolescents' sexual and reproductive practices is in itself a source of concern; that is, even as the general approach and policy goals are widely shared, the integration of various efforts, across regions as well as organizations, is not always as smooth and efficient as one might wish. Finally, the current efforts to evaluate the effectiveness of a wide range of programs and initiatives are likely to continue unabatedly; this is so especially since it is getting increasingly clear that there are extensive regional variations when it comes to several areas of concern, including the prevalence of sexually transmitted infections and abortion. Nonetheless, and in short, it is likely that the Swedish approach to adolescent sexuality generally, and adolescent pregnancy specifically, will look much the same in the future. In what follows I will briefly discuss a few of the areas likely to receive intensified attention over the next decade: boys and men, cultural diversity, and pornography.

One area of concern refers to the still fairly limited involvement of boys and men in sex and reproduction services. That is, the efforts to eliminate gender equities with gender-neutral laws and benefits have failed to bring about parity in the context of sex and intimate relations. It may even be that the many benefits available to parents in the context of childbearing and family life have inadvertently served to reinforce gender inequities; that is, as long as women are more likely to interrupt their careers when they have children and also more likely to work part-time while the children are growing up, they continue to fall behind men in the labor market. Hence, the current efforts to encourage men to take greater advantage of parental leave and be more involved in the care for children. In terms of adolescent sexuality specifically, both sex education teachers and youth center staff are working to bring in the boys.

What drives these efforts is not so much an ambition to get boys to have sex more responsibly—although that too is a major concern, especially in light of recent evidence of a decrease in condom use—but instead a recognition that boys have feelings too. Even if not a novel realization exactly, the efforts to recruit boys to the support system around sex and intimate relations are inspired by recent work on men and boys as gendered beings, which has revealed that boys live in a considerably more complex emotional world than hitherto recognized. An earlier and overly simplified view of men's and boys' sexuality was rooted in traditional manhood concerns of confidence and sexual prowess, but more recent research findings reveal that boys too are concerned about love and intimacy. Given the persistence of traditional masculine ideologies, however, these concerns are likely to trigger feelings of uncertainty and embarrassment. At this point, however, the knowledge base is fairly limited—that is, we do not know enough about what boys and young men think, want, and need when it comes to sex, intimacy, and family—which means that we can probably expect more research in this area over the next decade.

Another area likely to receive increased attention by both scholars and practitioners refers to questions and consequences of cultural diversity (Folkhälsoinstitut 2010; Forsberg

2006). Increased immigration has diversified Sweden in all different ways, including in the area of sex and intimate relations. Until quite recently (1990s), the assumption guiding the official approach to sex and intimacy was that newcomers in Sweden would eventually abandon the culturally specific attitudes and practices they came with and embrace the Swedish approach. This was so especially in light of observations that at least some immigrant cultures were organized around what seemed like a traditional and outdated gender hierarchy. The high value placed on women's virginity, for example, which has never been prominent in Sweden, was not only jarring to observers but also ran counter to the official approach that adolescent sex, given the right circumstances, was part of healthy development. More recently, however, research has started to approach diverse cultural expressions of adolescent sexuality with considerably more nuance and sensitivity. Placed in the larger context of social marginalization that characterize life for many immigrant groups in Sweden, scholars have come to understand that what they previously viewed as imported and "foreign" social-sexual practices may also, in part at least, be rational responses to the gender demands of the immigrant experience. This has also led to a recognition that adolescents from these backgrounds might be less able to learn from and take advantage of the schools' sex education programs (Östlund 1996).

A final area likely to receive increased attention refers to the links between sexual practices and new technology. At the same time as those who work with adolescents are taking advantage of the opportunities afforded by innovations, by offering internet-based information, chat groups and counseling, for example, there is growing awareness that those opportunities also make it easier for adolescents to access materials that, at least potentially, might undermine the overall goals of healthy sexuality and gender equity. This is so especially when it comes to pornography. Recent studies have shown that a new relationship has been "forged between pornography and youth culture" (Löfgren-Mårtenson and Månsson 2010: 568), and this new relationship has implications for how adolescents think of their bodies and sexual experiences. The majority of Swedish adolescents—both boys and girls—have had at least some exposure to pornography, even if girls, generally speaking, feel more ambivalence in relation to pornography and are more likely to be critical of what they see. Nonetheless, to both boys and girls, pornography has become part of their sexual lives, whether directly or indirectly, and as such pornography has entered the mainstream. However, because pornographic consumption remains linked to sexual practices that erode, even disrupt, what Giddens (1992) has termed the romantic love complex, the increased availability, and consumption of pornography by young people have triggered renewed concerns among public health professionals (Löfgren-Mårtenson and Månsson 2010). Moreover, the gendered dimensions of pornography threaten to undermine the work geared at eroding the traditional bifurcation—and double standard—of male and female sexuality and fostering gender equity in intimate relations.

Taken together, these frontlines of research and public concerns do not represent departures from the long-standing Swedish approach to adolescent sexuality and reproduction. Rather, they suggest an unabated concern for the health and welfare of young people and a strong commitment to a rationalistic approach to sexuality that integrates education, information, counseling, and training in ways that remain sensitive to the larger social forces that push the needs, experiences, attitudes, and desires of different adolescents in somewhat different directions.

Conclusion

Adolescent pregnancy in Sweden is currently not a major concern, either socially or medically. Adolescents become pregnant, of course, but they are unlikely to carry the pregnancies to term. Most adolescent pregnancies, in other words, end in abortion. The low number of adolescent births does not mean, however, that the issue is of no concern. On the contrary, the

sexual practices of young people are subject to extensive discussion and scrutiny by an array of public actors, including schools, organizations, agencies, and professionals. However, available evidence of the consequences of the efforts to instill in youths a foundation of healthy sexual practices and attitudes that they can carry with them into adulthood is somewhat mixed. On the one hand, a large portion of adolescents take advantage of available resources and act fairly responsibly when it comes their sexual lives (by using contraceptives, for example). But, on the other hand, there is also persistent evidence of the failures to reach all young people as well as to counteract social practices that foster "risky" sexual behaviors. Moreover, the efforts to eliminate gender inequalities in the area of sex and intimate relations—as part of a more general effort to reach gender parity—have only been partially successful, thus signaling that more work needs to be done.

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Adolescent Pregnancy in Switzerland

Françoise Narring and Michal Yaron

Keywords

Switzerland: Abortions · Adolescent birth rate · Adolescent pregnancy · Cultural values · Migration status · Pre- and postnatal care · Religious affiliation · Sex education

Introduction

Germany, France, Italy, and Austria surround Switzerland, which is located in the middle of Western European. We have a population of approximately 8 million people living in 26 provinces (cantons). Switzerland is multicultural and multilingual, with four official languages. Although the Alps cover the greater part of the country, there are thriving urban areas and cities and a large rural area. The Swiss Confederation established 1291 was a defensive alliance between three cantons. This confederation evolved to a fully fledged federal state of 26 cantons. The constitution of 1848 established the centralized government that exists today. Over the centuries, Switzerland's neutrality, has for the most part, been respected and is well known worldwide. During the last half of the twentieth century, as the political and economic integration of Europe has moved forward, Switzerland's has taken a corresponding path. Switzerland is not a member of the European Union (EU) but participates in the EU single-market system. The Swiss people rejected membership in the EU in 2001. Yet, the country has close ties with the EU established through a series of bilateral treaties. In these treaties, the Swiss government adopted provisions of the EU law. By adopting the provisions in these bilateral agreements, the Swiss are allowed to participate in the EU's single-market system and still maintain their sovereignty. Although today, Switzerland is less insulated from other European countries and more involved in projects sponsored by the United Nations and other international organizations around the world, Switzerland maintains its long-held conviction of sovereignty and neutrality (Foulkes 2012; swissworld.org 2012).

Adolescent Pregnancy

Currently, the number of live births in Switzerland before the age of 20 is approximately 4 per 1,000 adolescent girls aged 15–19. This is the lowest prevalence of adolescent pregnancy in

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Europe along with the Netherlands, which is also 4 per 1,000 live births among adolescent girls (Bajos et al. 2004; World Bank 2011). In other European countries, rates of live births range from 10 to 20 per 1,000 adolescents females. In the United Kingdom, the rate of live births is around 30 per 1,000, and in some Eastern European countries, the rate is 60 per 1,000 adolescent girls.

In Switzerland, starting in about 1970, the adolescent birth rate among 15–19-year-old girls began to decline. It declined from a high rate of 16 live births per 1,000 to 5 births per 1,000 by 2000 to 4 per 1,000 by 2007. The rate has remained stable at 4 per 1,000 since. The influence of major social changes like sexual liberation, increase of the adolescent population, and women empowerment during these years may partly explain this decline. Cultural changes such as independence, education, and professional activity available for young women may have resulted in older mean age at marriage and childbearing.

Adolescent pregnancy is not necessarily perceived negatively within the Swiss society. Often, parents accept their daughter's pregnancy and the fact that she will stay at home. In school, the pregnant girl is not categorically rejected. Social and school health services are available to negotiate special arrangement for school attendance. Public assistance exists for child day care and is accessible for adolescent mothers.

Swiss Abortions are Safe, Legal, and Rare

Swiss adolescents have one of the lowest birth and abortion rate in the world. A rate that can be described as, "safe, legal, and rare". Access to contraception plays a major role in reducing the rate of adolescent pregnancy in Switzerland. Switzerland pioneered contraception and family planning centers in Europe. In cantons where Protestantism was regarded as the principle religion, sex education and contraception were available in most clinics.

Oral contraceptives in Switzerland have been on the market since the early 1960s, and condom use has been promoted through the national campaigns for AIDS prevention since the 1980s. Additionally, when young women and girls become sexually active, it is standard practice for them to visit a gynecologist to determine the best contraception. Subsequently, most youth (75 % among 16–20 year old) use at least a condom during first intercourse and the vast majority of youth (87 %) use oral and/or condom) contraception (Narring et al. 2000).

The first HIV prevention campaign in 1985 and all subsequent preventive efforts resulted in effective promotion of condom use in the general population and especially among youths (Dubois-Arber et al. 1989; Gutzwiller et al. 1998; Narring et al. 2000). In 2011, the objectives of preventive campaigns were enlarged to include not only HIV but also other sexually transmitted infections (STIs). The strategy included availability of high-quality condoms, mass media "love life stop aids" campaign, sex education in schools, and individual counseling.

Avoiding pregnancy through using effective contraceptives at sexual intercourse is the preferred preventive method, but in case of contraceptive failure (lack of contraception, condom failure, or disruption in oral contraception), emergency contraception (also called "postcoital contraception" or "morning-after pill") has been used for about 20 years in Switzerland and other European countries.

Swiss law changed in 2002 to allow abortion on request within the first 12 weeks of pregnancy. Progestogens were also introduced in 2002 in Switzerland as emergency contraception and are available over the counter for adolescents older than 16 years. Pharmacists were trained in consulting women, and every pharmacy has a confidential space where initial evaluation takes place. Emergency contraception is also given in gynecological emergency services in hospitals, family planning clinics, and by gynecologists and general practitioners in private practice. Since then, the abortion rate has gradually fallen and stabilized (Ottesen et al. 2002).

In Switzerland, family planning services are widely accessible and frequently visited by adolescents and youths. Family planning consultation is free of charge. EC costs about US$7 per dose of single use (2011) and may be prescribed to young girls younger than 18 years without parental consent. Although there is not a strict age for decision-making capacity in Switzerland, a variety of clinical decisions or treatments are permitted if the decision-making capacity is confirmed by a medical professional, which in practice is usually given to females between 13 and 14 years.

Despite a restrictive federal law on abortion, dating back to 1942, the possibility to terminate a pregnancy is offered in almost all cantons. Required by this law, abortion was authorized if the pregnancy was a life-threatening danger, or a danger that could seriously harm the health of the mother. Two medical professionals must attest to the level of potential harm to the mother before abortion services are provided. The most liberal provincial authorities had established practical regulations, making abortion accessible to women for more than 40 years. In 2002, Swiss citizens voted in favor of new laws that legalized the termination of pregnancy up to 12 weeks of amenorrhea. As of 2012, some 22 other European countries have enacted new abortion laws (Boland and Katzive 2008).

The laws on abortion do specify a minimum age. Girls younger than 16 years, seeking an abortion, are required to go to specialized centers for younger girls where they receive age-appropriate counseling based on their age and development stage. The team in that center determines if the adolescent has the decision-making capacity to decide on abortion. In general, girls under 16 are encouraged to inform one of their parents or another adult. Ninety percent of the costs of the procedure are paid by medical insurance.

The abortion rate has remained stable in Switzerland at 6.4 per 1,000 women of childbearing age (Office fédéral de la statistique 2011). The abortion rate for adolescent females aged 15–19 is 4.0 per 1,000.

Birth Rate and Determinants Associated with Adolescent Motherhood

The adolescent birth rate has also decreased in the last 20 years. A study conducted by the federal office of Statistics has underlined level of education, nationality, and cultural backgrounds as associated parameters to adolescent deliveries (Wanner 2005).

The proportion of unmarried adolescents has dramatically increased. The father is usually older than the mother (mean difference + 7.7 years) (Wanner). This observation has not changed since 1969. Level of education seems to be one of the variables showing a strong association with adolescent deliveries. Adolescent mothers have a lower level of education than their counterparts of the same age, demonstrating the difficulties passing to a higher level of education or achieving a better level of training with a child.

Studies in the United Stated and the United Kingdom demonstrate that a higher proportion of adolescents pregnancies occurring with ethnic minorities (Berthoud and Robson 2000; Ventura et al. 2001). In Switzerland, the adolescent delivery rate is also higher among non-Swiss compared with Swiss women (Women from non-UE/AELE nationality exhibit the highest rates). Over the last decades, a higher adolescent delivery rate has originated from the successive waves of migration from Spain, Portugal, Yugoslavia, Africa, and Central and South America.

Studies in Switzerland suggest that migration status, religious affiliation, and cultural values are important determinants (Fontana and Bernand 1995). Migrant status and culture might account for less access to contraception and reproductive health services. Cultural values and religious affiliation might attenuate sexual education or reduce acceptance of abortion.

Medical Issues

Pragmatic approaches to sexual health of the adolescent, with improved access to confidential contraceptive services, are considered to be the main determinant in the decline in adolescent pregnancy rate in occidental and Northern European countries (Singh and Darroch 2000). The different causal factors related to adolescent pregnancy are precocious sexual relationship, absence of contraception, pregnancy in adolescents, a lack of adolescent friendly services, and availability of health services, socioeconomic conditions, cultural and social context, and the predilections of each individual adolescent (Fullerton 1997).

Pre- and Postnatal Care

Access to contraception and pregnancy tests are crucial for adolescent girls. Counseling in sexual and reproductive health and behavioral issues increases the quality of care related to adolescent pregnancy. Access to health care is relatively high for adolescents and young women in Switzerland because the country has a private insurance system with universal coverage. In a national school-based survey, more than 75 % of young females visited a doctor during the last 12 months. In this health care system, high-risk and low-SES individuals can access general practitioners to the same extent as less vulnerable young people (Haller et al. 2008).

Pregnant adolescent girls benefit, in most cities of the country, from a structured prenatal follow-up visits, conducted by midwives or physicians, and if they are near large university hospitals, by a multidisciplinary team, which addresses not only the somatic aspects of the pregnancy but also the patient's psychosocial well-being. Patients are entitled to "private" sessions with physicians who specialize in adolescent care. When appropriate, the partner and other members of the extended family are involved directly in the care. From about 20-week gestation, midwives begin the preparation for the delivery and newborn care. Patients and partners participate in a structured individualized course, which prepares them for the actual birth and instructs the parent(s) on the best way to care for a newborn.

Young parents are encouraged to join a support groups for young mothers and young parents. They are encouraged to meet with others in the support group before and after the delivery. As well, services provided by the midwives, trained nurses, and psychologists are available as needed. In these groups, meeting advice is sought and support is offered. These groups work closely with hospitals and provide not only emotional support but also medical attention when required (pelvic floor relaxation, urinary stress incontinence, breast-feeding complications, etc.)

Continued follow-up with the multidisciplinary adolescent medical team is based on the need of the parent(s) and the child. The network includes the doctor and the nurse who can help with other medical, psychological and social needs, in an organized link with social services and the family, or foster home.

Poverty, Family Supports, and Structure

Childbirth before the age of 20 seems to be associated with single-parent family later (Wanner 2005). When asked, most adolescent mothers consider taking care of their child while working in a fulltime job. Even so, the response remains allusive because a higher percentage of young females who express this view are unskilled workers, which suggests fewer work opportunities available to them after delivery (Narring et al. 1996).

Legal Issues

Swiss law supports the right of a child to know who his or her father is. A woman of any age who does not give the name of the father on the birth certificate will loose her parental authority

over the child until an investigation is carried out. A man who fathers a child has the obligation of responsibility for some of the care of the child. A minor is considered an assisted parental authority. There are no maternity rights for women. She is given six weeks of maternity leave; however, if this is paid or not is decided by the individual company. Availability of social funds helping young mothers from poor families is different from canton to canton. Public health interventions include prevention through sex education, general communication campaigns, and birth control.

Sexual Education

In nearly all regions of the country, sex education classes include information on preventive measures and available services. Sex education classes are conducted at least once a year during middle school age. Sex education while relatively well established in Switzerland, it is not mandatory. Sexual education has a long tradition in Switzerland, starting in the 1970s in the French- and Italian-speaking regions and later developing (in the last 20 years) in the German-speaking region. Depending on the canton, different agencies are in charge of sexual education in schools. It may be the family planning association, school health services, teachers, and in some cases private associations provide it. In most cantons, school nurses are available in schools and serve as referral consultations, as well as, liaison for sexual education sessions. In general, nine out of ten residents in Switzerland have had at least one sexual education lesson. Sexual education includes human immunodeficiency virus (HIV) and sexually transmitted infection (STI) prevention, unplanned pregnancy prevention, and sexual abuse prevention (Balthasar et al. 2004).

Prevention Campaigns

Following the AIDS epidemic, the federal government implemented a national prevention program, recognized as one of the most aggressive campaigns in Europe (Dubois-Arber et al. 1997). This preventive effort is comprehensive, involving STI prevention in its 2010 objectives.

Young people were one of the target groups with messages encouraging the use of condoms in their sexual encounters. A continuous evaluation of this prevention strategy has shown its effectiveness in improving condom-based protection against HIV infection without inducing other major changes in sexual behavior. Population surveys confirm that around 80 % of people ages 16–20 have used a condom at their first sexual intercourse (Narring et al. 2000).

Birth Control

Contraceptive services are available in all cantons through family planning clinics (financed by the government), gynecological private and public clinics, hospitals, and general physicians. All consultations are reimbursed by the mandatory medical insurance.

Conclusion

For the past twenty years, the adolescent birth rate has decreased in Switzerland. A number of important social influences have contributed to this decrease. Greater access to education and professional development for females has become widespread. Moreover, adolescent pregnancy is not necessarily perceived as negative in Switzerland. Often, parents accept their daughter's pregnancy and the fact that she will stay at home.

The preferred method for preventing adolescent pregnancy is encouraging the use of contraception during coitus or postcoital ("morning-after pill"). These prevention programmmes are well established, easily accessible, and confidential. These approaches are considered the primary determinant of the decline in adolescent pregnancy rate. Finally, although unplanned adolescent pregnancy will never disappear,

Swiss medical and social service providers will continue to try and improve contraceptive prevalence and efficacy as well as improve care for adolescent females facing crisis pregnancies.

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Adolescent Pregnancy in Turkey

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Keywords

Turkey: Adolescent pregnancy • Female literacy • Gender equality • Married adolescent • Maternal–child education program • Maternal–child health services • Maternal mortality • Premarital sexuality • Physiological immaturity

Introduction

In line with the anti-natalist policies implemented in the 1960s, Turkey has become acquainted with the notion of population planning. As a means of population planning, the concept of women's health has been added to the concepts of birth control and family planning. Particularly in the 1990s, the scope of women's health and family planning has increased in Turkey (as it did in the rest of the world) as a result of the decisions made at international conferences. Reproductive health and family planning have been integrated with fertility and maternity. The International Conference on Population and Development (ICPD) organized in Cairo in 1994 resulted in a more comprehensive definition of reproductive health (General Directorate of Mother and Child Health and Family Planning 2005). Adolescent reproductive health and rights have been added and assessed as a prioritized domain on an international level for the first time. However, even though there is a consensus on the significance of adolescent sexuality and reproductive health needs, services oriented at adolescent reproductive health are inadequate (Rivers et al. 2002).

The provision of sexual and reproductive health (SH/RH) services for adolescents is becoming a field unto itself. While gradually increasing in importance, especially in developed countries, the focus is on youth experiencing their sexuality in a safe and responsible manner. In developing countries, however, the SH/RH services are important in terms of marriage and fertility at an early age. In Turkey, both approaches are being used due to the differences between regions and settlements (General Directorate of Mother and Child Health and Family Planning 2005).

Youth are affected much more than adults by early and unprotected sexual intercourse. The knowledge of many adolescents about "safe

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sexuality" is limited. Sexual health education is not part of compulsory education or included in the school curriculum in Turkey. Thus, young people are denied to accurate and correct sexual information. They instead acquire knowledge from informal sources, especially pornographic publications and hearsay information acquired from friends. This is often misinformation that can influence sexuality in an adverse manner (Özcebe et al. 2007).

Gender discrimination plays an important role in the lack of providing these services. There is a difference in education in Turkey at every age in favor of males. Even though the rate of literacy in Turkey has increased for both male and females since the 1930s, the difference between men and women persists. After a basic education, most girls are unable to continue their education because of school expenses and because they are required to help their mothers with household chores, childcare, etc (Akin and Demirel 2003).

According to the Turkey Demographic and Health Survey (TDHS) of 2003, the average age of first marriage was 20 among women between 25 and 49. The age of first marriage varies according to region and level of education; however, the average age for first marriage is increasing gradually across the country. The basic influential factor in the increase in the age of first marriage is the level of education of women. As the level of education of women increases, the age of first marriage also increases. While the age of first marriage of uneducated women in the 25–49 age group is 18, the age of first marriage for women with secondary or higher education is 24.8 years of age (Hacettepe University Institute of Population Studies 2004).

According to the regulation with the Civil Code in Turkey, couples cannot marry until they are 17 years of age. However, even though a civil marriage is mandatory according to the Code, religious marriages at very young ages occur, especially in the eastern and southeastern regions (Turkish Republic Ministry of Family and Social Policies Directorate General on The Status of Women 2008). Thus, adolescent sexuality begins to be experienced under the institution of marriage in the eastern and southeastern regions of Turkey and outside of marriage in western regions and urban regions Turkey.

Adolescent sexuality and reproductive health problems continue to be a sensitive matter in Turkey. Premarital sexuality is not approved of in Turkish society and maintains a strict attitude against extramarital and random sexual intercourse (Ince et al. 2006). It is considered unsuitable for Muslim adolescents to be active sexually until marriage; however, there is a more tolerant attitude toward adolescent males (Rademakers et al. 2005).

This inequality among adolescents has caused young girls to suffer much more harm than boys (Blanc 2001; Tangmunkongvorakul et al. 2005). In the study conducted by Ege et al. (2008), majority of midwifery students believe that virginity is important, premarital sexual intercourse is wrong, and young women have to be aware of the negative outcomes of premarital sexual intercourse.

Many studies conducted in Turkey demonstrate that young people have deficiencies in knowledge about sexual health and reproductive health (Akin et al. 2003; Ozcebe et al. 2007; Topbas et al. 2003).

In another study conducted by Ege et al. (2011) of university students, they found that the average age of first sexual experience of students was 17.8 ± 1.8 years. Among those students, 17.7 % of them had a sexual experience and 53.3 % of those who have had a sexual experience used contraceptives. Among the students, 65.6 % stated that they had adequate knowledge about SH/RH, while 57.2 % stated that they had accessed this information through the media and press. Only 4.2 % stated that they received their information from a health center consultant. Other studies found that the knowledge of youth on sexuality and sexual health are incorrect and deficient. These studies pointed out that the basic reason of this deficiency of knowledge is mainly because information pertaining to sexuality is obtained from private, inadequate, and incorrect sources (Civil and Yildiz 2013; Kukulu et al. 2009).

When the reason for this lack of sexual knowledge is considered, it is in large part because families continue to support traditional attitudes about sexuality among youth as being taboo and shameful. They prefer not to speak to their children about issues concerning sexuality (Akin et al. 2010). It is generally the family and social circle that creates taboos. Being at a different cultural and educational level does not generally alter this outcome (Kukulu et al. 2009).

Young women are the group that is most affected by social pressure resulting from traditional values. This social pressure has forbidden premarital sexual activity for women and has burdened them with the responsibility of maintaining their virginity until the day they are married. Otherwise, still today in Turkey, young girls and women are exposed to violence committed for *honor purposes* (Kardem 2005).

Adolescent sexuality is shaped by cultural norms (Sandfort and Ehrhardt 2004). Many societies prohibit, deny, or disregard premarital sexual activity (Ahlberg et al. 2001; Olukoya et al. 2001). However, despite the possible adverse outcomes of premarital sexual activity and the moral prohibition, many adolescents have unprotected sex (Warenius et al. 2006). *Honor* is a vital concept in Turkish society. Even though *honor* harbors moral values related to the social reputation of a family or individual, in Turkey, *honor* is generally considered equal to sexual purity (Sev'er and Yurdakul 2001).

When controlling her sexual behavior, a woman demonstrates to society that she is concerned not only about her honor, but also about her family's honor. In such societies where the patriarchal family structure continues to subsist, the honor of the woman is considered to be the responsibility of the men of that family. The prohibition of premarital sexuality and maintaining virginity until marriage are fundamental objectives. This social norm prohibits premarital sexual activity of female adolescents, but approves male adolescent's engagement in an active sexual life. Women are kept under the control of men in order to protect the family and traditions (Kardem 2005).

These social and religious prohibitions are the reason sexually active girls resort to practices such as hymen restoration prior to marriage. In a study conducted to better understand young Muslim girls by Rademakers et al. (2005), it was determined that 10 % of Muslim girls in the 12–19 age group are sexually active. Furthermore, it was found that a number of these Muslim girls had requested documents certifying that their hymen was intact; while other girls requested a hymen restoration procedure from medical staff. Until 2004, hymen examinations in Turkey were conducted in line with the request of families and legal institutions. However, when Turkish leaders ratified the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) in 2004, hymen examinations in Turkey are only permitted if requested by a Turkish court. CEDAW is an international convention and can be described as an international bill of rights for women. It was adopted by the United Nations General Assembly in 1979 and finalized in 1981. By 2012, the United States was the only developed country that had not ratified the CEDAW.

Even in the absence of many studies with extensive samples in our country, people believe that sexual experience between adolescents is increasing (Akin et al. 2003; Ozcebe et al. 2007; Topbas et al. 2003). However, knowledge on a healthy sexual life has not kept pace with the freedom concerning sexual practice. The knowledge and living skills concerning reproductive health and sexually transmitted diseases such as HIV/AIDS are limited. Adolescents rarely find the opportunity to discuss such sensitive issues with their parents, elders, or teachers. One of the reasons is the social perspective which only approves of sexual intercourse the institution of marriage (UNICEF 2002). Every culture has norms regarding sex and sexuality. These norms determine sexual behavior, marital traditions, punishments concerning unapproved sexual behavior, and sexual education (Turkish Republic Ministry of Health 2005).

In Turkey, however, marital sexuality and pregnancy is approved of, while extramarital sexuality and pregnancy is not approved of by

Turkish society. However, in the globalizing world, the rapid social change process causes increases in unhealthy behavior such as risky sexual activity and the use of alcohol, cigarettes, and other drugs (Tangmunkongvorakul et al. 2005).

Recent studies indicate that many youth experience premarital sexuality under unsafe conditions. They participate in risky behavior such as sexual intercourse with *sex slaves*. They become involved with numerous partners and fail to utilize methods to protect themselves against pregnancy and sexually transmitted diseases (WHO 2002). As a result, marital or extramarital pregnancies cause multiple problems for this age group.

Adolescent pregnancies are considered to be one of the most important health problems of the twenty-first century. Today, 1 in every 10 adolescent girls in the world becomes a mother. Adolescent mothers account for 11 % of all deliveries, and 23 % of these adolescent mothers suffer health problems related to pregnancy and birth (Turkish Republic Ministry of Health 2009).

According to the World Health Organization (WHO), a lack of education and living in a rural area are factors that contribute to the increase in adolescent pregnancies. Studies conducted on adolescent pregnancies indicate that the adolescent, their spouse or partner, and their families generally have a low level of education (Gökce et al. 2007; Turkish Republic Ministry of Health 2009).

Marriage at an early age is one of the important factors preventing the adolescent girl from receiving an education and acquiring a profession. In this process, married adolescents take on responsibilities that are beyond their years. If girls are under the age of 18, they are too young to marry legally, and therefore, they are deprived of their civil rights (Polat et al. 2006).

In this context, girls are prevented from continuing on with their secondary and higher education due to traditional norms in some regions of Turkey. As a result, adolescent pregnancy is a significant problem that increases maternal and infant mortality and morbidity.

In Turkey, the main reasons for maternal mortality among pregnant adolescents are births with complications and unsafe dangerous abortions. Pregnancy in this age group can cause adverse outcomes in terms of both the mother's health and plans concerning her and her baby's future. When the western regions and urban areas of Turkey are considered, becoming sexually active at an early age is related to rapid growth in cities, migration from rural areas to the cities, socioeconomic status, weak family ties, domestic conflicts, the social environment that youth are in, and sexually active friends. In addition to these conditions, the lack of knowledge concerning safe sex results in unwanted pregnancies. Extramarital adolescent pregnancies, with their health, economic, and social aspects, can become a chronic social problem that affects the girl and her family throughout their lives (Ozgunen 2006).

Since a large majority of adolescent pregnancies are unwanted, they result in either legal or illegal abortions. In Turkey, where sexuality is perceived within cultural and moral boundaries, extramarital pregnancies can lead to significant problems (Akin et al. 2003).

Even though elective abortion (up to 10 weeks) has been legal since 1983 in Turkey, illegal abortions among unmarried adolescent girls in unhealthy conditions occur frequently. Lack of knowledge concerning sexual health and reproductive health underlies unwanted pregnancies among sexually active adolescents. Many studies conducted in Turkey suggest that there is a lack of knowledge concerning sexual matters (Ege et al. 2011; Kara et al. 2003; Inandi et al. 2003). Apart from the difficulties experienced in the effort to obtain an abortion, adolescents encounter numerous barriers when trying to access contraceptives. Too many are embarrassed when trying to obtain methods of birth control, fear that the family will find out, and the negative attitude of medical staff when adolescents request birth control.

Families and medical staff have an important duty in the prevention of sexual health and reproductive health risks among adolescents. Communication and support of the family and

the family acting as a role model regarding sexual and reproductive health is a major influence on the sexual behavior and attitude of adolescents (Aspy et al. 2007; Hutchinson 2007).

Unmarried young people have difficulties in obtaining information concerning sexuality, talking to their families, accessing contraceptive methods, and benefitting from services provided by reproductive health centers (Klingberg-Allvin et al. 2007; Tangmunkongvorakul et al. 2005; Warenius et al. 2006). The difficulties faced by adolescents obtaining methods of birth control are caused by services that are not adolescent friendly, service providers that are too judgmental, and lack of financial support (Kostrzewa 2008; Tangmunkongvorakul et al. 2005).

When providing services concerning sexual and reproductive health, medical personnel need to be aware that the strict rules of society related to premarital sexuality affect adolescent behavior.

Significant work to provide age-appropriate service to adolescents has been accomplished in Turkey in recent years on sexual reproductive health. To that end, training programs have been organized for midwives, nurses, and doctors (Acikalin et al. 2007a).

These trainings focus on safe maternity programs, family planning services, prevention, and treatment services related to sexually transmitted diseases, and they have developed sexual and reproductive health services specific to adolescents (Acikalin et al. 2007b). In some regions, youth centers, under the Ministry of Health, have been opened and health personnel working at these centers have been trained to work with adolescents. These centers, however, are unable to meet the need. The centers are still inadequate in both numbers and qualification of personnel. Additionally, an educational campaign is needed to inform families and people in the field of education and health that using an approach where pregnant adolescent girls are judged as bad, rather than using a public health approach, will not solve the problem of adolescent pregnancy. These efforts made toward using a public health model, however, are a positive step forward (Turkish Statistical Institute 2010).

Statistics on Adolescent Pregnancy in Turkey

National data for Turkey specific to the fields of economics, society, demographics, culture, environment, science, technology, justice, transportation, and agriculture are collected and published by the Turkish Statistical Institute. Detailed data in areas such as reproductive health, infant and child mortality, and family planning are found in the TDHS, which is based on a national sample. As there is no adequate record keeping system that collects data on adolescent pregnancy, much of what we know is based on this study (Hacettepe University Institute of Population Studies 2009).

To put adolescent pregnancy in context, the population of Turkey is 73,722,988 and 76.3 % of the population live in the urban centers of provinces and districts, while 23.7 % live in townships and villages. Whereas 67.2 % of the population is between the ages of 15 and 64, some 25.6 % are in the 0–14 age group, and 7.2 % is in the 65 and older age group. The percentage of young people between the ages of 10 and 24 within the total population is 21.1 %, or one in every five persons is in this age group. Furthermore, half of the population of Turkey is under 29.2 years of age (Turkish Statistical Institute 2010). When the rate of school attendance in Turkey is examined, one finds that 93 % of children attend primary school and 61 % of children between 14 and 16 years of age attend high school. The rate of attendance in secondary education is higher for males (65 % for males and 57 % for females). The status of secondary education attendance varies between east (41 %) and west (73 %), and between the wealthy (83 %) and poor (28 %). The gender difference index in education (GDIE) is determined as 0.98 for the primary education period and 0.83 for the secondary education period. The GDIE indicates that gender difference in education still continues to be in favor of males, although the gap has narrowed compared to previous data (Hacettepe University Institute of Population Studies 2009).

Marriage is widespread in Turkey. This is because the vast majority of pregnancies occur within marriage. Statistics on marriage provide information concerning the mother and includes the age of the mother when she gave birth. These data indicate that 99.9 % of women in Turkey (at the end of the reproductive stage) are married. The marriage rate of adolescent females 15–19 years of age was 9.8 % in 2008. The rate of marriage among girls 15–19 years of age was 22.2 % in 1978. The marriage rate among girls 15–19 years of age in 2008 was less than half the rate observed in 1978 (Hacettepe University Institute of Population Studies 2009).

When data concerning the age of marriage are referred to, it can be observed that 43 % of women between 25 and 49 have been married before the age of 20. A quarter of them married before 18 and 5 % of them before 15. In 2012, the average age at first marriage was 20.8. While the median age of marriage was 19.5 for women over 40 years of age, among young women in their 20 s, the age of first marriage was 22.1 years. The data show that there has been a regular increase in the age of first marriage in Turkey over the past 20 years (Hacettepe University Institute of Population Studies 2009). Today, in Turkey, the average age of the first marriage is 23.5 years (TUİK 2012).

There is also a positive relationship between the level of education and the median age of first marriage. While 23.8 % of married women, between 16 and 19 years of age, had attended primary school, only 3 % of these young women had received a secondary education (TUİK 2012).

These data also show that there is a positive relationship between the level of education and the age at first marriage. The median age at first marriage for women with a secondary education or higher is 24 years. And for women who have not been educated or have not graduated from primary school (5 years of schooling), the median age is 19 years (Hacettepe University Institute of Population Studies 2009).

In Turkey, age-specific fertility rates have decreased over the years in nearly all age groups. The increase in median age at first birth has resulted in a decline in the number of children per family. There were over four children per family in the 1970s. By the 1980s, the number had declined to about three children per family. In the early 1990s, there were 2.6 children family. The data show that this tended to continue into 2008 when the number of children per family had dropped to around 2.16 children per family. This change in the Turkish family has affected the fertility rate in Turkey. Between 1978 and 2008, the fertility rate decreased by 50 %. Age-specific fertility rates have also decreased in nearly all age groups. Between 1978 and 2003, the fertility rate, in the 15–19 age group, decreased 38 %. The impact was profound. Adolescent girls and young women in masse began to postpone childbirth. As a result, the age group with the highest birthrate changed from the 20–24 age group to the 25–29 age group (Hacettepe University Institute of Population Studies 2009).

Based on the latest data, the fertility rate in the 15–19-year-old age group is 7.1 %. In 2001, age-specific fertility rate among the 15–19-year-old age group was 0.49 %. It was determined to be 0.29 % in 2012. Some 30.7 % of all births are to young women in the 25–29 age group. The total fertility rate has dropped to 2.0 children; and the mean age of the mother at birth increased to 27.5 years of age. These findings indicate that fertility in Turkey is being postponed to young adulthood (TUİK 2012).

According to TDHS (2008), 6 % of adolescent girls were mothers or going through their first pregnancy. Of that number, 0.4 % were 15-year-old married adolescents, 2.2 % were 16-year-old married adolescents, 4.4 % were 17-year-old married adolescents, 9.7 % were 18-year-old married adolescents, and 12.9 % were 19-year-old married adolescent girls. Adolescent maternity is more common in rural settlements (9 %) compared to urban settlements (5 %). The adolescent fertility level is 3 % in the Eastern Black Sea region and 10 % in Central Eastern Anatolia. While 7 % of uneducated women give birth during adolescents, the rate is 4 % among high school graduates. The adolescent

maternity level is 2 % among wealthy households and increases to 8–11 % among women living in poor households (Hacettepe University Institute of Population Studies 2009).

While 99.1 % of married girls in the 15–19 age group are aware of modern birth control methods, only 38.4 % used a modern method of birth control at least once, and only 17.6 % of these girls consistently used a modern method of birth control. Among modern family planning methods, the "pill" and the intrauterine devices are most frequently used. Of those girls between 15 and 19 years of age, 22.6 % used a traditional family planning method and 59.8 % did not use any methods of birth control. Married adolescents in the 15–19 age group prefer using family planning for increasing the intervals between pregnancies. For 14.7 % of these married adolescents, the objective was not achieved (Hacettepe University Institute of Population Studies 2009).

Medical Concerns Associated with Adolescent Pregnancies

The main health concern associated with adolescent pregnancies is physical development. Has the adolescent mother's body developed to the point where she can carry and deliver her baby? Physiological immaturity is a risk factor for the mother and the infant. Next is the concern about the mother's psychological and social maturity. Will psychosocial immaturity be a factor in the mother meeting her health responsibilities (i.e., clinic visits, doctor's appointments)? Is she emotionally and mentally prepared for pregnancy? These are important concerns because they can put both the adolescent girl and her child at risk.

The data support these concerns. Among adolescent girls who gave birth in 2008 in Turkey, 8 % did not receive prenatal care and no medical personnel were present during delivery in 10.5 % of births (Hacettepe University Institute of Population Studies 2009). In another study, the number of adolescent girls receiving prenatal care was only 7.6 %, and on average, the first perinatal visit by pregnant adolescent girls was later than mature women (Celik-Yigit 2009; Duvan et al. 2010). Hospital-based data suggested that the rate of pregnant adolescents receiving regular perinatal care is 18.1 % (Sekeroglu et al. 2009).

In terms of problem deliveries, it was found that 81.6 % of adolescent pregnancies had no serious problem during pregnancy and their delivery was normal. Some 7.4 % of adolescents miscarried, 6.8 % experienced pregnancy complications, 2.2 % experienced medical problems, and 2.0 % experienced puerperal problems (Malatyalıoglu et al. 1992). This research finding also shows that adolescent pregnancy has unique risks, even though they have been followed up at least once at a hospital. The primary pregnancy complications observed in this study are hyperemesis gravidarum (nausea and vomiting—often referred to as morning sickness), early membrane rupture, medical problems during preterm labor, urinary system infection, anemia, vulva edema and the puerperal period problems or puerperal infection, lactation amenorrhea, and placenta retention.

The most frequently encountered maternal problems among pregnant adolescents in Turkey are preterm labor (Keskinoglu et al. 2007, Dallar et al. 2007; Duvan et al. 2010; Imir et al. 2008), early membrane rupture, eclampsia/preclampsia (Canbaz et al. 2005), and anemia and postpartum hemorrhage (Keskinoglu et al. 2007). The rate of maternal mortality associated with adolescent pregnancy in Turkey is 18.7 per 100,000 live births (Hacettepe University Institute of Population Studies 2006).

The rate of caesarian among pregnant adolescents varies between 26.6 and 55.7 %; however, this is a lower rate than for women in other age groups. Caesarean birth is relatively common in Turkey, and according to TDHS data, 37 % of births in the last 5 years (2003–2008) have been performed through caesarean sections (Hacettepe University Institute of Population Studies 2009). The factors that cause the birth to result in caesarean section is as important as the rate of caesarean sections in adolescent pregnancies. Adolescent pregnancies result in caesarean section mostly due to immaturity-related

malpresentation and head/pelvic incompatibility (Canbaz et al. 2005; Duvan et al. 2010; Imir et al. 2008). In addition to these problems, adolescent mothers adhere to their pregnancy-specific diet at a lower rate compared to women in other age groups (Babadaglı 2008). Moreover, these adolescent mothers had nutrition problems even before the pregnancy (Demirezen and Cosansu 2005). Furthermore, adolescents experience problems such as fatigue, thamuria, and breathing difficulties more than mature expectant mothers (Babadaglı 2008).

Medical Concerns Associated with Infants of Adolescents

As would be expected, data also show the rate of mortality and morbidity among the infants of adolescent mothers are high. The infant mortality rate within the first year of life for all girls and women is 12 per 1,000 births. The infant mortality rate within the first year of life for adolescent girls is 22 per 1,000 births. The mortality rate for children under five years of age is 24 per 1,000. The age of the mother is extremely important. When the mother is under 20 years of age, the neonatal, infant, and child mortality rates increase by 50 % in comparison with mothers in the 20–29 age group (Hacettepe University Institute of Population Studies 2009).

The most common health problem related to infants of adolescent mothers is giving birth to low-weight babies. Adolescents give birth to a disproportionate number of low-weight babies (Sezgin and Akin 1998). According to the Organisation for Economic Cooperation and Development (OECD), the rate of low-weight babies in Turkey is 11 % (OECD Health Data 2011). Intrauterine growth restriction is another problem identified, among adolescent mothers, that puts the infant at risk (Meydanlı et al. 2000).

These risks are somewhat modified by a positive response by the adolescent mother to her infant. The rate of infants who are breastfed is another positive and important behavior. Breastfeeding is higher among adolescent mothers than mothers in other age groups. As well, the rate of infants who are breastfed for the first 6 months of life is higher among adolescent mothers than mothers in other age groups (Dallar et al. 2007). Moreover, congenital anomalies occur at a lower rate in the infants of adolescent mothers than mothers in other age groups (Canbaz et al. 2005; Imir et al. 2008). Perinatal complications among all women are the fourth leading cause of death in Turkey and constitute 5.8 % of all deaths. This number of perinatal deaths, 821,008, constitutes the greatest proportion of Turkey's mortality burden. Among diseases constituting the disease burden, perinatal reasons again have the greatest share with 8.9 %. Adolescent pregnancies, which have important risks for both the mother and her infant, can be assumed to contribute significantly to perinatal mortality and to the overall disease burden.

Social Matters Concerning Adolescent Pregnancy

The level of education, family structure, and economic status are closely related risk factors for adolescent pregnancies. The median age of first marriage for women who have received secondary and higher education is 24.1, the median age for women who have completed the second stage of primary education is 3 years younger (21 years old), and the median age for uneducated or non-primary school graduate women is 5 years younger (16 years old) (Hacettepe University Institute of Population Studies 2009). The most significant reason for older age of first marriage is the increase in educational opportunities, access to a profession, and the use of effective birth control methods (Cetinoglu et al. 2010).

Factors (all related to poverty) causing adolescent pregnancies in Turkey are girls being exposed to domestic violence prior to marriage, tendency of the family for adolescent marriages, low level of education, not having social security, having more than one person per room in the home they live in, and having a sister with a history of adolescent pregnancy (Gökce et al. 2007).

Pregnant adolescent girls were found to be from families with an inadequate family income, lived in a large family with lots of siblings, with higher-than-average rates of unemployment, and with lower rates of civil marriage (Ozsahin et al. 2006; Sekeroglu et al. 2009).

Early-age marriages occur because of economic insufficiency, traditional and religious beliefs resulting from incorrect and deficient information, lack of education, domestic violence, social pressure, and property ownership (Turkish Grand National Assembly 2009).

In some families, small girls are considered an economic burden. Sometimes, the scarcity of food is a factor for marriage at an early age. Furthermore, married girls provide income for their family from a *bride price*. These practices are encountered mostly in the eastern and southeastern regions of Turkey. However, the prevalence of such customs across Turkey is unclear.

Many idioms and proverbs in Turkish approve of marriage at an early age. A few examples are as follows:

> The girl is in the cradle, marriage portion is in the chest
>
> A girl at fifteen is either with a man or in the grave
>
> Iron is hot and the beautiful girl has reached her age
>
> The one who gets married at an early age gets offspring and the early bird gets the worm.
>
> The one who gets married at an early age is not mistaken.

The majority of pregnancies in Turkey occur within marriage. Many young people become sexually active at an early age, and the rates of extramarital sexual experiences among adolescents are increasing (Pınar et al. 2009).

Approximately 40 % of youth in Turkey have stated that sexual intercourse should be experienced after marriage. The next most common response was the view that sex should be experienced when one feels ready or with someone special (Biri et al. 2007). Among unmarried girls in the 15–19 age group, 61.6 % stated that they had a female friend, who had a sexual experience. In another study, 12.3 % of single women who responded to the survey reported that they were sexually active (Giray et al. 2006). In a more recent survey, researchers found that the rate of university students experiencing sexual intercourse within the past week was 21.6 % (Dabak et al. 2010)

According to a study conducted among male university students, the age of first sexual intercourse was 17.8 ± 2.6 (Essizoğlu et al. 2009).

In other studies, the percentage of adolescents experiencing sexual intercourse was 4.7–5.1 % for females and 25.3–56.6 % for males (Kaya et al. 2007) (Ozan et al. 2004). In general, it is estimated that in Turkey, the first sexual experience occurs on average at about 17 years of age. In a study to identify the psychosocial characteristics of adolescents who were sexually active, among the 22.8 % of adolescents who had experienced sexual intercourse, almost half (48.2 % of females and 47.5 % of males) said that they had sexual intercourse 10 times or more in the last year.

Females in this group reported feeling more stress and pressure to engage in sexual intercourse than males. Additionally, a number of important relationships were identified. It was found that the lower the adolescent's perception of social support, the higher the likelihood that the adolescent would be sexuality active. Adolescents, who report lower levels of social control from family and friends, tended to be younger at age of first sexual intercourse. At the same time, there are a number of other risk behaviors that were found to be associated with sexual intercourse at an early age. Depression, feelings of alienation, risk-taking behavior, smoking, drinking alcohol and using drugs, and a susceptibility to peer pressure were among the most often reported differences (Siyez and Siyez 2007).

The research results related to male university students in Turkey conclude that males have sexual intercourse and experienced sexual intercourse at a higher rate than their female counterpart (Essizoğlu et al. 2009). Even so, despite the estimated rate of sexual intercourse among university students, a significant proportion of university youth do not seek out or receive

services related to sexual and reproductive health. Most do not know about family planning methods or do not use them appropriately. These students need information and education concerning the use of condoms and emergency contraception (Karaduman and Terzioglu 2008; Koluacık et al. 2010; Yılgor et al. 2010). Furthermore, due to the fact that sexual intercourse is within a paradigm related to the sex trade, information from a number of studies cannot be generalized to all adolescent behavior in Turkey (Essizoğlu et al. 2009). Due to all these reasons, youth constitutes a high-risk group in terms of pregnancy and sexually transmitted infections. In this group of adolescents who are unmarried and sexually active, there is a history of pregnancy and these pregnancies result in elective abortions (Giray et al. 2006). Whether or not these abortions are performed in sanitary conditions is an important national problem.

There is sufficient evidence to conclude that the rate of adolescent and youth groups receiving sexual education is unacceptably low. When these adolescent are asked where they obtain information on sexual topics, they respond that school friends are the major source of information. The family, media, and health establishments play a minor role as sources of information about sexuality. It continues to be a reality that the level of knowledge on sexual topics among female students in these adolescent or youth group is lower than that of males. Other sources of information outside of the family and friends are the Internet, newspapers, and magazines (Pınar et al. 2009). Communication between mothers and daughters concerning sexuality is minimal. In addition to young people who are married and who are university students, there are other groups of young people in Turkey that must be considered when planning policy or public health interventions (i.e., working youth, youths living on the streets, and disabled youth). Among youth living on the streets, there is a significant deficiency of knowledge about sexuality and reproductive health. This is especially true among youth with a history of crime and drug addiction. These youths are identified as being at the top of the list among high-risk adolescent groups (Devletkusu et al. 2010; Yalnız et al. 2011).

In Turkey, when adolescent pregnancy is discussed, the number of early-age marriages and adolescent pregnancies within marriage is considered to be a serious public health and economic issue. Although the numbers continue to decline, the underlying cause of “early-age marriage and adolescent pregnancies within marriage” is a culture that supports the tradition of early-age marriage and adolescent pregnancies. It is a tradition that is self-perpetuating. Due to the social perception of the appropriate role for women, especially in poor families, girls are taken out of school at an early age and forced into marriage with few opportunities open to the adolescent wife other than giving birth. Adolescent mothers and their children will then live in poverty. These adolescent mothers will insist on their daughters marrying at an early age. Thus, the cycle of generational poverty continues, caused by a lack of gender equality based on tradition, a lack of education among adolescent wives and mothers, and early-age marriages and adolescent pregnancies within marriage.

The Legal Status Concerning Adolescent Pregnancies

It is possible to evaluate the legal status concerning adolescent pregnancies under three different structures. The first one of these structures consists of the regulations designed to prevent adolescent marriages and the prevention of the adolescent from engaging in sexual intercourse against his or her will or at an age where he or she cannot take responsibility for the sexual act. The second legal structure is based on social policies related to family planning and the delivery of protective services. The third structure consists of regulations designed to protect the mother and infant after the adolescent has become pregnant.

Legal regulations to prevent adolescent pregnancy are based on the Turkish Civil Code and Turkish Penal Code. Article 124 of the Turkish Civil Code states that males and females cannot get married until they are 17, but in

extraordinary circumstances, judges can permit 16-year-old males and females to marry with the consent of their parents or their legal guardians. This Article is relatively important in the prevention of early-age marriages. However, the public view in Turkey is that a religious marriage is as acceptable as a civil marriage. To deal with this attitude, there is a provision in Article 143 of the Turkish Civil Code that requires a civil marriage before a religious marriage can be performed. According to Article 230 of the Turkish Penal Code, a person who performs a religious marriage and the people married in a religious ceremony (who were not first married in a civil marriage ceremony) can be imprisoned for 2–6 months (Turkish Civil Law 4721 numbered Turkish civil Law Item 124th, 143rd 2001; Turkish Criminal Law 5237 numbered Turkish Criminal Law Item 103rd, 230 2004). However, despite the punishment, studies related to adolescent pregnancy have shown that many of the girls married in religious ceremonies are too young to be married in a civil ceremony. Religious marriages are still being performed because of a patriarchal ideology and traditional social structure that has normalized and legitimized marriage at an early age (Ozcebe 2010).

The Turkish Penal Code also includes sanctions to prevent forced and unwilling sexual intercourse and sexual intercourse with a child that is not legally old enough to give consent. Article 103 of the Turkish Penal Code states that "whether performed with will or through force, threats, manipulation, or any other reason influencing the will, the crime of sexual abuse committed against children under the age of 15 can be imprisoned for 3–8 years. Moreover, according to the second clause, if the abuse involves the penetration of an organ or inserting an object into the body, the guilty person can be imprisoned for 8–15 years. In Article 104, penal sanctions are permitted without the need for filing a complaint if the partner in cases of children is over the age of 15 and is 5 years older than the victim. If the partner is less than 5 years older than the victim, a complaint is needed (Turkish Criminal Law 5237 numbered Turkish Criminal Law Item 103rd, 230 2004).

All regulations concerning the delivery of health services in Turkey are provided for under the country's constitution. Article 56, in the Constitution of the Republic of Turkey states:

> Everyone has the right to live in a healthy, balanced environment. It is the duty of the state and citizens to improve the natural environment, and to prevent environmental pollution. To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and maternal resources through economy and increased productivity, the state shall regulate central planning and functioning of the health services.

In Turkey, the state fulfills this duty within the framework of the provisions of related legislation primarily as the Law on the Socialization of Health Services, Health Services Fundamental Law, Law on the Pilot Application of Family Medicine, and the Social Security Law and international conventions, of which Turkey is a signatory. In these laws, regulations concerning reproductive health and target groups are a priority. With Maternal and Child Health and Family Planning Centers, extensive basic health services including reproductive health services are provided to the population consisting of every age and gender through primary healthcare institutions across the country. Basic health services include the following: education about maternal and child health and family planning to adolescents, young adults, and adults. The provision of these services is the responsibility of all government institutions and must be provided by professional organizations, public institutions, and private and voluntary organizations.

The United Nations CEDAW, ratified and signed by Turkey in 1985, is binding and used as guidance in the delivery of medical and social services. The change experienced in the public health policies of Turkey has been an important factor in the prevention of adolescent pregnancies and the increase in the age at first birth. The Law on Population Planning (ratified in 1965 and revised in 1983 into a liberal structure that included more extensive civil rights for females) has permitted major changes in the health services available to women and girls. Modern pregnancy methods are now being imported into

Turkey and are available to most women and girls. The costs of family planning services are free at state health institutions. There is support for providing education to couples concerning family planning. Under the "Law on Population Planning," the regulation of birth (i.e., the availability and knowledge related to birth control methods) is defined as a human right. This has legalized elective abortion in pregnancies up to 10 weeks. It has further legalized elective surgical contraceptive methods for males and females upon request (tubal ligation for women and vasectomy for men). The implementation of and free access to modern family planning methods has especially been affective in the prevention of adolescent pregnancies and increasing the age at first birth in Turkey (The Republic of Turkey Prime Ministry General Directorate 1996; The Law About Socialization of Health Services, Number 224 1961).

Despite these legal regulations against adolescent marriages and pregnancies, in cases of pregnant adolescents under the age of 18, there are specific procedures that must be followed by medical and social service professionals. For example, when an underage pregnant adolescent asked to be admitted to a hospital, the nurse or social services expert on duty at the hospital assumes legal responsibility for her protection. If a nurse is the first person to identify the girl as underage, the nurse is responsible for notifying the social services expert. The social services expert is then obliged to notify the case to the Children's Office of the Provincial Police Department. Thus, the prosecutor's process commences in order to assess the status of the adolescent. In necessary cases, the adolescent can be taken under the protection of the state even to protect them from their families (Dede 2011).

Public Policies Concerning Adolescent Pregnancy

Programs for preventing adolescent pregnancies, educational activities, and maternal–child health services are revised to promote national strategies intended to support development at an international level. Activities concerning women's health in Turkey have recently advanced. After the proclamation of the Republic (1923) and until the 1960s, population increase was supported as a state policy because of the need for people in agriculture and the military force. Economic development required a high fertility rate because of the high rate of mortality due to contagious diseases. National policies of this period intended to increase fertility, provided exemption of tax and granted agricultural land to families with many children, and increased the number of maternity hospitals. The law prohibited abortion, contraceptives, training on how to use pregnancy prevention methods, and the literature concerning pregnancy prevention methods. However, during this period, organizations developed, which benefited maternal health. For example, population commissions were established in order to investigate maternal and infant mortality cases. This approach emphasized public health measures to decrease maternal and infant mortality rates. In the 1950s, fertility, illegal abortions, and maternal mortality increased. Maternal and infant mortality data compiled over the years made it clear that Turkey was in the grip of a national crisis. To deal with these national concerns, the Maternal–Child Health Centers (MCHC) were established.

In 1960, policies that encouraged population growth were changed or eliminated. The Population Planning Law legalized family planning services. Mothers and children were identified as priority groups for the delivery of health services. In 1978, the Basic Health Services Law insured that they would continue to be the focus of health care services. In 1982, the General Directorate Maternal and Child Health and Family Planning (GDMCHFP) program was established. Finally, in 1983, with the "Law on Population Planning" (#2827), voluntary surgical sterilization and elective abortion of pregnancy up to 10 weeks became legal (Law About Population Planning Number: 2827 1983, May 27; The Republic of Turkey Prime Ministry General Directorate 2008). Although these were important changes, these policies related to

family planning and fertility did not adolescents. However, when modern family planning methods became widespread and when government agencies developed specialists in maternal–child health, the delay of adolescent pregnancies was a priority, which facilitated the delivery of maternal and infant health service to adolescents.

The low level of education and poverty are fundamental factors in adolescent marriage and pregnancy, and these factors are closely related to the social gender inequality formed by the traditional and patriarchal social and family structure. The grounds of social gender equality policies in Turkey were founded during the revolutions of the Turkish Republic. The most prominent among these policies provided women equal rights to education. This right became law in 1924. These policies also formed the basis for the restructuring of women's social life to be more compatible with contemporary norms. This occurred in 1926 with the passing of the Turkish Civil Code. Enfranchisement of Turkish women in 1930 allowed women to work for and serve in local government administrations. Several years later, in 1934, women were allowed to participate in parliamentary elections. When these national policies made possible by the Republic era are evaluated using universal criteria, they are considered to be significant transformations that set the example for contemporary life in Turkey.

The more recent developments of policies and practices intended to eliminate social gender inequality are in line with international developments. Primarily, the United Nations CEDAW, the European Social Charter, Convention on the Rights of the Child, conventions, resolutions, and recommendations of organizations such as ILO, OECD, CSCE, the Cairo ICPD Action Plan, Action Plan of the Fourth World Conference on Women, and the Beijing Declaration form the bases of policy intended to eliminate social gender inequality. Turkey also ratified the documents (Beijing Declaration and Action Plan) adopted at the finalization of the Fourth World Conference on Women. At the conference, our country committed to reduce maternal–child mortality by 50 %, increase compulsory education to 8 years, and increase female literacy to 100 % by 2000 (Turkish Republic Ministry of Family and Social Policies Directorate General on The Status of Women 2008).

With the increasing of compulsory education to 8 years in 1997, the level of female education has increased. As a result, there has been a significant decrease in maternal–child mortality. Because of this act, the rate of female literacy has increased due to widespread availability of literacy courses. Furthermore, the average age of marriage among adolescent girls that received 8 years of education is 19 years of age or older. The rate of observed adolescent pregnancy is 1 % (Hacettepe University Institute of Population Studies 2009).

The participation of women in employment is lower than that of men, and there has been a decrease in female participation in the workforce over the years. The primary reasons for the number of women decreasing in the workforce are difficulties in obtaining childcare, low wages, employment without social insurance or shutdown in the workplace, and the woman's interest in employment. With the amendments to the New Labor Law, which regulates work life, in 2003, significant developments were made in order to ensure male–female equality in work life. In 2003, Turkey joined the Gender Equality Acquis, which is one of the European Union's social policy programs. The term "EU gender equality *acquis*" refers to the relevant treaty provisions, legislation, and the case law of the European Court of Justice in relation to gender equality. In order to ensure harmony with directives concerning male–female equality in work life under the scope of the Turkey National Program, dated 2003, regulations and activities have been revised. With the amendment to the Income Tax Law in 2007, income of women obtained through the sales of products produced in the household by women at organized fairs, festivals, kermises (i.e., fund rising events), and at sites assigned temporarily at public institutions and organizations are exempt from tax.

These initiatives were instituted to increase female employment and prevent the unemployment of women. However, no study has been

commissioned to determine whether these changes in the Turkish law have had the positive effect intended on adolescent marriages and pregnancies. Some of the action titles included in the national action plan for ensuring social gender equality between 2008 and 2013 are as follows (The Republic of Turkey Prime Ministry General Dırectorate 2008):

- Increase of schooling rate of girls (enrollment, attendance and completion).
- Increasing "Female Literacy" among adults.
- Having educators, education programs, and materials to become conscious of "Social Gender Equality."
- Expediting activities for increasing female employment with all parties under the objectives of the Development Plan.
- Improving the economic position of women in rural areas.
- Tackling gender discrimination in the labor market.
- Decreasing wage differences among men and women.
- Carrying out works for improving the position of poor women excluded from employment.
- Having public policy provide female–male equality.
- Taking all measures including the development of policies for enhancing the quality of women's conditions in accessing health services and the quality of the service.
- Making research, scientific studies, and information concerning women's health more widespread.

Under this action plan, the strategy for "Raising the awareness of society on the adverse effects of early-age marriages and consanguineous marriages (from the same lineage or origin; having a common ancestor), on maternal-child health" is the responsibility of the Ministry of Health, Directorate General of the Status of Women, Provincial Governorships, Presidency of Religious Affairs, Directorate General of Family and Social Research, and in cooperation with media organizations, universities, employee–employer unions and confederations, and non-governmental organizations (NGO). This strategy has been identified as one of the most significant actions, to date, in the effort to improve maternal–child health (Turkish Republic Ministry of Family and Social Policies Directorate General on The Status of Women 2008).

In light of these initiatives in our country for developing adolescent health, success can be determined by the degree in which the strategies have informed and raised awareness and in terms of the increase in services, delivered to adolescents. The Puberty Change Program, implemented in 1993, is the oldest of the programs for informing this adolescent group. Another project is the "Development of Health Awareness in Adolescents," which was implemented in 2001. This project is a partnership between Turkey and the United Nations' Population Fund. The target of the training provided to adolescents includes education intended to help adolescents get to know their own bodies (including sexuality), make healthy and responsible decisions, and acquire the awareness of the importance of respecting the rights of others while making these decisions. This project, which has a basic objective of having strategies developed for addressing the information and service needs of adolescents concerning reproductive health, includes students of primary and middle school, teachers, school administrators, and parents of students. The programs designed to address these adolescent service needs are Adolescent Centers, the Reproductive Health Services for Adolescents, University Models of Reproductive Health for Youth, and Youth-Friendly Health Centers (Simsek 2007).

The first adolescent center outside of the USA was established in Turkey in 1965 at the Hacettepe University Children's Hospital by Dr. Mithat Çoruh and Dr. Erol Kinik. Youth consultancy and Health Service Centers have been increasing rapidly. These programs are being established by the Ministry of Health, universities, and various international support organizations and their members. For the purpose of developing and improving adolescence health in our country, the Ministry of Health has established the "National Service Delivery

Model." Additionally, youth-friendly health centers, where youth can obtain information and physical–psychological services, are being established. The "Turkey Reproductive Health Program" began in 2003. The specific objectives of the program are based on agreements between the Government of the Republic of Turkey and the European Commission (EC). These objectives are designed to increase the utilization of sexual health and reproductive health services and improvement of policy related to adolescent sexual health.

The following have been identified as goals of the program:

- Expansion of the scope of reproductive health delivery and the area it reaches.
- Increase in access to the services.
- Improvement of the quality of sexual health and reproductive health services and increasing awareness on sexual health and reproductive health needs of youth and an increased response to these needs.
- Ensuring that members of parliament, policy makers, and decision makers are more informed of and have an understanding toward rights and preferences concerning sexual health and reproductive health.
- Decreasing the difference between rural and urban areas and the East and the West.

The first component of the Turkish Reproductive Health Program consists of activities that provided support to the Ministry of Health to improve service delivery quality and strengthening the institutional capacity. The second component was to increase the demand for sexual health and reproductive health services and achieve cooperation with and strengthen NGO. In addition to the educational activities implemented under the scope of the first component of the program, 75 Reproductive Health Education Centers have been established, 12 of which are regional. Likewise, in addition to the 18 Youth Centers previously opened, the Ministry of Health has opened 20 Youth Consultancy and Health Service Centers. Educational maternal have been developed for these programs; and, pregraduation and in-service training has been provided. For the purpose of raising the awareness of youth about reproductive health matters (between 2001 and 2005) in pilot provinces, the "Project on the Development of a Strategy for Addressing the Reproductive Health Information and Service Needs of Adolescents" and the "UNICEF Adolescent health and Development Program" have been implemented. Furthermore, activities such as premarital consultancy and sexual health programs, prevention of consanguineous marriages, and perinatal and neonatal scans are being conducted. Women and health standards are included in the subheading of program policy related to the service implementation at Community Centers affiliated with the Directorate General of Social Services and Child Protection Agency.

These policies guide the development of services provided by the Women's Human Right Program, Maternal–Child Education Program, and My Family Program. The "Women's Health and Family Planning-National Strategic Action Plan," which has been prepared for the first time to parallel the ICPD and developed with primary consideration of the topics of women's status and reproductive health, was implemented in 2000. In line with occurring developments and requirements, the plan was updated in 2005 as the "Sexual Health and Reproductive Health for the Health Sector National Action Plan." This plan sets forth Turkey's objectives and priorities and the things that need to be done for the period between 2005 and 2015. With this strategic plan, Turkey's priorities are the reduction in maternal mortality, prevention of unwanted pregnancies, improvement of youth health, prevention of sexually transmitted infections, and the reduction in regional inequalities of health. One of the titles in this action plan calls for an increase in the sexual health and reproductive health of youth people in Turkey. The plan also calls for a reduction in adolescent pregnancies, an increase in youth-friendly sexual and reproductive health services across Turkey on a regional basis, and the reduction in differences between regions and settlements in the delivery of these services (Turkish Republic Ministry of Health 2011; Turkish Republic Ministry of Health and the European Union Turkey Reproductive Health

Project 2007; Turkish Republic Ministry of Health 2005).

In Turkey, the provision of adolescent health services and general reproductive health services is determined by the funds allocated for health from the general budget of the country. Even so, reproductive health services are free of charge for those under 18 years of age, regardless of them or their families being covered by general health insurance. In the same manner, family planning services are also health services that are delivered free of charge. In addition, if an individual has health insurance, he or she can use either public or private health institutions to access reproductive health services. Individuals without health insurance can access services from private health institutions with the green card scheme. However, international funders support some of these private health programs. In December of 2001, the Government of the Republic of Turkey and the EC signed the Turkey Reproductive Health Finance Agreement. This program that began in January of 2003 has contributed to the overall levels of the SHRH status of Turkish adolescent girls and women. Services oriented to safe maternity, including emergency obstetric care, family planning, and prevention of sexually transmitted infections. The development of sexual health and reproductive health services that are youth oriented have been selected as prioritized areas of reproductive health. On the other hand, because of increasing demand for quality reproductive health services, the program also provides financial support to NGO that provide reproductive health services. This has been possible in part because of the support of the United States Agency for International Development (USAID), cooperating organizations such as the International Family Health Training Program (FHTP), and the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). Various projects supported by UNİCEF and the United Nations Population Fund also contribute to the improved state of sexual and reproductive health of the Turkish people.

The Turkish Perspective on the Future of Adolescent Pregnancies (Research, Policy, Program)

In light of international developments, the understanding of delivering services based on maternal–child health and family planning has changed in the direction of reproductive health. The same change has occurred in research in Turkey concerned with reproductive health. The International Reproductive Health and Family Planning (UUSAP) Congress, held in Turkey once every 2 years, is the group with the most multidisciplinary participation and interest in reproductive health. This group identifies scientific up-to-date developments and reflections on Turkey's research related to sexual and reproductive health oriented to practitioners. Assessing the content of the proceedings of the UUSAP Congress helps identify the changes that have occurred in the practice of maternal health care in Turkey. Over the years, the research focus has decreased on family planning methods, providing information about family planning methods, and satisfaction with the methods used. In recent years, the focus has been on maternal–child health, reproductive health rights/expectation/service quality, menopause, adolescents, infections, sexuality, violence, and emergency contraception. This focus reflects the action plan adopted by the ICPD-Cairo. While there were only two adolescent studies presented at the Congress in 2001, this number increased to 37 in 2007 (Sahin and Gungor 2008).

Although supported by research efforts presented at the National Congress, it can also be said that there is an increasing interest in adolescent sexual health and pregnancy in Turkey that is independent of this Congress.

The research related to adolescent pregnancy in Turkey has focused on three major areas: (1) the prevalence of adolescent pregnancies and the evaluation of risk factors associated with adolescent pregnancy; (2) the impact of adolescent pregnancy on maternal and child health; and (3) the assessment of the sexual and reproductive health among adolescents as a group.

In general, there are fewer society-based studies. Most studies use adolescent populations from hospitals and health centers and are either a comparison between pregnant adolescents and pregnant women of other age groups, or the research is retrospective based on file analyses. Apart from the TDHS that provides information on adolescent pregnancies, many studies have been conducted with small sample groups. In light of the research needs in this area, we recommend that future research in Turkey on adolescent pregnancies should consider the following areas of inquiry:

- Qualitative studies of adolescent pregnancies based on data collected from multidisciplinary teams consisting of members such as doctors of medicine, nurses, sociologists, and psychologists.
- Studies that explore solutions and provide suggestions for reducing adolescent pregnancies and for improving adolescent maternal and child health.
- Research designed to evaluate interventions that consider culture and social dynamics for the prevention of adolescent pregnancies.
- Society-based studies that include groups in Turkish society that are different in cultural and socioeconomic status.
- Meta-analyses of current studies.

Conclusion

In Turkey, marriages under the age of 17 and all marriages other than civil marriages have been legally prohibited; however, as illegal marriages at early ages are accepted by society, they are still performed. In an effort to enforce this prohibition, all institutions must actively help enforce the prohibition, and these institutions should to be audited to ensure compliance. Penal sanctions need to be increased, and public awareness of this prohibition needs to be raised. Because a large majority of adolescent pregnancies in Turkey occur within marriage, the prevention of early-age marriages in the effort to prevent adolescent pregnancies is of great significance. Furthermore, in the laws of the country, the notion of child refers to those under the age of 17 according to the Turkish Civil Code, those under the age of 15 according to the Turkish Penal Code, and those under 18 according to the Law on Child Protection. It is necessary to correct these various age definitions of “child” to be under the age of 18. This would bring the definition of child in line with the Convention of the Rights of the Child. This change in the definition of the age of a child will increase regulations that can be used to reduce practices threatening the sexual and reproductive health of those under the age of 18 (Turkish Grand National Assembly 2009).

The prevention of social gender inequality and the increase in education level appear to be the most effective solution in the prevention of adolescent pregnancies and marriages. In order to achieve social gender equality, it is necessary to raise the awareness of the public, raise the awareness of male and female students, increase women’s employment, and increase gender consciousness among media outlets, politicians, the judiciary, and the educational system. We also need to strengthen the position of women especially in rural areas and in socioeconomically weak areas caused by migration. Policies and programs oriented at eliminating the difference in schooling between male and female students, which favors males, should be developed, and these policies and programs should be widespread. In order to increase the rate of schooling and increase the period of compulsory education to 8 years, it will be a necessity to provide economic and transportation support for families who send their children to school. The school constitutes a great environment for the prevention of early-age marriages and raising the awareness of adolescents concerning their sexual health. However, it can be observed that current regulations and practices do not ensure constancy in how sexual health is presented at schools. Awareness-raising activities concerning adolescent sexual health are typically provided by projects that are short in duration. When these projects end, the effort to raise awareness ends. To change social attitudes, these initiatives need to be sustained over time.

School health services and nursing services in Turkey are not required by policy. However, providing school health nursing services and school health clinics that can deliver services under the society–school–family–student scope could be a major strategy in the prevention of adolescent pregnancies and can create reliable solutions for adolescents' sexual and reproductive health. School health services should be a priority for Turkey. Because adolescent pregnancies are higher in rural areas and because many adolescents do not attend school, it is necessary to develop outreach programs that are oriented to adolescents who live in rural areas and do not attend school.

Finally, surveys have shown that unprotected sexual intercourse is widespread among university youth in Turkey. This occurs because of a deficiency in the sexual knowledge of Turkish college students. To increase gender equality, university-based health programs that provide sexual and reproductive health services are necessary. In Turkey, there are 210 universities owned by the government, foundations, and other institutions. However, only a few of our universities have sexual health consultancy and treatment units that provide these services to their students. As gender equality is a public policy goal, it is important that all universities develop sexual and reproductive health services.

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Adolescent Pregnancy in Uganda

Ann-Maree Nobelius

Keywords
Uganda: Adolescent pregnancy · Age of consent · Clan · Condom use · HIV · Paternity · Pregnancy prevention · School-going girls · Sexual education · Survival sex · Traditional relationship

'If You had No Plans for Her Future, Why Did You Make Her Pregnant?' The Meaning of Teen Pregnancy for Out-of-School Young People and Their Communities in Rural Southwest Uganda

> Arriving at the top of the hill in the bright sunshine and cool breeze I was met with the most amazing vista. Hundreds of children from schools all over the district gathered in their bright monochromatic uniforms. A riot of radiant purple, red, yellow, blue and green cotton! Children marched, performed military drills, ran in egg-an-spoon, and 3-legged races, all to the unrelenting electrifying screams and delight of their school mates; this was 3 h of pure, unadulterated fun!
>
> (Diary, 16th December 1998)

Sadly only 16 % of Ugandan young people will attend secondary school (Neema et al. 2006), and on this day, in the rural district in which I lived and conducted this study with out-of-school young people and their communities, the other 84 % of young people aged 13–19 years were not having fun, but they were laboring for little or no money.

Uganda has the dubious honor of having one of the highest rates of adolescent pregnancy in Africa with roughly 25 % of girls becoming pregnant before the age of 19 (Republic of Uganda et al. 2006). This carries with it all the risk to maternal and child health, which have been well documented by numerous researchers and clinicians. The government of Uganda is not unaware or unprepared for these facts and for many years has responded with policy and laws to address these issues. Chief among these laws was raising the age of consent to marry for young women to the age of 18 (Republic of Uganda 1995). Yet, with an engaged and interested public and no shortage of donors to assist with family planning and social and health development, these efforts in Uganda have not solved the troublesome rate of teen pregnancy.

As public health practitioners, we analyze the great public health issues of the day. We define the issues. We debate the issues. We work out the human and economic cost of the issues so that we can rationally explain to government

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representatives where their public health priorities should lie and how they should prioritize their limited funding to balance the cost of doing nothing now and facing the cost and consequences later if we do nothing now.

We call the sexual behavior that results in teen pregnancy, 'risky behavior' that leads to 'adverse health outcomes.' At the core of these great public health issues related to adolescent pregnancy are social behaviors of real people who are living their everyday lives. The young couple having unprotected sex is unlikely to be thinking about the public health consequences for any potential children born of the union. There are other human reasons for these behaviors, and demonizing them either for moral reason or for economic reason does not change them. In order to change these behaviors for positive health benefits, we must understand them.

Background

The data presented here were gathered in collaboration with the Medical Research Council/Uganda Virus Research Institute, Uganda Research Unit on AIDS between 1998 and 1999. This collaboration has continued to produce some of the world's most impressive epidemiological data on the progress of HIV in this community (Mulder et al. 1994, 1995; Kamali et al. 2000; Whitworth et al. 2002; Shafer et al. 2008) (see Fig. 1).

I lived in a rural village in one of the study areas. The focus was to give some meaning to the high number of cases of HIV among 13–19-year-old adolescents. I gathered qualitative data through role-play, focus groups, mixed gender group discussions, participant observation, key-informant interviews, and semi-structured interviews with 31 young people 13–19 years of age. I also interviewed their parents, community leaders, health service providers (both Western and traditional) and politicians, bureaucrats, and NGO employees responsible for the health and well-being of young people.

The young participants were stratified into 3 age-groups which had been shown through prior research to represent developmental stages in young people in this area; 13–14, 15–16, and 17–19 years. At this time, HIV had 'plateaued' though rates of HIV were still high (Kamali et al. 2000), but the ABC strategy of HIV prevention appeared to be working (Middlestadt 1993; USAID 2002) and government radio and print-based health messages appeared to be working well. Acceptance of the need for condom use as a prevention strategy was high.

Analysis of this data regarding the sexual health needs of young people revealed some surprising findings. Young people who participated in the study lacked adequate knowledge regarding sexual and reproductive health issues. They lack adequate knowledge regarding the negotiation of sexual behavior and sexual relationships and making decisions related to the transition into adulthood. These adolescents requested that another source of information on sexual health and reproductive issues should be provided by trained community workers, rather than only being available from clinic-based educators. This would help them avoid the stigma associated with a young and apparently healthy adolescent visiting a clinic unsupervised. On the issue of relationship negotiation, they preferred the traditional source *ssenga* (paternal aunt), particularly for adolescent girls. On issues regarding becoming a good and responsible adult, the adolescents felt parents, grandparents, and religious and community leaders should play a predominant role. These adolescents considered the experience and expertise of these adults as invaluable. They cited current information sources such as friends and print or film media as confusing and incomplete. They considered the Ministry of Health information to be accurate and valuable. Hence, the adolescents in the study wanted people who were authorities in different areas of sexual health and reproductive issues to provide sexuality information (Nobelius et al. 2010a, b, c).

All participants in the study, both young people and people living in their community who were interviewed, felt that young people begin their sexual lives too early. Yet, teenage boys still felt pressure from peers as well as older relatives and other men to proposition and

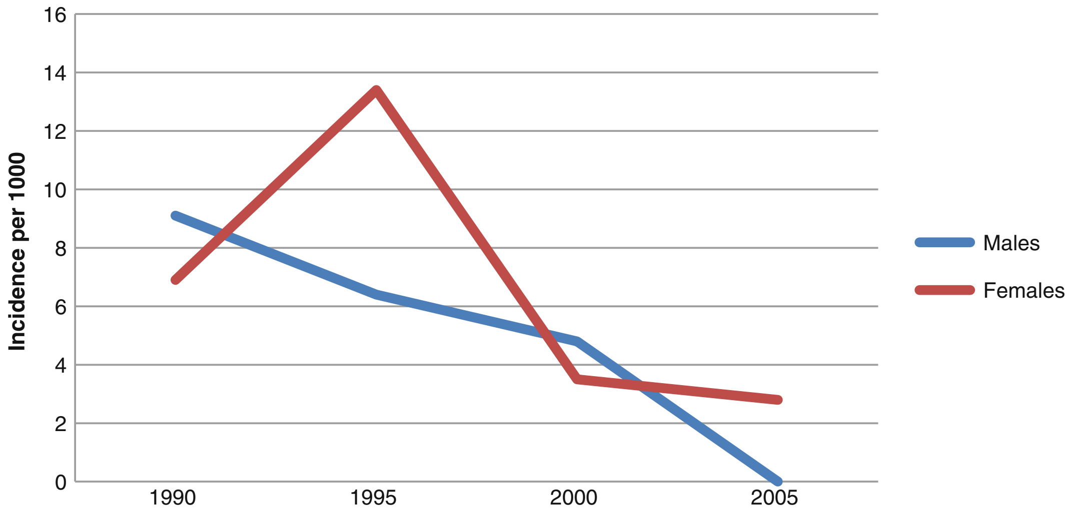

Fig. 1 Incidence rates for 13–24-year-old males and females across all Uganda villages combined. *Source* Data from HIV prevalence and incidence in southwest Uganda, (Shafer et al. 2008)

have sex with teenage girls or young women to prove their masculinity. Once these boys have proven their manhood to their peers, many realize that they were truly not ready to be sexually active and delayed further sexual activity until they felt ready. Many adolescent boys expressed the desire for strategies to resist this type of early pressure. As adolescent girls begin to mature, boys and men begin 'pestering' them for sex and offer gifts as is the custom in this region. Girls are also encouraged to debut to their sexually active status to peers who tell them how easy it is to receive gifts 'for such a little thing.' Unlike many adolescent boys, adolescent girls remain sexually active once they have debuted. These girls believe that young adolescent girls need assistance to resist pressure (Nobelius et al. 2010a, b, c).

The issue of girls receiving gifts is controversial in the literature. Too often girls receiving gifts for sexual favors is defined as 'survival sex.' On the contrary, these young people have developed gendered courting scripts and exchange models that parallel the exchange of 'bride wealth' in marital relationships in a modern-day cultural context. While there are a number of types of exchange relationships that are considered transactional and immoral in this context, exchange of gifts and money from young men to young women in adolescent relationships is not. In this context, exchange signifies that young women are valued and respected by their partners. For young women, to accept gifts for extended periods of time before agreeing to a relationship demonstrates self-respect. The suitor's persistence in giving without any exchange signifies his commitment to his role as provider. It is clear from the evidence that when conducted properly, this type of exchange does not result in increased rates of sexually transmitted infections (STI) in these young people. Rather, the practice encourages commitment and monogamy in young people's relationships (Nobelius et al. 2010a, b, c).

Unfortunately, as has been documented in the literature, the system is open to exploitation by young women who seek to extract money from a number of potential suitors with no intention of engaging in a relationship with their paramours. This cynical game known as 'detoothing' (Nyanzi et al. 2001) was cited by the young people in the study as a cause of 'justifiable' sexual violence in their age-group.

Adolescent girls in this age-group had little problem in their relationships with age-mate young boys. Nonetheless, for many, the temptation of relationships with older men, more able to provide for them, was a pattern that exposed

them to increased sexual health risk. Older men of the type they were likely to meet and establish relationships with are more likely to be HIV positive. The phenomenon of 'sugar daddies' 'bribing' young women for sex and leaving them with HIV was considered a serious issue in the community. While this practice, in a traditionally polygamous society, would be interpreted as 'seeking another wife,' the community increasingly sees this practice as lechery, with dangerous consequences for the younger generation. This practice outrages young men who see it as older men 'planting' HIV in their generation for them to 'weed out' when they marry these agemates.

These out-of-school adolescent boys are also highly exposed in their chosen sexual relationship. These boys most commonly have relationships with schoolgirls whom they intend to marry when the girls are old enough. A study of schoolgirls facing these sexual issues has demonstrated that schoolgirls commonly have concurrent relationships with these adolescent boys and with an older man, called a 'sugar daddy' (Nobelius et al. 2011).

Condom use for these young people is therefore of paramount importance. Despite the widely reported myths surrounding condom use in sub-Saharan Africa, these young people believe that condoms are vital for the prevention of both STI/HIV and pregnancy.

While adolescent girls want their partners to use condoms, the older the partner the harder they find it to insist on condom use. Surprisingly, the 13–14-year-old girls reported the least difficulty in insisting on condom use. A fact the young men in the study supported. Older girls felt that this was because young girls were becoming sexually active in the era of AIDS when condom use was expected. Boys under 16 years lack the skills and confidence to accurately apply the condom when the moment comes; they would rather look macho than ignorant for fear of being teased. Young men older than 17 years say they use condoms on every encounter with a casual sexual partner, but only occasionally for pregnancy prevention with steady partners (Nobelius et al. 2012).

This research has touched on the subject of adolescent pregnancy as one issue in a myriad of competing sexual health needs. This chapter therefore focuses on providing the reader with a clear understanding of the reasons why a high number of Ugandan adolescents experience pregnancy in comparison with other parts of the world. It will provide insight into the community perceptions and influences that shape young peoples' understanding of the consequences for adolescent pregnancy along with their capacity and desire to avoid it. Until the meanings and consequences of teen pregnancy that are significant to young people and their community are understood and addressed, the teen pregnancy rate will remain resistant to change.

Life Course for Young People

Out-of-school young people living in rural areas make up the largest demographic group in the population, and yet, they are socially marginalized with little political voice (Obbo 1995; Population Secretariat 1996). Education is highly valued in Uganda. Despite the national commitment to Universal Primary Education, however, attending school remains expensive for any family. In general, families would like to be able to make the commitment to send all of their children to school, girls as much as boys. Given the rate of poverty, it is not always possible.

Children value school because they see it is the path to a better life. Educated people are wealthier, and young people understand this. This is quite aside from the social enrichment of their lives that comes from the kind of school activities mentioned at the beginning of this chapter. The majority of this population will not make it through primary school, which will negatively affect their life trajectory.

Under the clan system in Uganda, girls born into their father's clan are traditionally considered only temporary members of the clan. Ultimately, all women will become part of their husband's clan and give birth to children who will belong to their husband's clan. In order for the woman to make the transition out of her father's

house, she must marry to join her permanent clan (Roscoe 1911; Mair 1934; Southwold 1965). Since current law forbids young women from marrying before the age of 18, young woman experiences a gap between leaving school and marriage.

Employment Opportunities for Young Women

Young men can leave school and take up a trade or find some type of manual labor employment for wages outside the home. For young women, work like this is socially unacceptable. Most adolescent girls who leave school early will work on their family land to produce food. They may receive pocket money, but it is typically much less than their brothers receive (Nyanzi et al. 2001). Many of these girls will supplement their income by weaving mats or making baskets to sell in order to buy nice clothes, shoes, and cosmetics for themselves, which their parents may consider to be unnecessary extras. Quite often for these adolescent girls, the temptation to receive gifts of appreciation from boys and men who are seeking their attention becomes a fun and entertaining diversion from the tedium of their daily lives.

Young People's Concerns About Sex

Although young people may enjoy the escapism of the intrigues of developing relationships and flirting with each other, they are also aware of the potential consequences of what is deemed 'bad behavior.' Having lived with death from HIV, weekly funerals, and forced residence with other relatives because their parents are gone, these young people have been aware all their lives of the consequences of Slim (wasting disease associated with HIV). Equally important to them is, at their age, that they also avoid pregnancy.

The following transcript illustrates youth who vocalize concerns about sex.

Boy4	I fear all of the repercussions of sex. But you can have protected sex and you don't contract HIV/AIDS. While for the pregnancy, you can avoid it in the same way. But should you make a mistake and have unprotected sex and you make the girl pregnant!
Girl1	So you fear the pregnancy so much like that!
Boy4	Indeed I fear the pregnancy so much. (Mixed Gender Group Discussion, 15–16 year olds)

Adolescents in this study were very good at accurately recounting community discourses as a substitute for areas where they have relatively little personal experience.

Facilitator	Okay, we have discussed this issue of becoming pregnant; now tell me what you really think about it. Is it a simple matter? Do you like it? What is your attitude towards it?
Girls (All)	We are scared of it.
Facilitator	How do you plan to avoid it?
Girls (All)	By not getting involved with boyfriends.
Facilitator	But what will you do when you get to that age where you need to start those relationships.
Girl2	We shall use condoms.
Girl4	The best thing is to wait until marriage and plan on getting it when you are married. (Post Roleplay Discussion, 13–14 year old girls)

This excerpt demonstrates the community discourse on ways for young people to avoid pregnancy, to avoid relationships with boys, and to do so until you marry. But among these discourses is the strong presence of protection via condom use. Within this community, the value that these adolescents place on condom use as a means of disease and pregnancy prevention illustrates that the idea of condom use is widespread and has clearly entered the community discourse.

Community Discourses on Teen Pregnancy

The Church

Uganda has been very well missionized by both the Anglican and Roman Catholic Churches and more recently by the evangelical religious groups. In the district where this research was conducted, 80 % of the population is Catholic (Kamali et al. 2000).

In line with local culture, the Catholics have a decidedly sex-positive standpoint in terms of fulfilling God's desire that all people 'go forth and multiply.' The participants in this study had heeded the message.

Facilitator	Why do you think girls do these things a lot before they get married?
Participant	You mean sexual activities?
Facilitator	Yes, those sexual activities, playing sex, loving men.
Participant	I do not know very well, but let me think that when God was creating us, he put love in us. We get periods like animals. When these periods come, the person changes. If you combine these with what the child has copied, ah ah…things happen.
Facilitator	What about boys? We have been talking about girls and why they indulge in sex before they marry. Now what about boys? Why do they indulge themselves in sexual play before marriage?
Participant	I do not understand this one very well, but let me think that God made certain things that they will not require going to school to learn. For example, when playing, boys play building houses while a girl will be playing carrying a doll. (laughter) Things are not very clear. Maybe as God planned it that way. He said, 'You should produce and multiply.' Maybe they want to produce and multiply. Maybe at 12 or 13 years, they start feeling like doing those things so that they can produce children and multiply. (76 year old grandfather in interview)

In Western societies, it seems that while older people are to be expected to heed religious messages, younger people are less likely to do so. In this cohort of Ugandan adolescents, they had also heard and understood the religious message.

Facilitator	Mm, why do you think that people love and sleep with others? Why do you think that people do those things?
Girl5	Because man was created so that he can be playing sex. We were created that this sin must be for all. Everybody must play sex. Eh, when somebody has not played sex, he may feel so bad. One may feel so bad if he spends a day without sleeping with somebody.
Facilitator	Now, you have said that when God created us…
Girl5	When he created us, our grandfather Adam—when he sinned, sin came into the world. There we were told that we should produce and multiply. Yes, things have to go like that.
Facilitator	But for you, what do you think? Will you do it?
Girl5	I don't hope so.
Facilitator	Now, if it is by nature, passed down from Adam to us, how shall you avoid it? Will you not get married?
Girl5	You should avoid boys or men. (19 year old girl in interview)

Adam and Eve featured strongly in all questioning the urge to have sex at an age participants stated they felt was too young. The biblical reference was also used to explain why

abstinence was a difficult thing for people to embrace. Even the youngest had received the message fully and coherently.

Facilitator	Why don't people want to leave these things (abstain)?
Boy1	I think it is because God created it, since the days of Eve and Adam, when they did it, I say it will never be removed, it will be to the children and grand children. I do not know even why it's so, why they do not want to leave it.
Facilitator	Uuu yes.
Girl1	For me madam, I think it is by nature.
Boy2	Some people want to give birth and increase the clan.
Facilitator	Uuu increase the clan?
Boy3	Madam even when they are teaching us they tell us, 'go and produce and multiply.'
Facilitator	Where do they teach you that?
Boy3	They usually teach this in the church.
Facilitator	What church?
Boy1	May be better in the religion they say that God said, 'go and produce and multiply, the church priests tell you so, 'go and produce and multiply.'
Facilitator	As you are here do they teach you this?
Girl2	Ahaa it is in church when they talk about family planning, they can say people are no longer producing well enough.
Facilitator	Do they say this when you are in church praying or is it when you are having some seminar or lessons regarding those things?
Girl3	It is during serious… it is when you go to pray on a Sunday?
Participant	Uuu
Facilitator	Uuu now what do you say you girls, why don't people want to leave these things? Uuu why don't people want to leave playing sex (abstain)?
Participant	I hear some people say that for them they enjoy sex.
	(Mixed Gender Group Discussion, 13–14 year olds)

The majority of the adolescents were Catholic and would attend services every week. Messages of 'producing and multiplying' were clearly linked to denunciation of family planning and condom use as God's pronouncement on the Catholic's duty to increase the clan.

The Desire for Children

Intertwined with the Catholic message of the necessity to reproduce, there is a deep-seeded desire for children in Uganda that has changed little with modernization. Though it is true in Uganda, as elsewhere, that the more educated women have fewer children and that the children of educated women have better health, in Uganda the average number of children for educated women is still around four. This desire for clan children mixes well with the Catholic message.

Facilitator	Okay. In case such people get married, what do you think the size of their family would be?
Boy1	Six children, three boys and three girls. (All laugh)
Facilitator	What do you think Boy2? How many children would you like to have in your life?
Boy2	A dozen—12 children (All laugh)
Facilitator	Why 12?
Boy2	I want to enlarge my clan (All laugh)
Facilitator	What about Boy3, Boy4?
Boy3	Because of financial restraints, I would like to have five children because I can send those to school at least up to Primary seven

Facilitator What about Boy5?
Boy5 Four.(Post Roleplay Discussion, 13–14 year old boys)

Traditional geopolitical discourses of the importance of large numbers of children for a strong clan, coupled with the agrarian desire for large numbers of children who labor to produce food to support the clan, are only recently being challenged by discourses about responsible parents living within their financial means and only having the number of children they can adequately provide for. In the face of the financial burden of the AIDS epidemic on extended families, the financial argument for fewer children is gaining traction.

Young Peoples' Reality

The Catholic Position on Condoms and Family Planning

Participants in the study had the clear understanding that the church's position on sex was that it was for procreation, and by default, that condom use and other family planning methods were not desirable.

Girl3 I always hear the Catholic priest criticizing condoms that people should not respond to condom use so that they produce and multiply.(14-year-old girl in interview)

But on this point, young participants in the study were not convinced by church's rhetoric. They were certain that in becoming sexually active, they were risking pregnancy and exposure to STIs including HIV.

Facilitator Don't you people who refuse to use condoms fear getting AIDS?
Boy1 We do and if we are certain they are infected we must use a condom.
Facilitator How about your village mates?
Boy2 I don't have to use a condom with them.
Girl1 Eh, would you know everyone they sleep with?
Boy3 Some girls don't want to use condoms.
Girl2 That is a lie; all want to use condoms lest they become pregnant!
Boy2 That is true because some are school girls.
Boy4 Even those who are not school girls want to use condoms, they also don't want to get pregnant.
Boy5 But adults don't mind getting pregnant, they may refuse using a condom.
Facilitator How old are those adults?
Boy5 About 18 or 20 years.
Boy1 These are still young girls.
Facilitator Now tell me, just as you are or from what you have observed, do you trust the condom?
All Yes.
Facilitator What do you think is the purpose or use of the condom?
All Preventing diseases and pregnancies.
(Mixed Gender Group Discussions, 13–14 year olds)

Despite the anti-condom and family planning messages from religious leaders, young people took the lead in getting the message out that condoms prevent disease and pregnancy. To reach their peers with this message, these young people use the Ministry of Health radio and print messages to make their case.

A Need for More Education

In all activities, younger people expressed a desire or demonstrated a clear need for more information on how and when adolescent girls become pregnant.

Facilitator Okay. What else do you feel you need to learn concerning the issues we have been discussing?
Girl5 I would like to be taught how to avoid becoming pregnant.

Facilitator How do you think you can do this? It seems you have told me how you can use a condom or wait until you get married.

Girl5 But there are many other things we may not know.

Facilitator Like going to family planning or what? Okay, who do you think are the right people to do this for you?

Girl5 Our parents, aunties (*ssenga*) and any other adult who may be well informed about those issues. (Post Roleplay Discussion, 13–14 year old girls)

There was a widespread mistaken belief about a young woman's fertile period that was expressed always as either during or just after menses. Though sexually active and capable of making a young woman pregnant, some of these adolescent boys did not understand the basic biological information.

Boy6 How is it that a girl gets pregnant after you have played sex with her only once?

Boy1 It may be that you play the game with her while she is 'sick' (polite way of saying a girl has her monthly period).

Boy2 What do you mean when you say she is sick. What disease would she be suffering from?

Boy1 I am talking about the girl being in her monthly period.

Boy2 Which month are you talking about? What do you mean by monthly period?

Boy1 You may sleep with a girl at a time when she is having blood issuing from her private parts. When you play sex with her, it is very easy for her to become pregnant.

Boy2 The reason I asked this question is because I played sex with Lubega's daughter once. She is now claiming that I am the one responsible for her pregnancy. I have refused to accept the responsibility.

Boy1 Don't you dare refuse that responsibility for such a pregnancy. You are the one responsible, face the consequences.(Post Roleplay Discussion, 13–14 year old boys)

In contrast to reports from Western young people, this group expressed the desire to receive information through traditional sources, their *ssenga*. The *ssenga* is a paternal aunt who is charged with the responsibility of educating young people in preparation for marriage. Although not traditionally a relationship for discussion back and forth, these young people value the education because *ssenga* can be explicit in language and explanation. In this culture, it is taboo for parents to speak to children about sex in any form. Culturally, seduction is considered a verbal art and for parents to speak about sexual issues to children is considered incestuous and therefore totally inappropriate (Nobelius et al. 2010a, b, c).

Pregnancy Stops a Girl's Education

While school seems to amplify the peer pressure for girls to have boyfriends, pregnancy is very problematic for girls. Pregnant girls do not appear welcome in school, so pregnancy and subsequent childbirth usually results in the cessation of education for adolescent girls. It is for this reason that pregnancy is perceived to be more problematic among young school-going girls than for girls who are not in school (Nyanzi et al. 2001).

Adolescent girls agreed that the interruption in one's life course created by pregnancy in school-going girls is the major cause of abortion among girls of their age.

Abortion

In a study of school-going girls of the same age from the same area as those in my study, Nyanzi and associates (2001) demonstrated a detailed knowledge and collective experience among adolescent girls managing a pregnancy. Most told a consistent story of seeking assistance from a Western trained doctor in the region, based on advice from friends and older siblings. A visit to

the doctor would result in a referral to a specialist who provided surgical abortions. Such abortions are very expensive and beyond the means of the adolescent girl. Most sought the money from their partner, but if the father denies paternity, then she will borrow money from friends and siblings. Very few adolescent participants in my study felt that in-school girls would carry a pregnancy to term. Most girls felt that they would choose to abort and stay in school.

Out-of-school girls were fearful of abortion. Though they held a sisterly bravado that out-of-school girls were smarter than their in-school compatriots, in managing the fallout from the news of their pregnancy, most out-of-school girls stated that they would first tell their mothers they were pregnant. If their mother's advice were to abort (lest they encounter the wrath of their fathers for becoming pregnant while still in his home), the girls said they would abort. The method of choice would be to use traditional herbal *abortifacients* provided by known traditional healers rather than to seek medical assistance from a Western trained doctor.

Facilitator	Do you think it is easy to overcome such problems (pregnancy and abortion)?
Girls	It is hard. (Chorus)
Facilitator	How?
Girls	Because at times it is life risk.
Girl1	Because, abortion always causes death.
Girl2	You end up dying.
Facilitator	What would you do in case you land into such a problem?
Girl1	I pick courage and inform my parents.
Girl2	We would be strong and inform our parents.
Girl3	Whether you are beaten, strokes do not kill!
Girl4	At times you may do the abortion in a bad way and you end up dying.
Girl5	And you go with the abortion (meaning to die).
Girl1	And you are blamed that, 'had she left the pregnancy!'
Girl5	That, 'Had she mentioned it! Would we kill her?'
Girl2	Yet at times they harass just to scare you not to mess around with boys. Instead you get scared thinking that you might be beaten.
Facilitator	What if you inform your parents? Or your mother and she opts for abortion?
Girl3	Haaa! (shock)
Facilitator	Then what do you do in such a situation?
Girl1	Some parents may tell you to abort.
Girl5	Your mother may love you so much; and thinks that in case she informs your father about it then your father may do something harmful to you; so your mother opts for abortion.
Facilitator	You have said earlier that, you just be strong and be with your pregnancy till you produce the child. But then you have informed your mother and who has opted for abortion. Then how is that?
Girl1	May be when I'm studying.
Girl3	Perhaps when I'm studying; but if I'm not studying I don't agree to what you tell me you the mother.
Girl4	Even myself I don't agree to abortion.
Girl1	In case you insist on the abortion, I run away.
Girl 5	Your mother may insist on the abortion and you refuse and she tells to go to your man the owner of the pregnancy.
Girl3	While your man may deny the pregnancy and says that, the pregnancy is not mine; it somebody else's pregnancy.
Girl1	Then I run away.
Girl4	I don't abort, for I think about it first and say that, but how I was not aborted and I'm alive.

Girl1 I just endure with my pregnancy.
Facilitator As Girl5 says that the owner of the pregnancy has sent you away as well; while your mother has also sent you to the owner of the pregnancy.
Girl2 While you fear your mother as well.
Facilitator So there what do you do then?
Girl3 Aren't there any other relatives!
Girl5 There are other relatives so I just go them. (Post Roleplay Discussion, 15–16 year old girls)

Herbal remedies are known to be painful and dangerous as it may result in uncontrollable bleeding. Out-of-school girls are fearful of the pain and potential bleeding and of the cases where young women have died before receiving treatment to stop the bleeding. In the cohort that participated in my study, when asked whether they would rather have an abortion or tell their parents and live with the potential shame of having a child from their fathers' house, none chose abortion. In fact, two young women aged 18 and 19 in my group were mothers of children under 2 years of age and had indeed continued to stay in their parents' home after becoming pregnant. While adolescent pregnancy is an unmitigated disaster for in-school girls, out-of-school girls were relatively positive about pregnancy. For them, it was not the worst-case scenario.

The Shame of Premarital Pregnancy

In terms of the culture, the problem of adolescent pregnancy is not so much the fact that the adolescent girl became pregnant; it is more that another clan's child has been born in a man's home (Kyewlyanga 1976). Traditionally, this is seen as shameful and many participants, both young and old, spoke of a father justifiably throwing a pregnant young woman out of his home as punishment.

No one, when asked, could think of an instance they knew where a young woman was thrown out of home for being pregnant. The worst they could report was of young women going to live with *ssenga*. Children moving to live with relatives, particularly *ssenga*, are not uncommon in this context so it was not seen as a great punishment, nor did participants in this study fear it.

The concept of shame for families over a teen pregnancy is less of a problem today. As a result of the new laws that encourage young men to deny paternity and because of the necessity for young women to remain at home and unmarried until they are 18, families are more apt to confront this problem. Communities are aware that at the same age, their parents and grandparents would have been married and settled by the time they are in their mid-teens. These women are not getting pregnant any younger than their forbearers; indeed, demographic evidence suggests that they may be becoming pregnant for the first time later that their mothers and grandmothers, though the evidence clearly shows that they may marry later. Nevertheless, as alluded to in the previous discussion, elders send the message that there are severe consequences in cultural terms for the transgression of having a child in your father's house.

Girl1 My *ssenga* told me this when she realized that I had started monthly periods, 'Don't run around from one boy to another. You will get pregnant. If you ever get pregnant, make sure you leave our compound before we notice that you are pregnant. You just run away.'
Facilitator But where does she expect you to go?
Girl1 You are to go to the man.
Facilitator But do the girls go away?
Girl1 No. They stay in the parents' homes.
Facilitator Then what happens? Do the boys accept they are responsible for the pregnancies?
Girl1 Some don't. They can even totally neglect the girl until after the child is delivered and even grows up. (Post Role-play Discussion, 15–16 year old girls)

People understand the rationale for the laws and accept that it is important to protect young women and their babies from the dangers of early pregnancy so they accept the status quo and manage it in their own way. Rather than involve the law, many families of young people who become pregnant sort out any number of 'arrangements' often with a Local Council Officer or *ssenga* as a mediator.

If the boy claims paternity, families may arrange for the girl to live at her father's home with her baby until she is old enough to marry. The young man's family will provide financial support until that time, and then, both families will support them to set up their own home together.

Young Men's Fear of Incarceration

In addition to the fear of making their partner pregnant and exposing them to disease, 'underage' sex leads young men to fear imprisonment. The legal age of consent for young people in Uganda is 18 years, and therefore, any person making a woman younger than 18 years pregnant has proven that they are guilty of the 'defilement' law (Republic of Uganda 1995). Though none of the study participants personally knew of anybody who had been charged with defilement, young men were fearful that it was possible.

Boy1 — There is woman that taught us in the program of 'Police and the Common Man' (a school based lecture from Police) told us that, a girl who is not yet 18 years and a boy who is not yet 18 years, let him be only 14 years and they have sex, the boy is arrested. So when you the boy of 17 or 16 years of age make a girl of 15 or 16 years pregnant. You really face it.

Boy2 — What if I intended to get the pregnancy?

Boy1 — The woman taught us that there is nothing like you intended for the pregnancy. Even if the girl's parents say that, they have forgiven you, she puts you in jail straight away.

Facilitator — Who puts in jail?

Boy1 — The policewoman puts you in jail straight away! That there is no such compromise with the parents on such an issue, a girl of below 18 years of age is not allowed to have sex. (Mixed gender group discussion 15–16 year olds)

This type of fear inspiring delivery is quite common in this community. Young people expressed the desire for information that was accurate and authoritative, but less negative and fear inspiring. Clearly, this scenario described by the Police Education Officer who gave the talk does not represent the reality that they see in their communities every day, and the mismatch of accurate information, on issues related to sex, sexual health, condom use, and pregnancy, causes confusion in the younger members of the community.

The threat of incarceration is said to be a strategy that parents use to ensure that young men who are denying paternity own up to their responsibilities. The local language and English language national newspapers occasionally run articles reporting on young men who have been thrown in jail for a relationship with an agemate. This law was clearly intended to ensure that the reproductive health of girls and young women appears to have the unintended consequence of encouraging young men to deny responsibilities for their partner's pregnancies.

Denial of Paternity

All participants noted that young men are likely to deny paternity for fear of the potential consequences, particularly imprisonment for defilement. If the young man denies paternity, this can raise a number of problems for the young woman.

Much depends on her reputation; if she is known to have more than one partner, the boy may plausibly deny paternity. However, clan children are always considered valuable, and if

there is any thought that paternity may lie with their son, families tend to wait until the child is born to look for family resemblance with the potential father, and if they baby looks like their family, they will then support the young woman until the baby is old enough to leave its mother. If they decide the young woman is an appropriate match for their son, they may go through the process of helping their son to establish a home for all three of them. If they do not like her, they may take the baby (as it belongs to the father's clan) but not the young woman, and she will stay at her father's house until she marries another man.

Facilitator Do most of the boys who make girls pregnant accept the responsibility? If they don't, why do they refuse?

Girls (speaking all at once) This is because some boys have more than one girl and may not be sure if the girl was also going with more than one boy. Another reason is lack of money. Sometimes it is fear. The boys fear to face the parents of the girl.

Facilitator When these girls get pregnant, where do they go? Do they remain in their parent's homes or go to the boys home.

Girl1 Some parents chase them away and they go to the home of the boy. Other parents keep them at their homes and look after them. In some cases the boys participate by sending finances to the girl to help towards her needs during and after the pregnancy.

Girl2 But in the cases where the boy denies or refuses to accept any responsibility, the parents of the girl take it up and look after their daughter.

Facilitator Do you know of any cases where those girls who get pregnant eventually end up getting married to the very boys who made them pregnant?

Girl3 Some of the boys who accept this responsibility end up deciding to get married, while others just don't.

Facilitator Do the girls on the whole like to get married to the boys who make them pregnant?

Girl3 Some do, and others don't. It all depends on the individuals concerned. (Post Roleplay Discussion, 13–14 year old girls)

Though the 13–14-year-old girls had no personal experience with being pregnant or knowing how to negotiate, many had elder sisters who had experienced this dilemma. It is apparent from the tone of this conversation that the consequences for out-of-school girls are less of a concern for them than would be the case whether they had the pressure of interrupting education of in-school girls.

These adolescent girls have no other future, other than to marry and have children; there are little or no employment opportunities for uneducated adolescent girls in this context, so pregnancy and marriage are inevitable sooner or later and they accept this as fact.

In a culture where a woman's value is in producing children for her husband's clan, proof of fertility is not as big a stigma as it may be in other cultures. In this culture, having been a teenage mother does not hold huge stigma. The worst fate for a woman in this culture is to be infertile.

Conclusion

Young people in this community do want to avoid pregnancy before marriage. The fact that Ugandan adolescent girls become pregnant—in such large numbers—indicates a tragic public health failure. This community is capable of behavior change. The proof is in the fact that

condom use, as a topic, has become a part of the public discourse. What is required for the community to made behavioral changes related to sexual and reproductive health is the proper structural and environmental support to achieve this change.

Adolescent pregnancy is perceived to be a problem in the community. However, to reduce the rate of adolescent pregnancy, we need to address community concerns and beliefs rather than those imported from the West and elsewhere. Information and educational efforts should include a discussion of the benefits of later pregnancy for young women and their children. It should address the benefits of smaller family size for the community and for clans. It should emphasize health improvement for children and improved educational opportunities as a benefit of reduced family size, which affects their budget. These are the aspiration of all families.

Providing factual information about youth capacity for fertility, effective contraception access and usage, and the value of condoms in reducing pregnancy and increasing disease prevention is essential. Young people in this study asked for this information. Families, communities, and health providers should be supported in engaging in this discourse because of the health and social benefits it can bring. This community's willingness to engage with difficult social issues has been amply demonstrated in its response to HIV. The crippling effects of HIV/AIDS touched every clan and every village. Likewise, adolescent pregnancy has touched all families. A modification in adolescent sexual behavior can change this outcome. Ugandan adolescents have demonstrated that they can change their sexual customs and behaviors. Educational programs (developed by a collaboration of agencies) created a positive view of condom use among adolescents as a group. Providing the appropriate programs and support to Ugandan adolescents will allow them to develop the skills and motivation to manage adolescent pregnancy and their reproductive health.

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Adolescent Pregnancy in the United Kingdom

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Keywords
United Kingdom: adolescent pregnancy · Alcohol and drug misuse · Anaemia · Contraception · Individual risk behaviours · Inequalities · Low birth weight · Mental health · Preterm birth · Social exclusion

Introduction

The United Kingdom (UK) of Great Britain and Northern Ireland comprises Great Britain (England, Scotland, Wales), and Northern Ireland. The seat of government is in London, England, and there are devolved administrations in Scotland, Wales and Northern Ireland. Some powers are retained by the central government (in England), and others are devolved to the other three nations. Health and Education are devolved powers in Scotland, Wales and Northern Ireland.

In England, there are nine regions, which are the highest tier of subnational division used by central government. Within each region, and in Wales and Scotland, there are local authorities with responsibility for services such as education and housing.

The Health care System

The National Health Service (NHS) is the shared name of three of the four publicly funded health care systems in the UK. Only the English NHS is officially called the National Health Service, the others being NHS Scotland and NHS Wales. Health and Social Care in Northern Ireland is called the HSC. Each NHS system operates independently and is politically accountable to the relevant government: the Scottish Government, Welsh Government, the Northern Ireland Executive or the UK Government (for the English NHS).

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Population Characteristics

In 2010, there were 62.3 million people residing in the UK. Females in the reproductive age group (15–44 years) accounted for 12.5 million of the population (20 %); 1.1 million (1.7 %) were females aged 13–15 years and 1.5 million (2.5 %) were females aged 16–19 years (Office for National Statistics 2011a).

Table 1 Ethnic groups, Great Britain, 2001

	Percentage of population
White	91.9
Mixed	1.2
Asian or Asian British	4.1
Black or Black British	2.0
Chinese	0.4
Other	0.4

Source Office for National Statistics (2004)

Ethnic Mix

In Great Britain, 91.9 % of people belonged to white British, white Irish or other white ethnic groups in 2001. People in Asian or Asian British ethnic groups made up 4.1 % of the population. The proportion of people in other ethnic groups is given in Table 1 (Office for National Statistics 2004). Data for Northern Ireland are available separately and show that in 2001, the proportion of people in a white ethnic group was 99.2 % (Northern Ireland Statistics and Research Agency 2008).

Socioeconomic Deprivation

The low-income threshold, which defines poverty in the UK, is 60 % of current equivalised median household disposable income after the deduction of housing costs (ONS 2010a). In 2007/2008, this represented a household income of £236 per week. The proportion of people living in poverty has fluctuated in the last 20 years. In 1987, 18 % of people lived in low-income households, increasing to 22 % in the late 1980s to early 1990s. The proportion decreased to 17 % by 2004/2005 and 18 % in 2007/2008. Children living in lone parent or non-working families, families with three or more children or families where the head of the household belonged to an ethnic minority group have a greater than average risk of living in a low-income household.

Perspective on Adolescent Pregnancy in the United Kingdom

The Office for National Statistics (ONS) in the UK defines 'conception' as pregnancy resulting in live birth, stillbirth or legal termination (Botting et al. 1998). Conception rates are available from the ONS for the under-20 (15–19 years), under-18 (15–17 years) and under-16 (13–15 years) age groups.

Figure 1 shows conception rates for the under-16 and under-18 age groups in England and Wales from 1991 to 2008. There has been little change in these rates over time. The under-18's rate was 44.6 per 1,000 in 1991 and 40.7 per 1,000 in 2008. The under-16's rate has also shown little change from 8.9 per 1,000 in 1991 to 7.8 per 1,000 in 2008 (Office for National Statistics 2001a, 2010b).

Figure 2 shows conception rates for the under-20 age group in England and Wales from 1970 to 2008. Rates have remained stable since 1975 with no significant change. A detailed examination of trends in adolescent live births and abortions from 1960 to 1997 in England and Wales has been described. There was a decrease in the adolescent live birth rate in the 1970s following the availability of abortion and increased contraceptive service provision. Increases in adolescent live births coincided with adverse publicity related to oral contraceptive use in 1976, 1977, 1983, 1986 and 1995 (Wellings and Kane 1999).

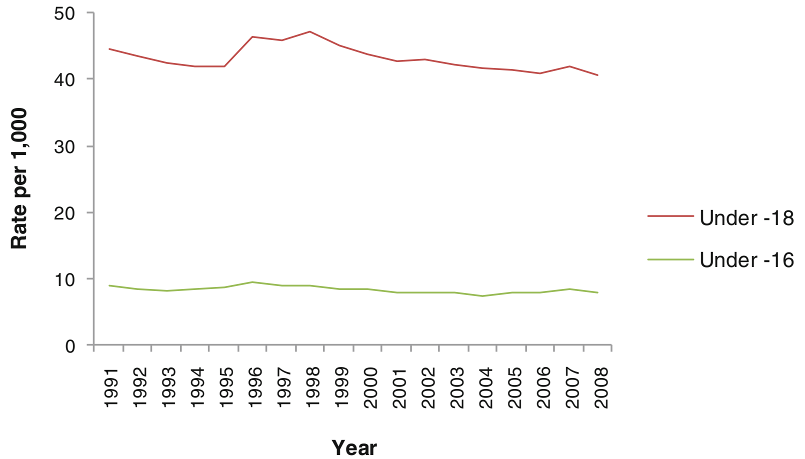

Fig. 1 Under-16 and under-18 conceptions, England and Wales, 1991–2008. *Source* Office for National Statistics (2001a, 2010b)

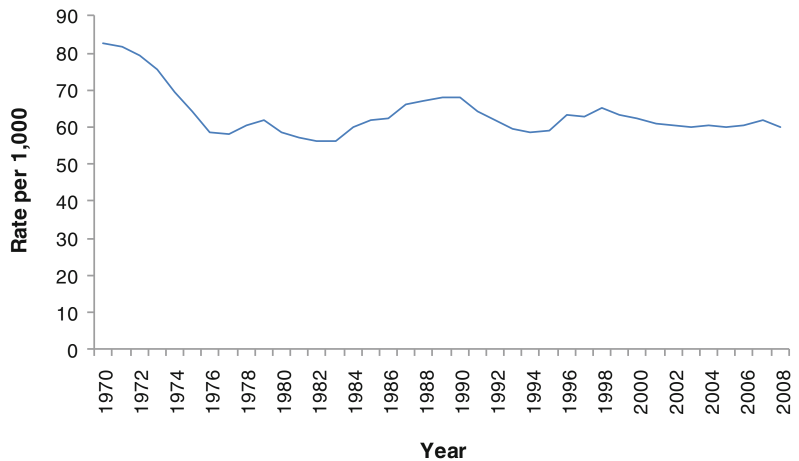

Fig. 2 Under-20 conceptions, England and Wales, 1970–2008. *Source* Office for National Statistics (2001a, 2010b), Wellings and Kane 1999

In Scotland, the under-18 conception rate was slightly lower than in England and Wales at 41.8 per 1,000 in 1994 and 40.2 per 1,000 in 2008 (Information Services Division Scotland 2011). Data on conceptions are not available for Northern Ireland. The live birth rate in the under-20 age group in Northern Ireland has decreased from 29 in 1980 to 23 per 1,000 in 2008 (Northern Ireland Statistics and Research Agency 2011).

Although overall conception rates are generally similar between England, Wales and Scotland, there is substantial variation between regions, and between local authority areas within regions. ONS data for 2008 suggest that under-18 conception rates in England range from 49.0 per 1,000 in the North East to 31.4 per 1,000 in the East of England. In Wales, the rates range from 73.3 per 1,000 in the highest to 27.2 per 1,000 in the lowest local authority area (Office for National Statistics 2010c). Similar variation has been observed in Scotland, partially attributed to variation in population and socioeconomic characteristics within the country (Information Services Division Scotland 2011; McLeod 2001).

Overall, 21.8 % of conceptions led to legal abortion in England and Wales in 2008. The proportion was highest in the under-16 age group at 61.5 % (Figs. 3, 4). The rate of legal abortions in females aged less than 18 years was 20.1 per 1,000 in 2008, which accounted for almost 50 % of conceptions. In 2001, the rate was 19.5 per 1,000, representing 45.7 % of

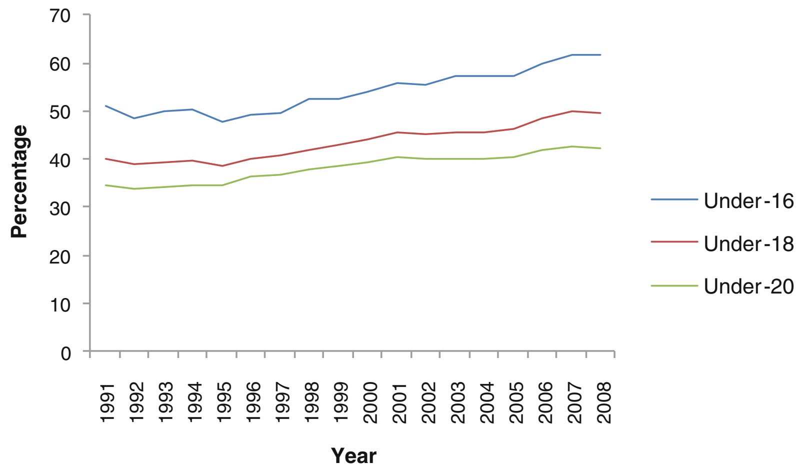

Fig. 3 Under-16, under-18 and under-20 conceptions terminated by abortion, England and Wales, 1991–2008. *Source* Office for National Statistics (2001a, 2010b)

conceptions in this age group, rising from 17.8 per 1,000, representing 39.9 % of conceptions, in 1991 (Office for National Statistics 2001a). In Scotland, the rate of legal abortions in females aged less than 18 years was 18.2 per 1,000 in 2008 (45 % of conceptions), rising from 15.7 per 1,000 in 2001 (40 % of conceptions) (Information Services Division Scotland 2011).

Birth Rates

The average age at first birth in England and Wales has increased from 23.7 years in 1971 to 25.6 years in 1991 (Office for National Statistics 2004) and 27.8 years in 2010 (Office for National Statistics 2011b). Approximately 7 % of live births in England and Wales are to females aged less than 20 years, although this varies according to the mother's country of birth. Nine percent of Bangladeshi mothers were aged less than 20 years, compared with less than 3 % of mothers born in India, East Africa, Australia, Canada and New Zealand. However, some of this difference may be due to the difference in age structure of these populations with more recent immigration from Bangladesh compared to other countries (Botting et al. 1998). In 2010, the majority of births to girls under 20 years (96 %) occurred outside marriage (Office for National Statistics 2011b) (Fig. 5), an increase from 90 % in 1999 (Office for National Statistics 2001b).

Medical Aspects

In this section, we consider the impact of adolescent pregnancy on the health and well-being of the mother, ranging from obstetric complications during pregnancy to psychosocial and mental health morbidity in the longer term. The majority of studies investigating the effects of adolescent pregnancy compare a young age group of 16–19 years to an older age group. This comparison does not allow for differences in physical or psychological maturity in the adolescent years. A further limitation is the lack of information on whether or not pregnancy is wanted, as this could affect behaviour during the pregnancy and attitudes toward antenatal care (Swann et al. 2003). Estimates from the Millennium Cohort Study in England and Wales suggest that only 15 % of adolescent mothers plan their pregnancy (Bradshaw 2006). A survey of UK mothers in 2010 reported that 57 % of mothers aged under-20 smoked before or during pregnancy, while 35 % smoked throughout pregnancy. Adolescent mothers are three times more likely to smoke throughout the pregnancy compared with older mothers (NHS Information Centre, IFF Research 2011). In addition, the prevalence of poor diet, alcohol and drug misuse is higher among younger age groups in the population and can impact negatively on the pregnancy, particularly in unplanned circumstances (National Centre for Social Research 2006).

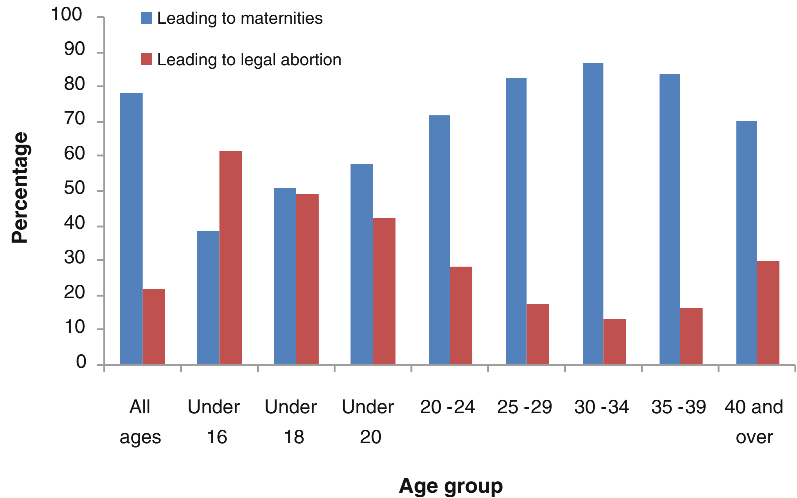

Fig. 4 Percentage of conceptions leading to legal abortion and maternities by age group, 2008. *Source* Office for National Statistics (2010b)

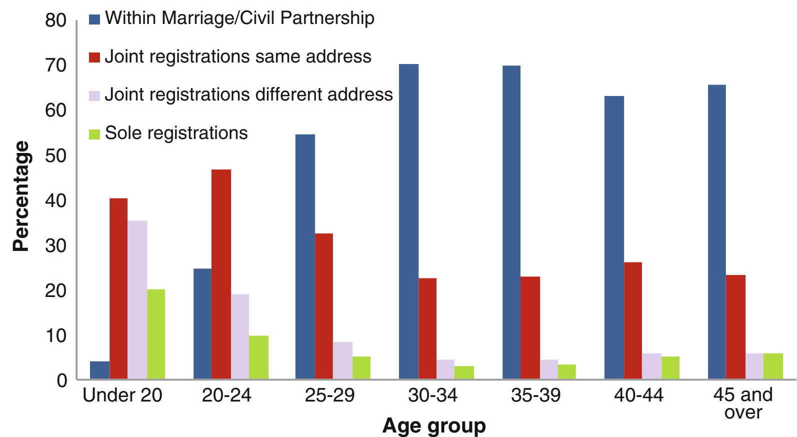

Fig. 5 Live births by type of registrations and mother's age group, 2010, England and Wales. *Source*: Office for National Statistics (2011b)

The Mother

Pregnant adolescents are at least twice as likely to be anaemic (haemoglobin < 10.5 g/dl). The most common cause for this anaemia is iron deficiency attributed to poor nutrition (Briggs et al. 2005; Jolly et al. 2000; Konje et al. 1992). Although severe anaemia during pregnancy is associated with poor health outcomes for the mother, the significance of moderate anaemia is less clear (Scanlon et al. 2000).

There is some evidence for an increased risk of pregnancy-induced hypertension for adolescents compared with adults (Konje et al. 1992). Studies that have examined the incidence of pre-eclampsia or proteinuric disorders comparing adolescents to adults did not find any difference between the two groups after adjusting for confounding factors such as cigarette smoking (Jolly et al. 2000; Gilbert et al. 2004). These studies support the view that obstetric complications in pregnant adolescents can be prevented with regular ante- and postnatal care (Creatsas 1997).

The caesarean section rate is lower in adolescents compared with women aged 25–29 years (Paranjothy et al. 2005). However, adolescents are at higher risk of instrumental deliveries. Adolescents aged under 16 years are twice as likely with have forceps delivery compared to women aged 20–24 years (Konje et al. 1992). The reason for higher rates of

instrumental delivery is not clear, although it is postulated to be due to the physical immaturity of the younger mother (Moerman 1982) or 'fright and lack of cooperation' in the second stage of labour (Konje et al. 1992).

In the UK, maternal mortality is rare at 14 per 100,000 maternities. The rate is lower in women aged less than 20 years, at 9.9 per 100,000 maternities. In the most deprived areas of England, maternal mortality is 46 % higher than in the least deprived areas and unemployment is associated with a seven-fold increased risk of maternal death. Although young maternal age is not itself an identified risk factor for maternal mortality in the UK, some of the vulnerable circumstances are that risk factors for mortality such as socioeconomic disadvantage are also risk factors for and consequences of adolescent pregnancy (Lewis 2007; Moffit 2002).

The Baby

Adolescent pregnancy is a risk factor for adverse baby outcomes such as preterm delivery, low birth weight, small for gestational age and neonatal and infant mortality (Amini et al. 1996; Briggs et al. 2005; Chen et al. 2007; Fraser et al. 1995; Gilbert et al. 2004; Olausson et al. 1999; Scholl et al. 1994). Young maternal age is also a risk factor for some congenital anomalies such as gastroschisis, a congenital anomaly in which a defect in the foetal abdominal wall (not involving the umbilicus) results in herniation of the bowel into the amniotic cavity (Rasmussen and Frias 2008). However, the socioeconomic and behavioural factors (tobacco, alcohol or recreational drug use, poor nutrition and poor antenatal care attendance) associated with adolescent pregnancy are also risk factors for these adverse baby outcomes.

Preterm birth, low birth weight and small for gestational age are important determinants of childhood mortality, morbidity and educational attainment (Amini et al. 1996; Bhutta et al. 2002; Chen et al. 2007; Fraser et al. 1995; Gilbert et al. 2004). Clinicians use low birth weight as a proxy measure for intrauterine growth restriction (IUGR). The social aetiology of IUGR includes psychosocial stress, which can result from social isolation, homelessness and violence (Kleijer et al. 2005; Rondo et al. 2003).

Babies born to adolescent mothers are at increased risk of maltreatment or harm and have higher rates of illness, accidents and injuries as well as cognitive, behavioural and emotional complications (Moffit 2002; Berrington et al. 2005). However, higher levels of behavioural problems in children born to adolescent mothers have been attributed mostly to the mother's mental state, rather than the young age of the mother (Berrington et al. 2005). The association between younger age at childbirth and poorer cognitive and behavioural outcomes in children is unlikely to be causal, as developmental outcomes in children have been shown to be associated with the mother's age at first birth, rather than her age at the given child's birth. Analysis of data from sisters who gave birth has shown that the disadvantage of children born to younger mothers is greatly reduced after controlling for maternal family background (Lopez Turley 2003). Further evidence suggests that the difficulties and disadvantages associated with early first childbirth are long lasting with poorer behavioural and emotional outcomes for children born to mothers who were under 20 years of age at first childbirth compared with those who were in their 20s (Moffit 2002). Recent developments in our understanding of child development have highlighted the importance of early environments, nurturing relationships and the health and well-being of their parents (Shonkoff and Phillips 2000).

Social Context

Factors Associated with Adolescent Pregnancy

Social risk factors for adolescent pregnancies are complex and include factors relating to individual risk behaviours and sexual health knowledge, socioeconomic status, family structure, or relationships, expectations of the future

and perceptions of peers (Allen et al. 2007; Swann et al. 2003).

Individual Risk Behaviours

Twenty-six percent of young women in Britain have reported first having sexual intercourse before the age of 16 (Wellings et al. 2001). Early regular alcohol consumption is associated with early onset of sexual activity, and it is known that adolescents who use alcohol at first sexual intercourse are less likely to use condoms. Alcohol consumption, and especially binge drinking and drinking greater quantities, is associated with an increased risk of becoming pregnant in females, getting someone pregnant in males and a greater probability of experiencing regretted sex and forced sex (Bellis et al. 2009). In the UK, an increasing trend of binge drinking among young people has been observed. Although the prevalence of ever drinking alcohol in young people aged 11–15 years decreased from 60 to 65 % between 1988 and 1998 to 54 % in 2007, the amount consumed per week by those who drink doubled between 1990 and 2000 and has changed little since (Lynch 2008). Data from the Health Behaviors in School-aged Children Survey 2005/2006 showed that 41 % of boys and 38 % of girls aged 15 years in England have reported drinking alcohol at least once in a week. These rates are higher than those observed in other European countries such as Germany and Sweden (Currie et al. 2008). Furthermore, between 2002/2003 and 2006/2007, hospital admissions for alcohol-specific conditions in under-18s in England rose from 49 to 64 per 100,000 for males and from 58 to 80 per 100,000 for females (Bellis et al. 2009).

A Scottish study found that the prevalence of self-reported sexual risk behaviours (early sexual initiation and multiple sexual partners) increased significantly in 18–19-year-olds between 1990 and 2003, but there was no significant change in self-reported pregnancy. The authors suggest that this could be due to more effective use of contraception by 2003 (Sweeting et al. 2011).

Socioeconomic Status

Adolescent mothers in the UK are reported to have lower socioeconomic backgrounds, more siblings and parents who show less interest in their education or live in a lone parent family (Kiernan 1980; Kiernan 1996; Manlove 1997; McCulloch 2001; Imamura et al. 2007; Sloggett and Joshi 1998). The risk of becoming a mother before the age of 20 is nearly one in three for adolescent girls from vulnerable backgrounds, and the majority (85 %) of these are unplanned pregnancies (Bradshaw 2006). Having a mother with no qualifications, low educational attainment or a mother who herself had an adolescent pregnancy is associated with increased risk of adolescent pregnancy (Rendall 2003; Ermisch and Pevalin 2003). Compared to girls in social class I (professional occupations), the risk of becoming an adolescent mother is nearly ten times higher for girls whose family is in social class V (nonmanual, unskilled occupations) (Botting et al. 1998; Swann et al. 2003). Following the birth of their baby, adolescent girls are less likely to complete their education or enter employment, particularly if they are already socially disadvantaged (Social Exclusion Unit 1999). It has been suggested that concern over adolescent pregnancies is misplaced, as younger girls can be physically and mentally better suited for pregnancy than older women. However, for young girls who live in deprived areas in the UK, pregnancy can increase the risk of social exclusion and socioeconomic disadvantage, leading to poorer health and well-being (Moffit 2002; Social Exclusion Unit 1999).

In the UK, research on mothers of twins showed that compared with adult mothers, adolescent mothers experienced more deprivation, more mental health difficulties, lower levels of educational attainment and more emotional and behavioural problems (Moffit 2002). Adolescent

mothers are three times more likely to be living in poverty compared with mothers in their 30s (Berrington et al. 2005) and are less likely to complete their education and training. They therefore face restricted job opportunities, potentially reinforcing the cycle of deprivation and adolescent pregnancy (Moffit 2002; Ermisch and Pevalin 2003; Mayhew and Bradshaw 2005).

Much of the evidence of the effects of adolescent pregnancy has been from UK cohorts from 1946 to 1958, referring to a population who were adolescents in the 1960s and 1970s at a time when early marriage and childbearing was the norm. As society has changed over time, women have delayed childbirth; women who have early childbirth risk disruption of their education and hence are at risk of disadvantage when compared with their cohort peers, many of whom would have continued on to post-secondary education. The cohort of young 'not in education, employment, or training' (NEET) mothers have a wide range of difficulties related to their social background, which can have long-term implications for their children and hence society in the future (Moffit 2002). Furthermore, evidence suggests that children with absent fathers in early childhood are more likely to be sexually active at a younger age and have an adolescent pregnancy, therefore, perpetuating the cycle (Ellis et al. 2003).

It is recognised, however, that some mothers who have an early childbirth have better psychosocial outcomes than others (Moffit 2002). Evidence from the 1970 British Cohort Study suggested that some of the health disadvantage suffered by adolescent mothers is explained by their parental background and childhood characteristics (Shonkoff and Phillips 2000).

Studies on adolescent pregnancies tend to focus on the mother and baby. The limited research available indicates that young fathers are more likely to have low socioeconomic status backgrounds, with low levels of education and low earning potential. Men who become fathers in their teens or early 20s are twice as likely to be unemployed, receive benefits and require social housing (Berrington et al. 2005).

Legal Issues

The age of consent to any form of sexual activity in the UK is 16 years of age. The Law in England, Wales and Northern Ireland is not used to prosecute adolescent sexual activity when both partners consent although there are laws to protect children under the age of 13 who cannot legally consent to any form of sexual activity. In Scotland, it is acknowledged that not every case of sexual activity in young people under the age of 16 will have child protection concerns (Family Planning Association 2011a).

The Fraser Guidelines regarding contraception advice or treatment to young people under the age of 16 years apply to health care professionals in England and Wales. In 1985, Lord Fraser introduced guidelines relating to contraceptive treatment following the House of Lords ruling in the case of Gillick v. West Norfolk and Wisbech Health Authority (Department of Health 2004). This guidance is endorsed by the General Medical Council, the regulatory body for doctors in the UK (refer to Box 1) (General Medical Council 2007).

Nurses and pharmacists are also able to give contraceptive advice or treatment to a person under 16 years without the knowledge or consent of the parent or guardian (Royal College of Nursing 2006). Nurses can undertake programs of study to be independent nurse prescribers to allow them to prescribe treatments, which includes contraception (Royal College of Nursing 2004).

Emergency hormonal contraception (the 'morning-after pill') can be obtained from doctors or nurses and some pharmacists (Family Planning Association 2011b). School nurses in England and Wales can provide sexual health and contraceptive advice, as well as providing emergency hormonal contraceptives, but not in Scotland.

Provision of emergency hormonal contraceptives in Northern Ireland varies depending on the education institution's policy on sexual health (Royal College of Nursing 2006).

In England, Wales and Scotland, legal termination of pregnancy may be carried out up to 24 completed weeks′ gestation if 'the continuance of the pregnancy would involves risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family'. Legal termination of pregnancy may also be carried out with no time limit if it 'is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; there is a risk to the life of the pregnant woman, greater than if pregnancy were terminated; or there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped' (House of Commons Science and Technology Committee 2007). Terminations can be carried out if two registered medical practitioners agree on the above criteria. A young woman under the age of 16 may consent to a termination without parental knowledge if both doctors agree that she has sufficient understanding of what is involved (Family Planning Association 2010, 2011a).

The law on terminations does not apply in Northern Ireland. Here, legal termination is only available in exceptional circumstances, which is when 'the life or the mental or physical health of the woman is at serious or grave risk, which has to be permanent or long term' (Family Planning Association 2010).

Box 1: Fraser guidelines for contraception advice or treatment to young people under the age of 16 years

Contraceptive, abortion and STI advice and treatment, without parental knowledge or consent, to young people under 16 can be provided if: they understand all aspects of the advice and its implications, you cannot persuade the young person to tell their parents or to allow you to tell them in relation to contraception and STIs; the young person is very likely to have sex with or without such treatment; their physical or mental health is likely to suffer unless they receive such advice or treatment and it is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent.

Source: General Medical Council (2007).

State financial support available in the UK is discussed in the section on Child welfare provisions: State financial support .

The National Institute for Health and Care Excellence (NICE) is the body responsible for providing national guidance on promoting good health and preventing and treating ill health. In 2007, NICE published guidance on interventions to reduce the rate of under-18 conceptions (National Institute for Health and Clinical Excellence 2007a). This is discussed in greater detail in the section on Prevention: Educational programs, sex education and birth control. The guidance explored the cost-effectiveness of interventions to reduce adolescent pregnancy but was hampered from the lack of a straightforward way to identify and measure future costs and benefits to society associated with adolescent conceptions. Furthermore, studies that have evaluated effectiveness of interventions to reduce adolescent pregnancies are limited by the lack of inclusion of outcomes such as Quality Adjusted Life Years in primary studies (National Institute for Health and Clinical Excellence 2007b).

The Financial Cost of Adolescent Pregnancy

It is estimated that the cost to the NHS alone of pregnancy in under-18-year-olds was over £63 million per year in 2002 (Dennison 2004). The private costs of raising a child (in the UK until they reach their 21st birthday) are estimated to be £210,000 (Liverpool Victoria 2011).

Public Policy

In England, the government published a 10-year Teenage Pregnancy Strategy in 1999 (Social Exclusion Unit 1999). The policy target was to halve under-18 pregnancy rates by 2010. The level of reduction against the target is not yet known, but in 2010 it was reported that the rate was behind the trajectory need to achieve the target (Department for Children, Schools and Families and Department of Health 2010). An earlier report showed that the majority of the observed decrease was attributable to reductions in less deprived areas. In areas of higher deprivation, there was little change, resulting in renewed efforts and interventions to meet this target and a shift from national to more localised initiatives (Department for Education and Skills 2006). This prompted the publication of the 'Beyond 2010' strategy to maintain focus on adolescent pregnancy. The key elements of this strategy include giving young people the knowledge and skills they need to experience positive relationships and good sexual health, improving access to, and use of, effective contraception and early intervention to improve outcomes for adolescent parents and their children (Department for Children, Schools and Families and Department of Health 2010).

In Wales, the Welsh Assembly Government set out the aim to reduce the adolescent pregnancy rates in the Sexual Health and Well-being Action Plan (Welsh Assembly Government 2010). The strategy has a similar focus to England's 'Beyond 2010' strategy including improving sex and relationships education (SRE), contraceptive and sexual health service (CASH) and addressing the wider determinants of adolescent pregnancy such as the reduction of child poverty. In Scotland, the 'Respect and Responsibility: Strategy and action plan for improving sexual health', published in 2005 (Scottish Executive 2005), made specific reference to reducing unintended pregnancies and set a target to reduce the under-16 conception rate by 20 %. Northern Ireland's sexual health strategy 'Sexual Health Promotion: Strategy and Action Plan 2008–2013' has set a reduction in the number of unplanned births to adolescent mothers as a key objective with a target of a 25 % reduction in the rate of births to adolescent mothers under 17 years of age by 2013 (Department of Health, Social Services and Public Safety 2008).

Prevention: Educational programs, Sex Education and Birth Control

England's Teenage Pregnancy Strategy recommended the implementation of a number of factors at the local level to reduce adolescent pregnancies, including provision of an effective sexual health service, prioritisation of sex and relationships education, focus on targeted interventions, training on SRE for partner organisations and provision of a well-resourced youth service (Department for Children, Schools and Families 2008).

The aim of the public health guidance published in 2007 by NICE for the Department of Health was to reduce the rate of under-18 conceptions especially among vulnerable and at risk groups (e.g. young people from disadvantaged backgrounds, who are in or leaving care (looked after by the local authority) or who have low educational attainment). The guidance was written for health and non-healthcare professionals with responsibility for sexual health services, underpinned by a systematically collated evidence-based and assessment of cost-effectiveness of interventions. It includes national policies and standards, sexual health programs, and local partnerships and networks. A key recommendation is the provision of one-to-one sexual health advice on how to prevent unwanted pregnancies and methods of reversible contraception including long-acting reversible contraception and how to access and use emergency contraception. The guidance also made recommendations for research. These include the need to identify the most effective and cost-effective methods of, and tools for, identifying women at high risk of conception under the age

of 18 years. Further work is also required to understand the key characteristics of effective and cost-effective one-to-one discussions to reduce conceptions in women aged under-18. There is also a clear need to ascertain which utility scores should be applied to adolescents who conceive less than 18 years of age to generate QALYs for use in cost-effectiveness analysis (National Institute for Health and Clinical Excellence 2007a).

SRE is covered under the Education Act of 1996 in England. Sex education is included on the science curriculum and includes anatomy, puberty, and the biological aspects of sexual reproduction. It is mandatory for pupils of primary and secondary school age. Information about sexually transmitted infections is provided in secondary schools. All schools should have a policy describing their SRE program and government guidance and is issued to help schools plan their policy. In Wales, SRE is a compulsory part of the education of secondary school pupils, and primary schools should also have a policy on SRE, although the policy may be that SRE is not provided. Scotland has no statutory requirement for schools to teach SRE although sexual health is included on the school curriculum, and schools are encouraged to provide sex education. In Northern Ireland, statutory relationships and sexuality (RSE) education is included on the school curriculum with elements included in primary and secondary school (Family Planning Association 2011c).

A survey and systematic review on school-linked sexual health services for young people found that there was a wide diversity in school-based and school-linked sexual health services for young people in the UK. They found a spectrum of service provisions ranging from no sexual health service to a comprehensive service. They also found that where there were services available, there was no single dominant model, but there were three broad types of provision: individual appointments and drop-in sessions provided by school nurses; appointments, drop-in sessions and outreach services staffed by school nurses, youth workers and other professionals and the same service just described but including a medical practitioner. The authors concluded that services were unevenly distributed and there is a lack of robust research from the UK (Owen et al. 2010).

National public information campaigns have been used to support adolescent pregnancy and sexual health policy. Campaigns have included 'RU Thinking', 'Want Respect? Use a Condom' and 'Condom Essential Wear' which have aimed to improve knowledge and encourage open communication about relationships and sexual health between parents and their children, young people and professionals and among young people themselves. The Department of Health and the Department for Children, Schools and Families published a Teenage Pregnancy and Sexual Health Marketing strategy which had the overall aim of 'to act as a catalyst for culture change: creating a more open, positive, supportive, and respectful backdrop against which a range of policy interventions can happen'. As part of the strategy, the 'Sex Worth Talking About' campaign was launched. It focused on contraceptive choice and testing for sexually transmitted infections such as chlamydia, specifically targeting 16–24-year-olds (Department for Children, Schools and Families and Department of Health 2009).

Programming: Maternal Care and Child Care

NICE has also made specific recommendations for vulnerable young pregnant women aged less than 18 years to improve outcomes for mothers in this age group. These recommendations included midwives and health visitors regularly visiting women aged under 18 who are pregnant or who are already mothers to include discussions about how to prevent unwanted pregnancies (where appropriate), methods of reversible contraception, health promotion advice and discussion about opportunities for returning to

education and training and employment in the future (National Institute for Health and Clinical Excellence 2007a).

Interventions to improve outcomes include comprehensive social and medical care using antenatal clinics specific for adolescents, which has been shown to reduce the preterm birth rate among females aged less than 18 years in a randomised controlled trial (Quinlivan and Evans 2004). However, there is no evidence that provision of social support on its own to pregnant adolescents, for example, with additional home visits, reduces the incidence of preterm birth or low birth weight babies in adolescents, although it is also useful for reducing caesarean section rates (Hodnett and Fredericks 2001).

A systematic review of the effectiveness of preventive psychosocial and psychological interventions compared with usual ante-, intra- or post-partum care to reduce the risk of post-partum depression found that intensive professional-based post-partum support may be helpful, particularly if these are targeted at an 'at risk' group, which includes adolescent mothers (Dennis and Creedy 2004).

Evidence from randomised controlled trials in the USA (Olds et al. 1986) showed that the home-visiting interventions that form the basis of the Nurse Family Partnership program have positive effects for mothers, such as fewer and more widely spaced pregnancies, and better financial status and higher levels of father engagement (Barnes et al. 2008). The program has been adapted for use in England and was piloted in 10 sites in England. The pilot evaluation reported high enrollment of women aged under-20, a 17 % relative reduction in smoking during pregnancy and high rates of initiating breastfeeding. Further evaluation is ongoing in a randomised controlled trial across various sites in England (Cardiff University 2008).

Recognising the need to support young families in disadvantaged areas, the UK Government launched the 'Sure Start Plus' initiative as a pilot in England from 2001 to 2005, in support of the Teenage Pregnancy Strategy. The intervention was targeted at areas of high deprivation with high adolescent conception rates. The aim of the program was to prevent long-term social exclusion associated with adolescent pregnancy by 'providing intensive support for young families, helping them with housing, health care, parenting skills, education, and child care'. The program involved a personal advisor offering one-to-one support to pregnant adolescents and adolescent parents less than 18 years. The national evaluation showed that there were multiple models of Sure Start Plus provision across the pilot sites, and there was effective joined-up working between local agencies and services. It also showed that the program was successful in providing crisis support to pregnant young women and young mothers, but it had less of an impact on specific health outcomes such as reducing smoking and increasing breastfeeding. The national evaluation concluded that the program was under-resourced and more funds would have, among other things, allowed longer engagement with young mothers, and more time to address longer term health and development issues (Wiggins et al. 2005).

Child Welfare Provisions: State Financial Support

In the UK, the main state benefit related to children is Child Benefit (Directgov 2012). This is paid to the parent with main responsibility for the child to help with the costs of caring for their child (or children); it is paid until the child is at least 16 years old. Child benefits may continue until the child's 20th birthday if he or she is still in some types of approved training such as apprenticeships. The rate of Child benefits in 2011 was £20.30 per week for the eldest child and £13.40 per week for each other child. It is not means tested and is available to parents living in the UK. The payment rate has been frozen until April 2013 after which families with a higher rate taxpayer will no longer be eligible for this benefit (Maternity action 2011). In 2011/2012, a high rate taxpayer was an individual with an income of greater than £35,000 per annum after tax-free allowances of at least £7,475 was taken into account (HMRC 2011).

Child Tax Credit is available to people who are responsible for at least one child. This benefit is means tested and the financial entitlement depends on whether people work and how many children they have. People in work who claim Child Tax Credit may also claim some of their childcare costs. The Healthy Start benefit is available for people who receive certain state benefits, if they are pregnant or have at least one child under 4 years old. Pregnant women under 18 years are automatically entitled to this benefit. The Healthy Start benefit includes vouchers that can be spent on milk, fresh fruit and vegetables and infant formula. In 2011, the vouchers were worth £3.10, and children under 1 year were entitled to two vouchers per week, and pregnant women and children between one and 4 years old were entitled to one voucher per week. The Sure Start maternity grant is available to people on certain state benefits, to help toward the cost of maternity and baby items. In 2011, this was a one-off payment of £500. There are also means tested benefits related to children's schooling such as free school meals, help toward the cost of uniforms and school trips and free school transport. These vary in the different UK countries and to be eligible parents or guardians would be in receipt of certain benefits. Pregnant women who are in employment but not entitled to Statutory Maternity Pay from their employer may be eligible for the Maternity Allowance. All children aged 3 and 4 years are entitled to 15 h of free nursery education for 38 weeks of the year. This applies until they reach the age of 5 when they attend school (Directgov 2012).

UK Perspective on the Future of Adolescent Pregnancy

A review of health inequalities in England (Marmot et al. 2010) and subsequent reports (Allen 2011; Field 2010) have highlighted the importance of the early years and the need for more effective interventions among children at risk. There is clear evidence that an individual's health, social and economic outcomes during the life course are dependent on their health, social and emotional experiences during the first 5 years of life, including pregnancy. All the UK home nations are committed to reducing inequalities in health and social outcomes for their populations and recognise that investment in policies that give children the best start in life are central to this aim (Allen 2011; Department of Health, Social Services and Public Safety 2004; The Scottish Government 2008; Welsh Assembly Government 2011). Policies that address adolescent pregnancies form a part of this overarching aim to engage with families, to provide early interventions to vulnerable groups and promote health and well-being for children and subsequent generations.

Conclusion

There has been little change in the adolescent pregnancy rate over the last decade in the UK. There has also been little change in the outcome of adolescent pregnancy. Pregnancy and childbirth during adolescence are still associated with increased risk of poorer health and well-being for both the mother and the baby for the most part caused by socioeconomic factors that precede and follow early pregnancy rather than the biological effects of young maternal age. There is little evidence on the impact of adolescent fatherhood on health. The overall impact on society is a perpetuation of the widening gap in health and social inequalities. Government initiatives, interventions and support services aimed at young mothers should continue to be targeted at vulnerable groups of society with specific socioeconomic and demographic characteristics. As the available evidence suggests, these groups and their children are at highest risk of poor health and social exclusion. Further research should examine longer term morbidity experienced by adolescent mothers, young fathers, and their children to gain a better understanding of how much of this morbidity is attributable to socioeconomic characteristics and the pathways that mediate adolescent pregnancy.

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Adolescent Pregnancy in the United States

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Keywords

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US Perspectives on Adolescent Pregnancy: Cultural Context

In the United States, adolescent pregnancy is largely conceptualized as stemming from sexual activity, which results in intentional or unintentional childbearing among teenagers between the ages of 12 and 19 years. The sexual development of adolescents and concurrent concerns over teenage pregnancy and reproductive health are inextricably linked within American culture. There are a host of factors—historical, developmental, environmental, religious, moral, social, cultural, economic, and political—which influence the degree to which adolescent pregnancy is experienced and socially accepted within the diverse cultural landscape of the United States. As we will discuss in depth, adolescent pregnancy rates and experiences vary greatly across geographic regions, cultural subgroups, and socioeconomic strata. The presence of diverse viewpoints and experiences surrounding adolescent pregnancy, in one country, has multi-systemic implications for individuals, families, and communities (Cavazos-Rehg et al. 2010; McKenry et al. 1979). We begin this chapter with a brief overview of the historical conceptualization of adolescent pregnancy as both a social norm and a social problem in the United States.

Historical Context of Adolescent Pregnancy in the US

During the late eighteenth century when the United States was founded, adolescent childbearing was, for the most part, an intentional practice that was deemed socially normative. Throughout the colonial period (seventeenth and eighteenth centuries) as well as westward territorial expansion (nineteenth century), a high adult death rate related to harsh living conditions combined with a high prevalence of infant mortality and child deaths necessitated a younger onset of acceptable marriage and

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childbearing age. Prior to the twentieth century, early childbearing occurred more frequently in southern, border, and western frontier states than in the more established regions of the northeast. These trends were often linked with desired economic prosperity and the need for larger household sizes to manage agrarian tasks leading to earlier and more frequent births (Furstenburg 2007). It was not until the rise of industrialization during the early twentieth century that adolescent pregnancy was perceived as a significant social, cultural, and economic issue in the United States.

The United States' booming socioeconomic tide shifted in the twentieth century. Girls and women began to work out of the home more often and boys and men were drawn away from the home for work and military service, which led to delayed marriage and childbearing (Furstenberg 2007). It was not until after America's social and economic rebounds from her experiences with World War I (1914–1918), the Great Depression (1929–1940s), World War II (1939–1945), and the Korean War (1950–1953) that adolescent pregnancy reached a pinnacle of social concern. During the baby boom era of 1955–1965, the USA saw a rise in fertility among women of all ages, including adolescence. In the midst of this post-war baby boom, adolescent childbearing rates peaked at the same time as issues of family planning and reproductive choice became an important topic in US society (Furstenburg 2007; Furstenberg et al. 1989).

As America dealt with political and social unrest during the Civil Rights Movement (1942–1968) and the Vietnam War era (1960–1975), citizens also lifted their voices about many social and domestic policy concerns, including the experiences of women, children, and disadvantaged groups. Just as mounting national concern regarding adolescent pregnancy began to escalate in the late 1960s and early 1970s, demographic trends presented a simultaneous decline in adolescent births and delayed age of marriage (Furstenberg et al. 1989). However, the social concern over so-called illegitimate children, defined as those born to unmarried adolescents, began to be viewed as threatening the sanctity of marriage and indicating perceived sexual fornication or permissiveness among the adolescents of that time period (Osofsky 1968; Plionis 1975). The promotion of contraception and family planning among all groups also increased in the 1970s, as scientifically informed methods of birth control became readily available. This trend toward family planning led to the largest birth rate decline in decades, but largely among adult women. Amid this general trend toward reproductive choice and family planning, adolescent parenthood was considered to be at epic proportions. During this era, teens were less likely to be married, plan for pregnancy, or have access to and knowledge of how to correctly use contraception (McKenry et al. 1979; Furstenberg 2007). Therefore, during the 1970s, the conceptual interconnections between unplanned pregnancy, non-marital births, and adolescent pregnancy became solidified in US culture.

Beginning with President Jimmy Carter in 1977, every US president has emphasized adolescent pregnancy as a social problem on his political agenda, often directly linked with non-marital birth (Furstenburg 2007). In President Bill Clinton's 1995 State of the Union address, he declared the nation's most serious social problem to be "the epidemic of teen pregnancies and births where there is no marriage" (Clinton 1995). This trend has continued during the recent presidencies of George W. Bush, a self-identified Republican conservative politician as well as the current president, Barack Obama, whose more liberal, Democratic administration also emphasizes social and economic concern over adolescent pregnancy rates. Thus, even in the contemporary United States, adolescent pregnancy is viewed as a bipartisan social concern, which impacts public policy.

Whether related or unrelated to the wave of political attention, overall adolescent pregnancy rates have actually declined substantially in the USA over time, from 61.8 pregnancies per 1,000 girls age 15–19 during the late 1960s to 40.5 pregnancies per 1,000 by 2005. Corresponding statistical trends note that the overall rate of

induced abortion has remained largely unchanged in the USA since 1972, except for a spike in the mid-1980s; overall fetal morality rates have also been consistently declining over time in this population group (Kost and Henshaw 2012). Historical trends also indicate a delayed age of sexual activity as well as improved contraception use among adolescents over time (Higgins et al. 2012). In spite of these recent trends, the United States still reigns as having the highest adolescent birth rate among developed countries, and public attention to the topic as a social, cultural, and political concern continues to remain steady (Elders 2012).

Cultural and Traditional Influences: Social Views and Customs

In the United States, there is considerable diversity in the overall population, including among pregnant adolescents. Corcoran et al. (2000) describe trends in adolescent pregnancy in the United States from an ecological perspective. In the macro-system, socioeconomic status and race have a significant impact on the prevalence of issues surrounding adolescent pregnancy, such as educational attainment, family size, structure, and functioning, and economic and non-economic resources. At the meso-system level, educational setting, family, religion, and peer group are strong influences. Micro-system variables include increased age of adolescence, psychological health, and substance abuse (Corcoran et al. 2000). This multi-systemic perspective is helpful in understanding the diversity of the experience of adolescent pregnancy in the United States. However, the clustering of common experiences across systems also emphasizes the emergence of predictable subpopulations which may be negatively labeled based on the elevated prevalence and perceived social acceptability of adolescent pregnancy.

In contemporary US culture, these prevailing epidemiological and cultural norms have implicitly created a perceived social "picture" of adolescent pregnancy (Furstenberg et al. 1989). Here, we paint this picture not as prescriptive, but as a composite of the demographic, social, and cultural influences, which are commonly attributed to adolescent pregnancy in the United States. An adolescent parent in the United States is likely to be of Black or Hispanic/Latino origin, which also correlates with a likelihood of living in a low-income household or community where there is a greater concentration of teen parents (Casares et al. 2010). He or she is likely to be of low educational attainment and lower socioeconomic status which, irrespective of race, decreases access to preventative resources, healthcare, contraception, or abortion (Corcoran et al. 2000). He or she is likely to be a child reared in family dysfunction or instability, insecure family attachments, support, and future parenting or interpersonal relationships (Feldman 2012). He or she is also likely to be the product of an unmarried couple in the family of origin, as adolescent parenting takes on generational pattern in the United States. He or she likely views desensitizing, highly sexualized figures and images of adolescent parents in various modes of media or parts of the environment (Furstenberg 2009) which shape his or her self-image. He or she has also likely experienced social pressures leading to the early sexual experimentation and reduced control of sexual impulses, creating the opportunity for adolescent pregnancy and parenthood (Furstenberg et al. 1989).

In spite of the fact that there are also a significant number of White/non-Hispanic and Asian American adolescents dealing with pregnancy, the rates of adolescent pregnancy in these groups in some communities are nearly half that of Black and Hispanic minorities. In 2008, the overall adolescent pregnancy rate was 67.8 per 1,000 for teens aged 15–19 years. While this is a significant reduction from a 1990 peak (116.9 per 1,000), the rate was only 43.3 per 1,000 White/non-Hispanic compared to 117.0 for Black and 106.0 for Hispanic adolescents (Kost and Henshaw 2012). Thus, the demographic face of an adolescent dealing with pregnancy may stand out from the perceived majority of Americans, who are often described as White

and middle-class (Morgan et al. 1995). In addition to higher birth rate prevalence, Latino adolescents are increasingly more likely to struggle with rapid, repeat births (defined as a subsequent birth within 24 months) and sexually transmitted infections (STIs) than other racial and ethnic subpopulations in the United States (Bouris et al. 2012). Thus, the American public tends to retain a mental image of adolescent parents as poor, minority boys and girls, from difficult homes and communities engaging in behavior that perpetuates the very circumstance from which they were born.

An interesting juxtaposition in the larger United States culture is the public outcry over the deviance of adolescent pregnancy on the one hand, coupled simultaneously with a media culture glamorizing teen pregnancy on the other. Today's adolescents live in culture focused on instant gratification and social media, one in which new terms such as "sexting" (exchanging sexually explicit photographs and messages via cell phone) have emerged into the vernacular (Gill 2012). American reality television shows, such as *Sixteen and Pregnant* and *Teen Mom,* which depict the patterns, struggles, and journeys of real, predominantly White teen parents, earn high viewer ratings across ethnic and cultural groups (Sanneh 2011).

Public perceptions about the deviance or glamorization of adolescent pregnancy are further stratified by cultural and socioeconomic differences. Exemplifying the public mixed messages regarding adolescent pregnancy in the United States, a portion of the media coverage for the 2008 US presidential election was usurped by news regarding the pregnancy of then Republican Vice Presidential Candidate Sarah Palin's adolescent daughter, Bristol. Bristol was first introduced to the American public as a 17-year-old, unmarried, and pregnant White/non-Hispanic girl from a stable, two-parent home and affluent community. From her national exposure during the presidential campaign and with parental support, Bristol mounted a platform to speak out against teen pregnancy and support abstinence-only education, which corresponded with her mother's political views (Weiser and Monica 2010). Bristol went on to appear on *Good Morning America* and the *Today* show (Weiser and Monica 2010) and gained enough popularity to star in her own reality television show about the joys and woes of raising her son as a single parent, *Life's a Tripp*. Additionally, she simultaneously went on to become a two-time celebrity on the popular ballroom dancing television show, *Dancing with the Stars*. Cohen (2010) contrasts the mainstream media's reporting of Bristol's adolescent pregnancy against the portrayal of Black American unwed teen motherhood by the same media. In Cohen's (2010) view, White teens, particularly those from more affluent classes, are granted amnesty for their indiscretions of youth, while Black teens continue to be viewed as deviant. This adds to a persistent mixed message in American culture for sexual acts leading to getting pregnant for some, but praise for adolescent parenting done well for others.

Adolescent pregnancy in the US too often focuses on adolescent girls because they are socially linked with developing, birthing, and raising resultant children. Adolescent teens are less likely to marry; therefore, the formal parenting roles of teenage fathers may have been legally minimized. Historically, Americans have viewed adolescent males as peripheral to the pregnancy, and thus, they have received less parenting education and support than pregnant girls (Furstenberg et al. 1989). In the past decade, the importance and relevance of the male ("fatherhood") perspective has been taken into account with more vigor throughout the United States. Adolescent men tend to view an unintended pregnancy during their teenage years negatively, due to the detrimental effect having a baby may have on their future goals (Lohan et al. 2010). Similar to adolescent mothers, adolescent fathers are more likely to have poor academic performances, drop out of school, and limit their future income potential (Klein 2005). Thus, adolescent fatherhood is viewed as a financial and economic issue, as well as a social issue in the United States.

In summary, the changing social and cultural makeup of the United States has transformed

social and cultural views regarding adolescent pregnancy. In early American history, adolescent parenting was a commonplace occurrence of family formation. In the mid-twentieth century, as public awareness of civil rights increased, adolescent pregnancy came to be viewed as a societal problem. Now, in the twenty-first century, adequately addressing adolescent pregnancy remains a topic of great concern for policy makers, while shifting demographic trends, public and social media images, and adolescent development itself strive to challenge dominant social norms.

Religious Influences

While the United States was founded on the premise of religious freedom, citizens of the United States ascribe to a myriad of belief systems, which implicitly shape cultural messages and public policy. The vast majority of Americans, approximately 78.4 %, affiliate themselves with Christian churches. According to the Pew Forum on Religion and the Public Life, this majority breaks down further into religious subgroups with approximately 26.3 % of Americans aligning with evangelical Protestant denominations, 23.9 % Roman Catholic, 18.1 % mainline Protestant, 6.9 % historically Black Protestant, 1.7 % Mormon, 0.7 % Jehovah's Witness, 0.6 % Orthodox, and 0.3 % other Christian denominations. The 4.7 % of Americans who classify themselves as practicing other religions include 1.7 % Jewish, 0.7 % Buddhist, 0.6 % Muslim, 0.4 % Hindu, and 1.75 % other faiths. The remaining 16.1 % classify themselves as unaffiliated (i.e., Atheist, Agnostic, non-religious) or uncertain (The Pew Forum on Religion and Public Life 2008). Although Judeo-Christian religious perspectives traditionally dominate Americans' cultural views, there is no singular religion which governs social norms regarding adolescent pregnancy.

In the USA, various Christian denominations and religious groups do hold specific views on the acceptability of sexual intercourse (or other sexual activity) outside of marriage, the ethics of contraceptive use and availability, the ethics of pregnancy termination, and the acceptability of the pregnant adolescent (and baby, once born) to be a part of the religious community. Religious affiliation varies across the geographic expanse of the United States, so what is defined as the "majority" set of religious and moral values may change from community to community. While freedom to practice one's religion is a core value of the United States Constitution and corresponding Bill of Rights, the values that are deeply held by particular religious groups may still exert an influence on the policies, programs, and services, which are supported in individual communities. However, the separation of church and state remains a vital force in US politics, so many national policies and programs are contingent upon non-discrimination based on religion, and the US government has generally acted in favor of freedom and individual choice in the policies that are nationally supported. Various religious groups may electively create, support, and fund non-governmental, sectarian programs which adhere to the values of their specific religious community (i.e., providing explicit alternatives to abortion, or offering youth development programs which promote only sexual abstinence).

Irrespective of religious affiliation, a commonly held belief in the United States is that religious faith and behavior among adolescents is related to the prevalence of adolescent pregnancy. Research supports this assertion: US adolescents who participate in religious activities tend to have high parental and social monitoring as well as more positive social bonds. Further, greater exposure to moral messages from religious activity has been found to increase the likelihood of teens internalizing salient messages about personal responsibility (Burdette and Hill 2009). Subsequently, when controlling for sociodemographic characteristics, religiosity among adolescents has been associated with pro-social values and behavior and negatively associated with early sexual activity, as well as suicidal ideation, substance

abuse, and delinquency (Donahue and Benson 1995). Religiously tied parents also have been found to have a significant influence on adolescents' decisions to delay sexual debut and/or to reliably use contraception (Manlove et al. 2006).

There are differences, however, in religious affiliation and adolescent sexual activity between and within some US-based religious groups. According to Burdett and Hill (2009), conservative religious affiliation (e.g., Mormon, evangelical, fundamentalist) is linked with delayed sexual debut. Mainline Protestants are also more likely to delay sexual intercourse than Jewish adolescents. However, related to the religious stigma of engaging in coitus, evangelical Protestant adolescents may be more likely to engage in oral sexual activity. Older religiously affiliated adolescents, who have had greater levels of religious exposure, are less likely to engage in sex than younger adolescents. Christian adolescent girls are more likely to delay or abstain from sex than are Christian adolescent boys; this practice may be linked to Biblical messages elevating virginity status for women. Black adolescents, even with Christian beliefs and practices, are more likely to engage in sex than their White peers; one explanatory theory is that traditionally Black Christian churches tend to be more forgiving of sexual transgressions than predominantly White Christian churches, which promote sexual piety and purity. Overall, *religious salience*, defined as the extent to which religion influences one's life, may prove to be the most significant influence on American adolescents' sexual behavior (Burdette and Hill 2009).

The diverse social, religious, and cultural groups that comprise the United States population present a diverse landscape of human experience, social sanction, and moral belief. In this context, we move on to discuss the epidemiological trends, health implications, public policy, and supportive services that have emerged to respond to the diverse landscape of adolescent pregnancy and parenting in the contemporary United States.

Overview of Adolescent Pregnancy in the United States

Birth Rate

The United States exhibits one of the highest adolescent birth rates among other industrialized nations (Hamilton and Ventura 2012), although these rates vary widely by geographic location, race, and ethnicity. As previously discussed, the highest levels of adolescent birth rates were exhibited during the 1950s and 1960s. Birth rates for adolescent females in the USA then dropped sharply until 1986, at which point they increased again through 1991 (Klein 2005). However, over the past 20 years, there has been an almost 40 % drop in the teen birth rate in the United States. Health service research data suggest that approximately 12 % of this decline can be explained through policy changes such as expanded family planning services through Medicaid as well as reduced welfare benefits (Kearney and Levine 2012). This long-term decline has also been linked to pregnancy prevention messages directed at adolescents, as well as increased availability and effective use of contraception (Martin et al. 2012). In the last several years, the adolescent birth rate in the USA has continued to decline, down 9 % from 2009 to 2010, putting it at a historic low of 34.3 births per 1,000 women (Hamilton and Ventura 2012). These overall birth rate trends are shown in Figs. 1 and 2.

The decline in adolescent birth rates occurred across all racial and ethnic groups in the United States, although significant racial and ethnic disparities in births to adolescents have persisted over time (Hamilton and Ventura 2012), as illustrated in Fig. 3. In 2010, Hispanic teens exhibited the highest rates of adolescent pregnancy, followed by non-Hispanic Black, then by American Indian/Alaskan Native, then by non-Hispanic White, with the lowest rates exhibited by those in the United States of Asian or Pacific Islander origin.

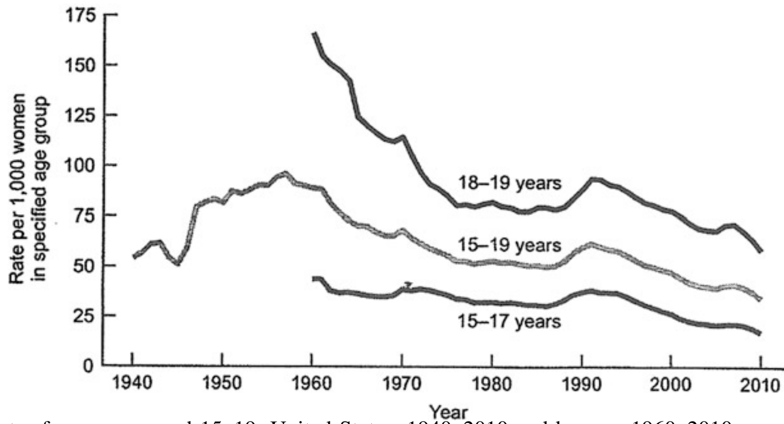

Fig. 1 Birth rates for women aged 15–19: United States, 1940–2010 and by age, 1960–2010

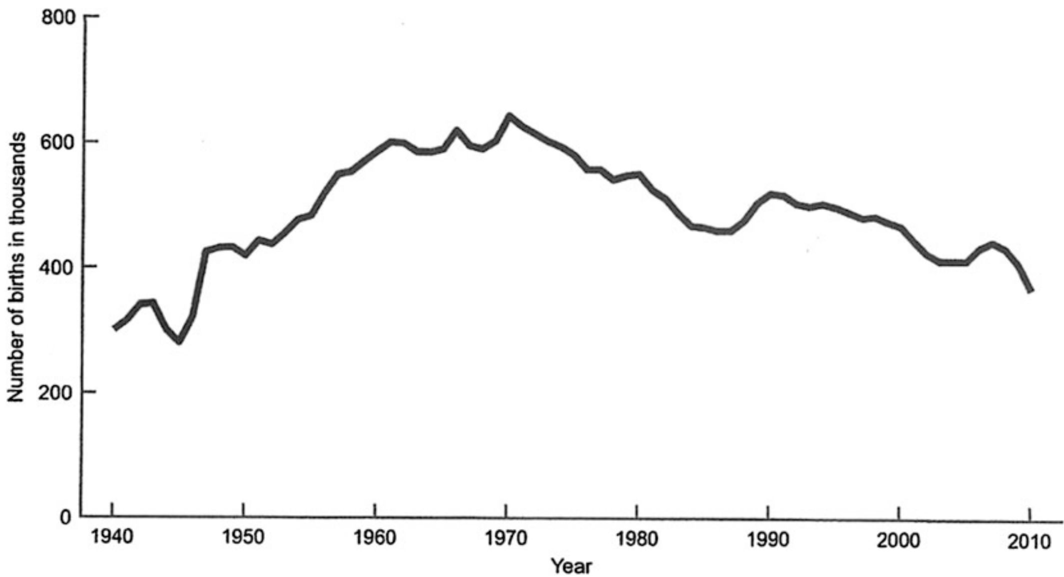

Fig. 2 Number of births for women age 15–19 in the United States, 1940–2010

The 50 states, which comprise the United States as a whole, also vary considerably from each other in terms of adolescent pregnancy and birth rates. These significant differences at the state level reflect, in part, differences in racial composition and Hispanic origin present in communities across the United States (Hamilton and Ventura 2012). Adolescent birth rates fell in all but three states between 2007 and 2010. Overall, declines ranged from 8 to 29 %, with 16 states exhibiting declines between 20 and 29 %; declines by individual state are illustrated in Fig. 4.

Medical Issues

One of the reasons that adolescent pregnancy remains an issue of public concern is the likelihood of health complications for babies born to adolescent mothers (Hamilton and Ventura 2012). The likelihood of delivering a low birth weight infant (weighing less than 2,500 g) is twice as high for a pregnant adolescent as for adults. Likewise, the mortality rate for an adolescent mother in the United States, although low, is still twice that as for an adult woman. Adolescent mothers are also more likely to give

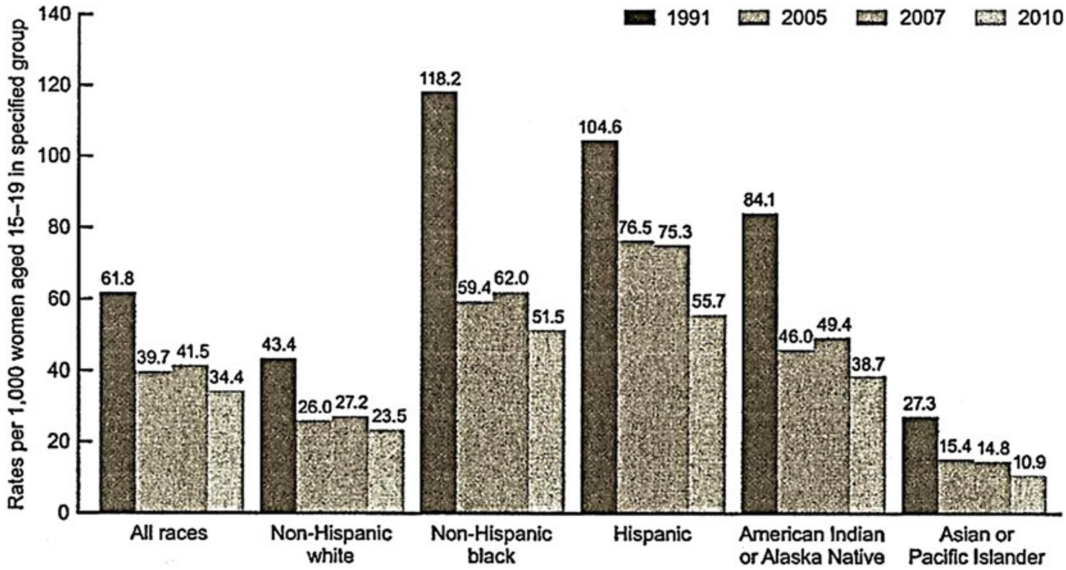

Fig. 3 Birth rates, for women aged 15–19 by race and Hispanic origin, United States

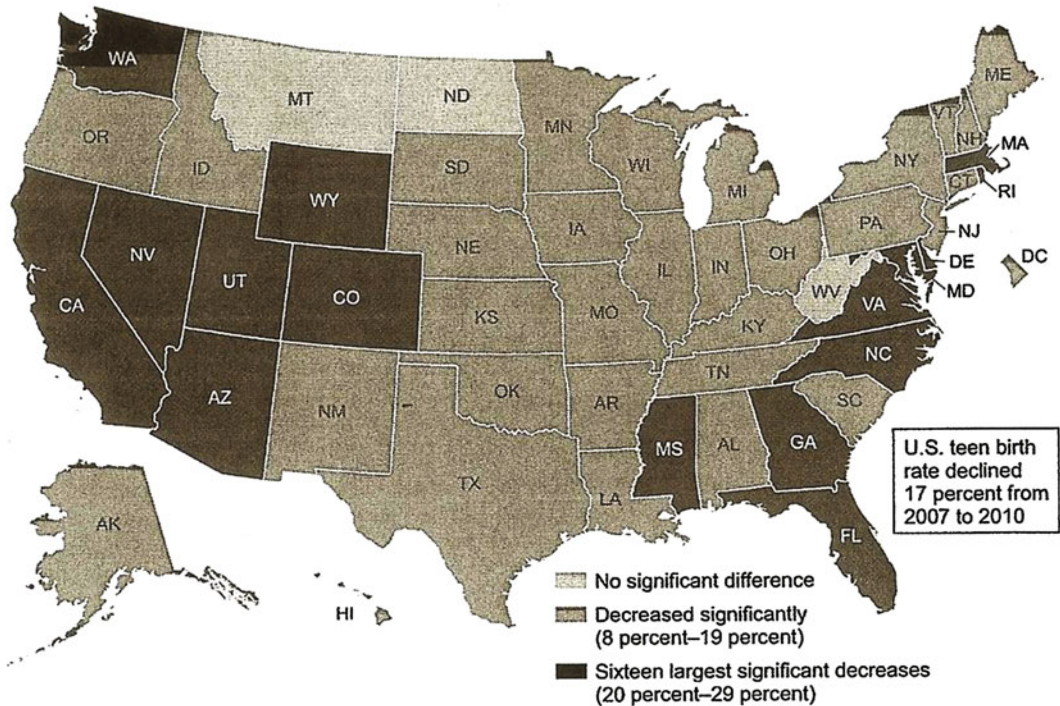

Fig. 4 Change in birth rate for women aged 15–19, by state: United States, 2007–2010

birth to premature and underweight children (Klein 2005). Children born to adolescent mothers have also been identified as at greater risk for developmental delays, long-term illnesses, and death within one year (Cherry et al. 2009).

Adequate prenatal care is the most effective way to lower health risks associated with adolescent pregnancy and birth (Feldman 2012). However, adolescent mothers are only half as likely as their adult counterparts to seek recommended prenatal care (Cherry et al. 2001). Adolescents, defined as under the age of 20, were found to initiate prenatal care at a rate of 56.5 %, which was lower than any other age group (Feldman 2012). Adequate access to developmentally appropriate and age-specific prenatal care, in combination with poverty, interpersonal relationships, and transportation challenges jointly contribute to health challenges among pregnant adolescents (Feldman 2012). These risks may be compounded in the United States by racial and ethnic disparities in rates of prenatal care as well as birth outcomes. Infant mortality, low birth weight, and prematurity are more common among Black, non-Latina as well as both Black and White Latina populations, as compared with White, non-Latina populations in the USA (Feldman 2012).

Health risk for adolescent mothers may be further compounded by mental health concerns. Adolescent parents in the United States have been found to have higher rates of postpartum depression, which can be compounded by lack of social support, low self-esteem, life stress, low socioeconomic status, substance use, and little religious involvement (Brown et al. 2012). Higher levels of social support, however, have been correlated with lower levels of depressive symptoms after birth (Brown et al. 2012). Thus, the importance of social support for the pregnant adolescent has been emphasized as a dominant issue in response to adolescent pregnancy in the United States.

Social Issues: Poverty, Family Supports and Structure

Pregnant adolescents in the United States may be challenged by poverty, public perception, and family support. The United States Department of Agriculture (USDA) sets specific poverty guidelines each year to correspond with the estimated costs of providing basic food, shelter, and sustenance for families living in the United States. This is an annual income, below which one is formally considered to be living in poverty. In 2012, the poverty guideline for a family of four in the United States was $23,050 (Sebelius 2012). Many public welfare programs in the USA use this guideline to determine eligibility, since few universal public welfare supports are available.

Adolescent mothers have higher rates of poverty, single parenthood, abuse, and achieve lower levels of education than their counterparts (Brown et al. 2012). In the USA, the publically supported compulsory education system extends from Kindergarten through secondary education, with most adolescents graduating from high school at age 18. Thus, pregnant adolescents may require additional supports to complete their standard education, or risk “dropping out” from the public education system and be at a significant economic and workforce disadvantage. Adolescent parents are also more likely to experience chronic long-term poverty, with subsequent dependence on public welfare (Casares et al. 2010). Adolescent parents living in low-income households are more likely to rely on public assistance programs and family support to assist with costs associated with the child, finding a job, or going back to school (Kearney and Levine 2012). This trend toward limited education coupled with limited job market offerings may make it increasingly difficult for adolescent parents to earn and save their way out of poverty.

Given the cyclical nature of poverty and adolescent parenthood, demographic trends can easily perpetuate both an actual and perceived cycle of poverty and adolescent parenthood in US society (Cherry et al. 2001). As previously discussed, research suggests that 33 % of the daughters of women who have dropped out of high school become adolescent mothers themselves (Kearney and Levine 2012). Being raised in a low-income family has been later associated with a greater likelihood of sexual activity at a young age, as well as incorrect or ineffective contraceptive use (Cherry et al. 2009). Those

who live in poverty or in single parent homes are almost twice as likely to have an adolescent birth as their counterparts (Kearney and Levine 2012). Adolescent girls living in low-income families constitute an overall 38 % of females between the ages of 15 and 19 in the USA, yet they account for 73 % of all pregnancies in that age group. Approximately 60 % of these mothers are living in poverty at the time of birth (Cherry et al. 2009). The social issue emphasized and re-emphasized through these demographic trends is that adolescent pregnancy is a cyclical and persistent problem which is embedded in familial, social, and economic systems in the United States, not simply an issue stemming from the life choices of individual adolescents.

One of the primary catalysts for this cycle of adolescent pregnancy and poverty in the United States is that residing in a low-income family tends to offer fewer opportunities for economic, educational, and occupational advancement. As previously described, adolescent pregnancy rates tend to be highest among the most resource-poor ethnic groups in the USA (Casares et al. 2010). While the majority (82 %) of adolescent births in the USA are unplanned or unintended (Feldman 2012), bearing a child as a teen may also reflect a conscious (or unconscious) decision to "drop out" of the economic mainstream. One conceptual framework posited, based on trends in health economics data, is that teenage girls and boys may choose adolescent parenthood rather than attempting to invest in their own educational and economic progress related to the hopelessness and futility that arise from persistent patterns of income inequality in the United States (Kearney and Levine 2012).

Family structure and support have also been linked with patterns of adolescent pregnancy in the United States. Early and unprotected sexual activity is more common when a child lives in a family in which a parent has a drug or alcohol problem, concomitantly raising the risk for adolescent pregnancy (Cavazos-Rehg et al. 2010). Teenagers with little family involvement or low levels of parental education may also have an increased chance of rapid, repeat pregnancies during their own adolescence (Crittenden et al. 2009). Conversely, parental supervision, parent–child connectedness, and parents' values against unprotected sexual activity decrease the risk of adolescent pregnancy (Miller et al. 2001). As will be discussed, public policies in the United States have been designed to bolster the family system of the pregnant adolescent as one effort to break the persistent cycle of poverty and adolescent parenthood.

Legal Issues

Legal issues related to adolescent pregnancy include the choice to carry a pregnancy to term, as well as issues around consent to medical treatment of an existing pregnancy. The legalization of abortion in the United States in 1973 influenced the adolescent pregnancy rates at that time (Cherry et al. 2009). However, more recent declines in adolescent births, particularly since 1991, are likely attributable to a decline in pregnancies rather than an increase in abortions. This trend is consistent across racial/ethnic groups (Kearney and Levine 2012).

The US Supreme court, in legalizing abortion, indicated that citizens of the United States have a fundamental, constitutional right to privacy, including the right to terminate a pregnancy (Stuart and Wells 1982). The main legal issue around abortion for adolescents is parental involvement or notification prior to terminating a pregnancy; this requirement is determined at a state level rather than through federal policy. As of 2012, there are 37 states in the United States that require some type of parental involvement in a minor's decision to have an abortion. This parental involvement may require parental consent (legal authorization of the medical procedure for terminating a pregnancy) and/or parental notification (informing parents that adolescent is intending to terminate a pregnancy). Currently, 22 states require one or both parents to consent to an adolescent's termination of a pregnancy; 11 states require parental

notification; and four states require both parental consent and parental notification (Guttmacher Institute 2012).

Should the adolescent mother decide to carry her pregnancy to term, other legal issues may surface regarding consent to medical treatment. Again, many legal precedents vary from state to state in the USA because legal jurisdiction for enacting most policies occurs at the state level. The majority of states define the legal age of majority to be 18 (in some states it is 19 or 21). In general, minors (under the legal age of majority) do not have the full legal rights of an adult. Some states have enacted exceptions upon marriage or upon parenthood, granting emancipated legal status to these minors so that they can engage in the legal activities normally reserved for chronological adulthood. Some states have also enacted exceptions to allow minors to consent for specific medical treatments or general medical care. This can include not only requests for contraceptives or consent to terminating a pregnancy, but also to consent for the basic medical care provided during a pregnancy and medical care for the child after birth. For many adolescents, their health insurance coverage may be linked to their own parent who is legally responsible for them; therefore, the pregnancy may not be covered, or the adolescent's own parent must consent and pay any costs associated with their pregnancy care or childbirth. Given that health insurance coverage has been largely privatized in the United States, securing adequate medical care and health insurance coverage is a prominent legal issue faced by many adolescent parents.

Cost of Adolescent Pregnancy

The true costs of adolescent pregnancy encompass the medical, workforce, social, interpersonal, and educational impacts of adolescent pregnancy that accumulate over a lifetime. The calculated economic cost to US taxpayers for medical care and programmatic support for adolescent pregnancy has been estimated at 10.9 billion annually (Hamilton and Ventura 2012). Adolescent pregnancy increases the likelihood of public welfare assistance use, which also has a taxpayer impact (Casares et al. 2010). Other projected economic costs of adolescent pregnancy include increased public sector health care expenses over the child's lifetime, child welfare benefits, public assistance use, state prison systems costs related to increased lifetime risk of antisocial behavior, and lost monies due to less taxes paid by the children of adolescent mothers over their own adult lives (Casares et al. 2010; Feldman 2012).

Adolescents who have unintended or unwanted pregnancies are faced with additional challenges, including an inability to complete their compulsory education or to invest in higher education, which ultimately serves to limit their future social and economic opportunities that are fundamental to success in United States society (Cherry et al. 2009). Adolescent mothers are more likely to drop out of school, remain unmarried, and live in poverty, and their children fare worse than the general US population based on economic, social, and cognitive standards (Kearney and Levine 2012). The children of adolescent mothers have increased risks for developmental delay, behavioral disorders, substance abuse, educational difficulties, early sexual activity, depression, and as previously noted, becoming adolescent parents themselves (Klein 2005). As dismal as this outlook seems, recent research suggests that these challenges may stem not from adolescent pregnancy itself, but rather from the underlying differences between US adolescents who give birth as teens and those who do not, such as growing up in disadvantaged circumstances, or in persistent poverty (Kearney and Levine 2012).

Public Policy

Public policy and social programs in the United States reflect the tension between the prevention of teen pregnancy on the one hand, and the desire to support adolescent parents on the other. Indeed, the USA faces the public health challenge of continuing to have the highest

adolescent birth rate of any industrialized country, in spite of the decline in adolescent pregnancy by nearly 40 % over the past decade (Elders 2012; Kearney and Levine 2012; Ventura et al. 2011). As previously discussed, adolescent pregnancy in the United States is highly variable by state and local regions, as well as in sociodemographic groups. Public health surveillance data, such as that previously presented, routinely correlate US rates of adolescent pregnancy with race/ethnicity and socioeconomic status. As Kearney and Levine (2012) discuss in depth, these epidemiologic patterns in adolescent pregnancy rates may be closely related neither to race or socioeconomic status alone, but to persistent income inequality patterns in the United States, which disproportionately affect some communities.

The United States federal policy tends to set the conceptual approach (and funding levels) regarding adolescent pregnancy prevention and support. However, efforts to implement and evaluate programs and policies targeting adolescent pregnancy occur largely in state, regional, and local community governments. It is also noteworthy that funding and programming initiated at a federal level are often targeted to specific geographic areas of the USA where rates of adolescent pregnancy and parenting are more common and potentially problematic. In this section, we highlight the contemporary political context surrounding adolescent pregnancy in the USA and provide current examples of three major directions for public policy and programming: prevention, public awareness, and parenting support.

Prevention Efforts: Sex Education, Birth Control, and Youth Alternatives

Given the high rates of adolescent pregnancy in the United States from a global health perspective, prevention has been a dominant theme in US public policy surrounding adolescent pregnancy. For example, the United States Centers for Disease Control (CDC) recently asserted that lowering the adolescent pregnancy rate is one of the "top 10 winnable" public health priorities in this decade (Centers for Disease Control and Prevention 2012a).

In spite of steadily decreasing rates of adolescent pregnancy in the United States, the national consensus echoes the global concern that these rates remain higher than desired. Public opinion and policy in the United States are guided by the concern that adolescent pregnancy does not allow adolescents to achieve their full opportunity for education and economic independence.

The awarding of public dollars which can be used to support local community initiatives is a hallmark of US policy. Indeed, this ear-marked national funding for local programs may be paramount to successful prevention efforts because of the pronounced, community-level disparities in adolescent pregnancy rates across the United States. Consider that on the US East Coast, largely suburban New Jersey sports an adolescent pregnancy rate among White, non-Hispanic adolescents at 8.5 per 1,000, while in rural Mississippi, among Black and Hispanic adolescents, the rate is 115 per 1,000 (Hamilton et al. 2011). Not only are these rates very different, but the life circumstances and needs of adolescents served by social programs in these communities are likely to be different. These disparities in the rates and experiences of adolescent pregnancy impact public health, individual care, as well as the availability and acceptability of supportive community response.

Over the past 20 years, the diverse cultural, political, and religious values in the USA have been reflected in public policy decisions surrounding specifically *how* to prevent adolescent pregnancy. From the mid-1980s to the early 1990s, adolescent pregnancy garnered increasing attention as a national concern including voiced, and often politically conservative, concerns regarding non-marital births and welfare dependency among adolescent mothers. In 1982, the Office of Adolescent Pregnancy Programs began the Adolescent Family Life project, with a dual aim of postponing sexual activity until marriage, as well as care demonstration projects that sought to improve health and parenting

skills of adolescent parents (Barnet 2012). While non-sectarian in nature, this "abstinence-driven" public policy emphasized a national campaign to prevent teen pregnancy, forego sexual activities outside marriage, and simultaneously funded numerous small grants to communities to enact these policies. In 1996, these efforts were augmented by a $250 million allocation for abstinence-focused education under welfare reform, the Personal Accountability and Work Opportunity Act. In spite of the investment in millions of dollars and hundreds of programs, a large-scale 10-year evaluation conducted by an independent evaluation agency in 2007 found that these abstinence-only education programs were actually no more effective than having no sex education programs at all in terms of risk for adolescent sexual activity, risk of pregnancy, or risk of STIs (Trenholm et al. 2008; Weiser and Monica 2010).

In an effort to move toward evidence-based prevention programs, attention has turned to the need for research to guide public policy and effectively prevent adolescent pregnancy. Since early 2000, several studies have examined the dual impact of comprehensive sex education and contraceptive availability on both the prevention of adolescent pregnancy and the promotion of sexual and reproductive health, including prevention of STIs and HIV/AIDS (Kirby 2008; Kohler et al. 2008; Martinez et al. 2011; Mueller et al. 2008). Thus, the most current public policy focus on a national level is to identify and target communities with elevated rates of adolescent pregnancy, engage these communities in specific initiatives targeted to their local population, and provide consistent evidence-based messaging and evaluation to assess programmatic impact. For example, in 2010 the Obama administration announced the "President's Teen Pregnancy Prevention Initiatives," reasserting the national intention to lower the adolescent pregnancy rate and equalize opportunities for adolescent parents. The US Office of Adolescent Health, which is responsible for the oversight of these programs, describes the goal of the program to "demonstrate the effectiveness of medically sound and age-appropriate, innovative, multicomponent, communitywide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates, with a focus on reaching African American and Latino/Hispanic youth in the program's targeted age range, 15–19 years" (Centers for Disease Control and Prevention 2010).

Concurrently, an emphasis on expanded access to birth control including both over-the-counter and prescription contraceptives has been heightened by the patient protection and affordable care act (PPACA). The PPACA provisions that grant greater access to birth control, emergency contraception, and widely available family planning through both private insurance and publically supported exchanges have been political controversial, as they do not reflect the value orientation of some religiously oriented groups in the United States. However, the PPACA provisions reflect the research evidence base and public health surveillance data which consistently demonstrate a significant public health benefit to increasing access to birth control and thereby reducing unintended pregnancies (American Public Health Association 2011). Although the PPACA provisions have not been in place long enough to fully evaluate the comparative benefit of this approach, this represents a significant US domestic policy shift which increases access to contraceptive and family planning information combined with community-specific comprehensive prevention and education.

In their comprehensive discussion of US-based prevention programs designed to target adolescent pregnancy, Harris and Allgood (2009) emphasize and discuss three broadly accepted approaches underscoring a wide range of current prevention programs in the United States: (1) sex education, which may occur with or without contraceptive information; (2) youth development and life skills enhancement programs, which include skill building as a central component); and (3) service learning programs, which combine direct education in the classroom with experiential learning in community-based settings. An ongoing challenge in designing effective prevention programs is the combination

of multiple strategies along with the need for a clear and explicit theory of behavioral change to guide the evaluation (Lachance et al. 2012). Thus, an important future direction in the United States is the measured integration of multi-systemic approaches that target the specific needs of diverse communities while closely attending to the evidence generated through public prevention and funding initiatives.

In summary, prevention policy in the United States has undergone several iterations in the most recent decades that reflect political and social values around "abstinence-only" versus comprehensive sex education. Research has demonstrated that comprehensive sex education and contraceptive availability may be successful in lowering adolescent pregnancy rates in the United States, particularly when targeting the specific needs of local communities. However, local communities as well as state governments may eschew these research findings and assert that "abstinence-only" programs are a preferred service delivery, in spite of their lack of demonstrated efficacy. Persistent income inequality in the United States combined with political tension between evidence-based and values-based prevention policy may be a contributing factor to the elevated rates of adolescent pregnancy in the United States in a global context.

Public Awareness Initiatives

In the United States, public awareness initiatives regarding adolescent pregnancy are often intrinsically tied to prevention programs. There are several public awareness programs, however, which specifically target adolescents by focusing on the frequent use of social media by this population. The CDC offers a social media toolkit, with specific messaging designed to raise awareness and prevent adolescent pregnancy. Their social medial Web site (Centers for Disease Control and Prevention 2012b) contains links to tools for specific social media include badges and buttons for Web sites and social media such as Facebook, Twitter messages which can be "retweeted" (posted for public viewing) on behalf of the CDC, podcasts, and video presentations. These publicly accessible media and awareness tools have been designed for parents, teachers, and the lay community and most are available in both English and Spanish.

Another social media approach targets developmentally appropriate health messaging that helps insure reproductive and pregnancy health. The national text4baby campaign (text4baby.org) is a public–private partnership designed to provide free cell phone text messaging through the course of pregnancy to remind parents about prenatal health and pregnancy care (nutrition and exercise, oral health, family violence, safety, mental health and substance abuse, labor and delivery) and offer advice for infant health and care (breastfeeding, infant safe sleep, immunizations, developmental milestones). States and communities may supplement the public awareness and public health messages of text4baby by providing free or low-cost cell phone access to participants.

Public awareness campaigns often serve as a bridge between prevention and support efforts. The political tensions that emerge regarding prevention of adolescent pregnancy are magnified when teenagers and young adults become pregnant. A major concern voiced by many groups is that adolescents will elect to terminate their pregnancy. However, according to data collected by the Alan Guttmacher Institute, the adolescent abortion rate (per 1,000 pregnancies) actually decreased from 43 to 19 % among 15–19-year-olds in the United States between 1988 and 2005 (Guttmacher Institute 2010). Moreover, these rates also vary across racial and ethnic groups, as well as by state. For example, in 2005, the abortion rate ranged from a low of 11 % among White/non-Hispanic adolescents to 24 % for Hispanic/Latino adolescents and 44 % for Black/non-Hispanic adolescents. Public awareness campaigns are often targeted to specific cultural subgroups in the USA, emphasizing ethnic specific messaging. Public awareness campaigns in the USA may be utilized by not only governmental agencies, but also by specific

political, religious, and social groups that wish to focus on pregnancy prevention as well as awareness of opportunities for tangible support and parenting assistance to adolescent parents. Public awareness campaigns by religious and community-based organizations may do so either explicitly or implicitly with the intent to provide alternatives to terminating a pregnancy.

Parenting Support

While a major focus of public policy in the United States is the prevention of adolescent pregnancy, parent support programs also focus on the health, psychosocial, parenting, and child welfare issues impacting adolescent parents. Similar to prevention efforts, the specific content of these parenting support programs and interventions are often targeted to the needs of local communities given the considerable variability with the United States. However, the three broad goals of health promotion, promotion of health attachment and parenting practices, and promoting the financial security and welfare of families headed by adolescent parents reach across federal, state, and community programs.

Maternal and Child Health Promotion

In the United States, the promotion of public health is a major concern for adolescent parents who have both their own health, as well as the health of their infant/child, at stake. One important initiative targeting adolescents and young adults focuses on preconception health; that is, the importance of young adults managing their own health status proactively with the knowledge that anyone in their sexual and reproductive years has the potential to have a child either now, or in the future. The US Office of Minority Health initiated the "Healthy Baby Begins with You" campaign in May 2007. This campaign enlists high school and college aged students in promoting preconception health and emphasizing health promotion activities through mentoring and peer education (http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=117, accessed December 12, 2012). An implicit health promotion goal of this program is to target racial and ethnic minority groups in the USA in order to break the historical trends of disparities in fetal and infant mortality, as well as unplanned pregnancy, in these populations.

Additional programs emphasizing maternal and child health promotion for adolescent parents are supported through the Maternal and Child Health Bureau (MCHB), a part of the Health Resources and Services Administration (HRSA). This federal agency administers the Maternal and Child Health Block Grant (Title V of the Social Security Act) to states, which supports early intervention, home visitation, as well as other health promotion efforts to reduce fetal and infant mortality and achieve positive maternal and infant health outcomes. The MCHB directly supports the Adolescent and Young Adult Health Program which aims to improve the comprehensive health, development, safety, and social and emotional well-being of adolescents and young adults in the United States (http://mchb.hrsa.gov/programs/adolescents/index.html, accessed December 12, 2012). It is important to note that for federal programs administered by the MCHB, adolescents as a group are considered a primary focus of health promotion regardless of their pregnancy status. Thus, adolescent pregnancy services are targeted to the specific developmental needs of the adolescent parent as well as the fetus/infant.

The importance of a "medical home" has also been discussed in the adolescent health literature, particularly with regard to the prevention of rapid, repeat pregnancies among adolescents which is a US public health priority. A medical home may be defined as receiving care from a specific provider or provider group familiar with the medical and human health needs of the patient. In light of the fragmentation of services often present in the current United States health care system, adolescent parents without a medical home may have to rely on

multiple providers and clinics simultaneously to meet their emergent health needs. Research on adolescent parents suggests that the promotion of medical homes may be an effective health promotion strategy in this population, particularly with adolescent parents who may lack knowledge and familiarity with community-based services (Cox et al. 2012). Similarly, alternative prenatal care, such as the Centering Pregnancy program (Klima 2003) has developed specific guidelines for adolescents in order to insure the unique health and psychosocial needs of this population are met. Many of these programs work with private managed care health insurance providers as well as the federal Medicaid health insurance program for low-income persons to insure coverage of adolescents both during and after pregnancy. Although many low-income adolescent parents may retain health insurance coverage under their State Child Health Insurance Program (S-CHIP), the availability of these benefits and age restrictions for receiving benefits may vary state by state.

Psychosocial Support for Adolescent Parents

Psychosocial support is offered jointly with maternal and child health promotion activities in the PPACA through the maternal, infant and early childhood home visitation (MIECHV) program, which is also administered by HRSA. Home visitation has been shown to be beneficial not only for promoting health but also for enhancing parenting skills and augmenting the psychosocial support for adolescent parents (McKelvey et al. 2012). The federal MIECHV program formalizes many of the home visitation programs that were separately administered by state and local governments and nonprofit organizations through a consistent evidence base, centralized funding, and targeted research and service delivery. Pregnant women who have not attained age 21 are a priority population of the federal MIECHV program, as are communities throughout the United States with disproportionately high rates of adolescent pregnancy, poverty, psychosocial risk, history of abuse, mistreatment or neglect, children with developmental disabilities and families serving in the military. MIECHV programs have been established in these designated high-risk communities across all US states and territories in order to provide targeted home visitation services that promote health, parenting, and social support.

Additional psychosocial support programs for adolescent parents are situated in state and local, nonprofit programming. Largely, these programs focus on reducing the risk for repeat pregnancy among adolescent parents, fostering positive relationships in the adolescent's family system, encouraging completion of school, and developing and maintaining economic self-sufficiency. As previously discussed, while many these psychosocial programs in the United States have historically focused on mothers, integration of the psychosocial support needs of fathers also served through these programs has increased, particularly in the past decade.

An opportunity amid the challenges faced by pregnant adolescents in the United States is the entry into a comprehensive system of interventions designed to support their health care, education, and social support. Pregnant adolescents, who may have lacked formal support resources during their own childhood, may find themselves in the midst of a support system with available resources to promote health care, strengthen opportunities to complete secondary and even post-secondary education as well as receive supportive case management and parenting support (Barnet 2012; Lachance et al. 2012). A review of support services for adolescent parents in both clinic-based and home-visitation-based programs in the United States identified 47 articles, which included a programmatic evaluation. While positive and equivocal effects were noted particularly for reducing repeat pregnancy and completing educational programs, many methodological constraints also led to a limited final analysis of the most effective programs and models (Lachance

et al. 2012). The challenge facing psychosocial service delivery programs in the United States is the development of clear linkages between the desired outcomes of the project combined with a rigorous evaluation of both the process and outcomes of these programs that can allow for between-program comparisons. This core framework for evidence-based programs and evaluation is essential to effective programs and policy, along with variability of programs to respond to the diverse needs and experiences of adolescent parents from different states, regions, communities, and ethnic groups in the United States.

Child Welfare and Financial Support

Federal support for child welfare and financial support in the United States dates back to 1935 with the passage of the Social Security Act. The Adoption Assistance and Child Welfare Act (1980) ushered in a new era of contemporary child welfare policy, largely reflected in Title IV-E of the Social Security Act. Under this policy, states are authorized federal funding and guidelines to provide child welfare services to their citizens. The child welfare provisions of the Social Security Act are permanently authorized and open-ended. Some adolescents are themselves part of the foster care component of the child welfare system in the United States. Adolescents enrolled in foster care are significantly more likely than their peers to become pregnant before age 18; one-third of female adolescents in the foster care system in a midwest study had been pregnant at least once by age 17 or 18 (Dworsky and Courtney 2010). For youth who are themselves recipients of child welfare services, the early onset of parenting poses logistical challenges in the transition from foster care recipient to head of household. In spite of these challenges, there is a concern that for some adolescents in the foster care system, the benefits of becoming pregnant before "aging out" of the system at age 18 might outweigh the costs (Dworsky and Courtney 2010).

In many states, the birth of a child emancipates minors from their parents and grants them legal status as adults. While this does not mean that grandparental support will not continue in some cases, the designation of emancipated minor is intended in order to insure that the adolescent parent is able to apply for public benefit programs that offer income support (i.e., temporary aid to needy families (TANF), nutrition and food subsidy (including the women, infant, and children (WIC) benefit program), rent and utility subsidies, public health insurance (such as Medicaid), and other services intended to provide a financial and social service safety net for the young family. The availability of and eligibility for these public benefit programs is income dependent and varies by state and locality of residence. The significant challenge faced by many adolescent parents is navigating a complex public benefit system that often requires proof of age, proof of income, and proof of residence as essential to receiving public support. In addition, a cadre of private and charitable, nonprofit organizations offer support to pregnant and parenting adolescents, including assistance with rent, food, clothing, education, and transportation. Many of these programs also have eligibility criteria which must be met in order to receive services.

Conclusion: United States Perspective of the Future of Adolescent Pregnancy

Although the United States has made great strides in reducing the rate of adolescent pregnancy, this politically and economically powerful country still lags behind global peers in responding to the full magnitude of this important issue. Future advances in research, policy, and programs are needed in order to create a comprehensive response to adolescent pregnancy that reflects the unique needs and experiences of its most vulnerable communities and citizens. Advocates of the *life-course perspective*, for example, assert that patterns of infant

mortality and health disparities cannot be eradicated without dedicated efforts beginning earlier in the life-course, such as investing in the well-being of children and adolescents who will become parents (Lu and Halfon 2003). This perspective requires a fundamental shift from conceptualizing adolescent pregnancy in the USA as a social problem affecting individuals who fail to make sound life choices, and instead, reconceptualizing the reproductive potential of children and adolescents as a collective opportunity to impact the health and well-being of future generations. From this life-course perspective, the United States may be able to advance specific goals in research, public policy, and support services that meaningfully enhance the lives of adolescents who are or may become pregnant.

Research

The United States collects extensive epidemiological and population health data, which highlights the subgroups and geographic areas in which adolescent pregnancy is most prominent. Research on the specific issues, needs, and concerns of adolescents and families in these communities is essential to understand persistent patterns of adolescent pregnancy and to determine the most effective approaches to both prevention and support. While these efforts are underway in many communities, participatory research with at-risk communities can be time consuming and costly. Thus, these initiatives will require an investment of public support both conceptually and financially. However, this process may be the necessary next step to undo the damage that has been perpetuated by persistent income inequality, institutional racism, and other historic disadvantage interwoven in the lived experiences of ethnic and socioeconomic subgroups in the United States.

Another key future direction in research, emphasized across studies, is to focus on the causal mechanisms that underscore effective prevention and support programs. While previous outcome-driven research has identified an evidence base of effective (and non-effective) programs, subsequent re-analysis of the programmatic components of these initiatives may reveal the specific elements of *behavioral change*, *motivational enhancement*, and/or *tangible benefits* that offer the most potential for successful replication. In this way, research at the community level can be enhanced by applying specific programmatic elements guided by a research evidence base, but tailoring them to the specific needs and concerns of the local communities in the USA disproportionately impacted by adolescent pregnancy.

Policy

As previously discussed, US public policy to reduce adolescent pregnancy must remain focused on evidence-based, rather than value-driven initiatives. The recent declines in rates of adolescent pregnancy need to be openly discussed as a success, along with the persistent issues and concerns that remain from a global health perspective. Essential public policies will advocate for continued and expanded access to contraception and family planning, coupled with health care reform which increases knowledge about, as well as access to, these services. Social policies can be simultaneously supportive of adolescent parents, as well as promote family planning, preconception health, and reproductive choice-making during early adolescence before the onset of sexual activity.

Adolescents in the USA are clearly surrounded by social media images that emphasize sexuality, and many of them are engaged in decisions and behaviors which may place them at risk for adolescent pregnancy. Policies which promote access to both over-the-counter and prescription contraceptives will afford adolescents the opportunity to make sound choices about their reproductive future. Public policies supporting readily available emergency contraception are also essential, given the known safety and efficacy of contraceptives such as

"Plan B" which can be taken immediately after unprotected sexual intercourse, which is more likely to occur among adolescents whose developmental age creates challenges with impulse control. Safe and legal services to terminate pregnancies that are not intended nor desired must remain a viable alternative for those adolescents who seek this option; likewise, the availability of meaningful alternatives such as planned adoption and supported kinship care should receive policy support in order to reflect the needs and viewpoints of adolescents who may become sexually active but based on their religious, cultural, and/or ethical values would not wish to consider abortion.

Programs

The future of US-based programs to prevent adolescent pregnancy and provide support to adolescent parents is contingent upon research and policy. Research can identify the causal mechanisms underscoring effective programs while epidemiologically identifying communities at risk based on adolescent pregnancy rates as well as social determinants of health, such as poverty and resource scarcity. Likewise, public policy delineates the funding streams for domestic programs and determines the directions in which tax dollars will be directed to local communities. At that stage, programs can emerge which blend research knowledge with funding priorities that can be modified and adapted to meet the unique needs and concerns of local citizens.

Programmatic organization can be complicated in the USA, but programs are essential to provide a familiar, community face to the national concern of adolescent pregnancy. Program and resource accessibility, cultural relevance, and responsiveness to the needs of individuals and families are the foundation of what is both needed and desired in communities at risk. Back to the life-course perspective, the programs that are able to target the expressed needs of a community in combination with the evidence-based changes in behavior, motivation, and tangible resources will be the programs that ultimately change the course of human health. In the United States, a diverse and affluent country still struggling with the concern of adolescent pregnancy, conceptual advances in program delivery that respond to the expressed needs and historical injustices within at-risk communities are necessary in order to meaningfully invest in the future of its youngest citizens.

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Vietnam: The Doi Moi Era and Changes in Young People's Lives

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Keywords
Vietnam: abortions • Adolescent pregnancy rate • Adolescent sexual behavior • Child mortality • Contraception methods • Maternal mortality • Premarital sex • Sexual and reproductive health education • STI/HIV • Unwanted child

Introduction

Vietnam is a small country, with an area of 331,212 km^2 in Southeast Asia. According to the census of April 2009, Vietnam had a population of almost 86 million. The average population growth rate during the period 1999–2009 was 1.2 % annually, 0.5 % less per year compared with the previous decade (Thethaovanhoa.vn 2009, August 14). Vietnam's young people, between 14 and 25 years of age, account for about one-fourth of the total population (General Statistics Office of Vietnam 2012).

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Vietnam and *Doi Moi*

In December 1986, Vietnam entered the "*Doi Moi* era." *Doi Moi* means "innovation" and refers to the fact that the government established more open economic policies and introduced an economic market mechanism to promote economic and social development. The economic changes were accompanied by social changes, which had an impact on the sexual and reproductive health and lives of young people.

After first presenting information on how norms regarding young people and sexuality were conceptualized in the more traditional culture before *Doi Moi*, we will then discuss some of the changes that have taken place in their sexual and reproductive lives since that period began. This is followed by a description of Vietnamese policies regarding young people's sexual and reproductive health and some examples of best practices in addressing this area of health care. We conclude with some recommendations on how further improvements can be achieved.

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Phu Quoc Island
Can Tho
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The Mekong Delta

Vietnam Before Doi Moi-sociocultural, religious and economic factors related adolescent sexuality and pregnancy

Relationship between men and women and women's status

Before *Doi Moi,* Vietnamese culture was strongly influenced by Buddhism and Chinese Confucianism. According to Confucianism, a woman's value is measured by four characteristics: doing housework well, a beautiful appearance, talking genteelly, and following traditional ethics.

Men and women were not allowed to have close relationships outside marriage as Confucianism states that: "Man and woman do not give and receive physically." This means that it is forbidden for men and women to physically touch one another. Another Confucian norm that influenced Vietnamese culture was that: "Before marriage, a woman must obey her father; after marriage, she must obey her husband; when her husband dies, she must obey her son." Women did not have the right to choose or decide anything during their lives, especially regarding relationships with a person of the opposite sex.

The expressions of this cultural norm can still be seen today: In rural areas, boys and girls do not play together, but in separate groups with different games. Relationships between young men and young women in society were limited. Dating before marriage was considered quite strange and not socially accepted by families and communities. Young men and women, however, could still meet at traditional festivals, such as *Hoi Lim*—a folk song festival, *Cho Tinh*—the Love Market in Sapa (Sapa is a mountainous province), and during the Lunar New Year festival.

These public events were times when young men and women could express their emotions and love. For example, a popular folk song that young people often sang at the end of *Hoi Lim* festival said: *Please don't go away. Your leaving makes me cry. Please stay here forever. If you love me, please don't meet anyone. Please wait for me.* Similar messages of love can be found in many Vietnamese folk songs.

Premarital sex and pregnancy were considered a source of great shame for both the family and the community. A premarital pregnancy was always a hot topic for any village gossip. The unfortunate girl's family would have to pay a penalty to the village with money or a buffalo and the girl would suffer a penalty of stigmatization: All of her hair would be cut off and her bare head would be painted with white lime. In many cases, the family was too poor to pay the penalty and so shamed that they kicked the girl out of the family. Children born outside of marriage were called *con hoang*, which means "wild children." They were discriminated against by communities and even by their relatives, having almost no chances of education and development and facing difficulties in getting married later in life. The men who impregnated these women were forgiven or only had to pay light penalties. The combination of heavy stigmatization and consequences led young girls to commit suicide when they had premarital pregnancies.

Although young people had some chances at public events to show their thoughts of love, young women did not have the right to make decisions about with whom they would live for the rest of their lives. In the past, women could not be involved in love, date, or have premarital sex. Their married lives were strictly arranged by their parents and the sadness of women who suffered from arranged marriages was also expressed in a folk song: *Why you didn't ask while I was single? Now I am married, like a bird in a cage, like a fish caught by a hook. How could a caught fish be free? When could the bird get out of the cage?*

In Vietnamese traditional culture, it was believed that a young girl's greatest value lay in her virtue before marriage, as reflected by the proverb "Virginity is worth a thousand in gold." It was only during the first night of the marriage that a girl could have her first approved sexual encounter. A white cotton sheet would be put under the new bride to see if she had bled during her first sexual intercourse. The two families silently paid a great deal of attention to that event as it was thought to confirm whether the girl was a virgin before her marriage. The next morning,

the newly married couple returned to the bride's family with a big tray of sticky rice and a boiled pig head. If the new bride was a virgin according to the sheet, the pig's head would have two normal ears, but if she was not a virgin, one ear would be cut and all members of the two families, as well as the community, would know this. If the new bride was a virgin, she would have a normal married life; however, if she was not "proved" to be a virgin, she would not be respected by her husband's family and her family would quietly give the groom's family many gifts. In many cases, this later led to violence against the woman (Research Center for Eastern Psychology 2010). This was the case in most circumstances, except for some ethnic groups that allowed the young couple to have sex before marriage.

Vietnam has a long history of war; the French war lasted from 1946 to 1954 and the American war took place from 1954 to 1975. During that time, love between men and women were considered equivalent to love for the nation. Vietnamese women were involved in a special kind of army called *thanh nien xung phong,* which means "volunteer youth." They built the paths and carried food and weapons to the front. Female soldiers also took care of injured soldiers, but they were kept separate from male soldiers. Almost of them were single and not allowed to have sex.

Faithfulness to the male soldiers at the front became the focus of ethics for women, not only by husbands but also by society. A soldier's wife who became pregnant in her husband's absence was a viewed as a source of serious stigma for the family, her clan, and her community. People thought that when a woman betrayed her husband who was serving in the army, she was also betraying the nation (Hong 2009).

The Importance of Family

Before *Doi Moi,* social values concerning the family were not significantly different between rural and urban areas, although family labor was not as important in urban areas. Vietnam's economy was mainly based on small agricultural cultivation of wet rice. Men and women without agricultural machinery did all of the work in the rice fields. The critical importance of a family manual labor force meant that families needed to produce a next generation. Families without children were considered unhappy (Tuyet and Tinh 1999). This was expressed in proverbs that encouraged couples to have as many children as possible: "Each child brings one luck" and "God produced elephants; he also produced grass" (i.e., there will always be resources for children to grow up).

A household with many children was rich in labor resources, and thus powerful in the community. In order to have a larger labor force, people often wed as teenagers or even younger through marriages arranged by their parents and women gave birth at a young age (Tuyet and Tinh 1999).

Having a large family was thus one of the strongest values in Vietnamese culture. Households included three or four generations living together, and the relationship among the members was strong, especially the relationships between husbands and wives and between children and their parents (Tuyet and Tinh). The following proverb taught children to be grateful to their fathers and mothers: "Father's care is as high as Thai Son Mountain; Mother's love is as plentiful as water from a water source!"

In traditional families, parents were respected and powerful. Their children were expected to obey without any discussion, as reflected by this proverb: "Fish without salt will be spoiled; children who do not follow their parents' advice are definitely bad children!"

Educational and Employment Opportunities for Adolescents Before Doi Moi

In the past, most people in Vietnam had limited opportunities for education. The number of children who could go to primary school in villages could be counted on two hands. Although people in urban areas had more chances to go to

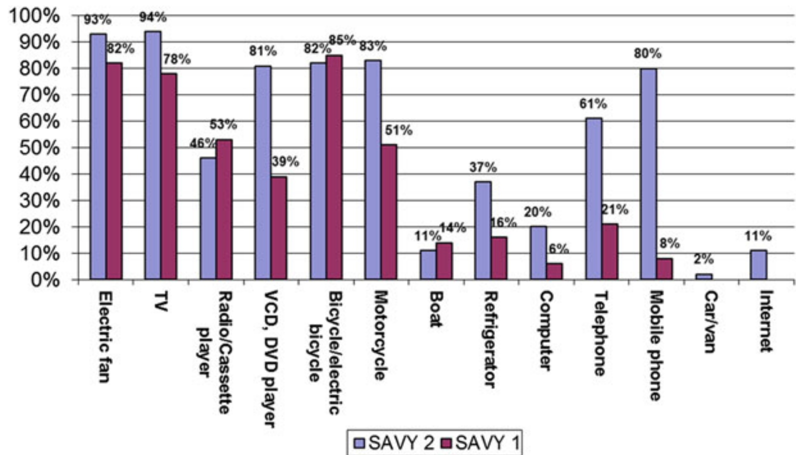


Fig. 1 Responses to the question: Does your family own the following items?

school, the number of well-educated people was small. In those circumstances, young girls—even from wealthy urban families—had few opportunities to go to school. It was believed that "Girls who were well-educated were so only to write letters to boys;" this was seen as negative and not expected by their parents.

As Vietnam's economy was mainly wet rice agriculture before the era of *Doi Moi,* people often stayed in their home areas during their whole lives. Their daily activities focused on cultivating rice and vegetable fields, raising animals, and catching fish in the coastal areas. Few people moved away for education or work and families were therefore quite stable (Tuyet and Tinh 1999).

Changing Lifestyles of Adolescents in the Era of Doi Moi

Vietnamese economy in the era of Doi Moi and its effects on young people's lives

Thanks to the policies that the country undertook during *Doi Moi,* the economy took off. Whereas Vietnam had previously run the risk of famines, it became the largest exporter in the world of pepper, the second largest exporter of rice, coffee, and cashews, and the fourth largest exporter of rubber. The textile industry and other consumer industries were promoted. Clothing and handicrafts made in Vietnam, such as ceramics, bamboo, and rattan products, began to be known in the global market. Vietnam's gross domestic product (GDP) increased every year, even when the country faced regional financial and economic crises and serious natural disasters. During the first five years of *Doi Moi,* when the old management mechanism was replaced by the new market mechanism, Vietnam's GDP increased on average 4.4 % per year. After that, Vietnam underwent a process of industrialization and modernization with the GDP increasing 7–8 % per year on average (VietBao.vn 2006, 2007).

With the development of the nation's economy, the average household income increased and quality of life improved, as families were able to purchase more commodities. This change is reflected in the results of two Survey Assessments of Vietnamese Youth (SAVY), which were carried out by the Ministry of Health and the General Statistical Bureau in 2003 and 2009 with young people aged 14–25 years who were still living with their parents. SAVY 1 surveyed 7,584 adolescents living in 42 provinces/cities (General Statistics Office of Vietnam 2005), while SAVY 2 included 10,044 youth living in 63 provinces/cities (General Statistics Office of Vietnam 2010).

During the period between the two surveys, there was a significant improvement in household property as seen in Fig. 1.

While investments in radios, cassette players, and bicycles declined, people began spending

more on television, video, and DVD players, motorcycles, refrigerators, computers, telephones, and the Internet. The popular use of communication equipment, such as television, computer/Internet, and especially mobile phones, has given people (especially young people) opportunities to access information not only from other individuals but also from national and international resources. This has had a strong influence on young people's lifestyles. Many of the changes accompanying the modern lifestyle have been positive for adolescents, such as a will to be educated, strong interpersonal links and friendship support, and openness to knowledge and new ideas, active exploration, and the willingness to take risks. In general, the older generations are worried about these changes and try hard to maintain the traditional culture, beliefs, and values. This explains the conflicts between generations in many Vietnamese families.

Adolescents and Education

In this new climate of socioeconomic development, young people have had the desire not only for education but also for educational opportunities. The government established the market mechanism and devoted more resources to education, adopting policies mandating that children go to school so that they are better qualified to participate in the growing economic opportunities. In 2008, 99 % of boys and 98 % of girls had ever enrolled in schools.

This rate was 3 % higher than that of 2003. The ever-enrolled rate was moreover not significantly different between urban and rural areas (Vietnam Ministry of Health 2012; Vietnam Ministry of Health 2006). Similarly, it was found that fewer young people were dropping-out of school. In addition, the proportion of young people taking extra classes increased significantly: 69 % in 2003 compared with 75 % in 2008. However, SAVY 2 showed that young people in urban areas have more opportunities for education than rural adolescents; the proportion taking more classes in urban areas was 83 % compared to 72 % in rural areas.

Since almost all Vietnamese children now have a chance to go to school, the literacy rate of adolescents is high—97.5 % by SAVY 2. Girls still have a slightly higher illiteracy rate than boys, 2.6 % compared to 2.4 %. Overall, as shown by the SAVY studies: "In both SAVY 1 and SAVY 2, youth appears to have good connectedness with their schools and they have positive attitudes about school environment and their teachers." (General Statistics Office of Vietnam 2010).

Adolescents and Work

Since Doi Moi began, adolescents have also had more employment opportunities. More than 50 % of adolescents have now ever been involved in work (General Statistics Office of Vietnam 2005, 2010).

In both rural and urban areas, between Kinh and ethnic minority groups, the proportion of adolescents who have been involved in paid employment increases with age.

As the country's process of industrialization and modernization continues, young people have become more mobile for education and work: 30 % of respondents in SAVY 1 and 38 % in SAVY 2 had been away from home continuously for a month or more. The average age when they first lived away from home for a month or more was about 17 years (17.3 in 2008 and 16.7 in 2003). Young men tend to leave their families to earn a living more than young women; young people in rural areas are doing so more than those in urban areas. Therefore, adolescent migration is an important factor in Vietnam's urbanization process (General Statistics Office of Vietnam 2010).

Changes in Relationships Between Adolescents and Their Families

"Family" continues to be of great value in people's lives, which also includes young people (General Statistics Office of Vietnam 2010). Within the family framework, parents still have a strong influence on their children's lives, especially regarding their children's marriages. While

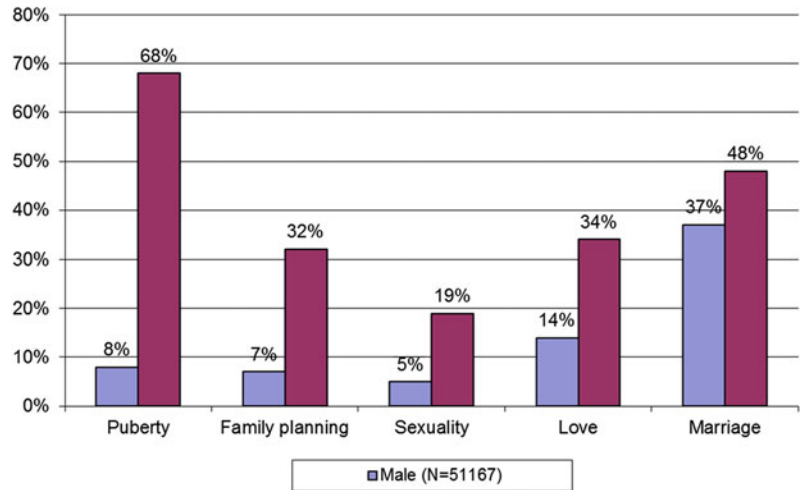


Fig. 2 Responses to the SAVY 2 question regarding listening to advice from parents and siblings on relationships and sexuality

young people today have much more freedom to choose a partner, their marriages still need approval from their parents. In contrast to other cultures, many young people in Vietnam live with their parents until they get married. After the wedding, the bride will often live with her husband's family. Some newly married couples live independently; however, the nuclear family (as defined in Western culture) is still not popular in Vietnamese culture.

In general, unmarried young people have close relationships with their parents and other family members. Parents are still powerful, but their role is not as dominant as in the past. As mentioned above, economic development has brought young people opportunities for education and work away from their parents' homes. As a result, they now also have chances to come into contact with many people and their parents' control has weakened. Norms concerning relationships between the sexes are also changing. Today, young people are free to make friends, date, be in love, and become sexually active with limited influence from their parents.

Although adolescents tend to have a close relationship with their families, they also tend not to reveal their difficulties to family members: 41 % of adolescents agreed and 29 % partly agreed with this statement in the SAVY 2 study: "When facing difficulties, you feel it is easier to talk with someone outside of your family" (General Statistics Office of Vietnam 2010).

As can be seen in Fig. 2, young women are more likely to discuss issues related to sexual and reproductive health with family members. However, both girls and boys appear less willing to talk about the more "sensitive" topics—sexuality and contraception—with their family members.

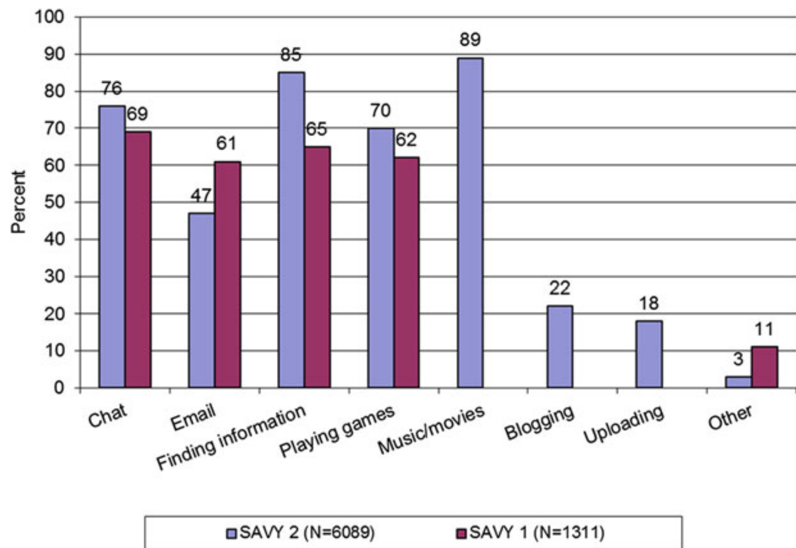
Changing in young people's sexual and reproductive since Doi Moi

Adolescents and Modern Communications Technology: The Internet

Today's young people are the first generation in Vietnam using modern communications technology in both their work and their personal lives. People can access news and e-mail not only from their computers but also from their mobile phones. Wireless connections can be found in offices, homes, and cafeterias in urban areas. Where wireless is not available, people can use Internet USB or General Packet Radio Service (GPRS) to access the Internet from their laptops and mobile phones.

Internet use has increased significantly. In 2003, only 17 % of SAVY respondents were using the Internet, but this rate jumped to 61 % in 2009. Not only the proportion of young people using the Internet expanded but also the frequency of Internet use also increased. In 2003,

Fig. 3 Responses to a question inquiring about why youth use the Internet



the average time of access was 11.7 h per month while in 2009, this average was 34.2 h per month —more than an hour per day (General Statistics Office of Vietnam 2010).

Young people use the Internet for different purposes: listening to music, watching movies, finding information, chatting, playing games, sending e-mails, blogging, and uploading information (Fig. 3). Thanks to this modern technology, Vietnamese young people have become much aware of global news, knowledge about different topics and changes in their peers' lifestyles.

Vietnamese adolescents are enthusiastically writing their own blogs, where they post-personal information, experiences, hobbies, interests, their feelings of happiness and sadness, as well as their hopes, desires and passions. Thanks to the blogs, young people are getting to know others not only based on physical appearance but also by learning about their ideas and thoughts. Some are becoming close friends and even lovers thanks to the connections made through personal blogs. This multidimensional communication possibility is also providing an opportunity for people to actively learn and share information.

The Internet is also helping people find answers to their personal questions and concerns regarding sexuality. One example: "My girlfriend and I had sex without a condom or contraceptive pills. We had sexual intercourse twice; each time, I dipped my fingertip in semen on her abdomen and then put it in her vagina to stimulate orgasm. Can my girlfriend get pregnant?" The young man received a friendly, correct answer and advice from an expert who told him that his girlfriend had a risk of an unwanted pregnancy and that she should have pregnancy test. The expert also advised them to use a contraceptive method (Tung 2011).

This modern technology also has other aspects. Sex chats and sex shows on the Internet are becoming increasingly popular in Vietnam (Research Center for Eastern Psychology 2010). Some sex workers use the Internet as a channel for their work (Teen9x 2011, Feb. 26).

There is growing concern among adults that not only professional sex workers but also high school and university students are becoming involved in Internet sexual activity. Some poor rural students practice sex chats to gain experience or as a means to get money to buy a mobile phone card. Each night, hundreds of young girls are using the Internet to show off their nude bodies with sexy movements. It is thought that many of these young women begin showing their bodies just to satisfy their curiosity; however, men wanting sex can call them or send a message asking to meet for sex at a hotel or some private place. It is known that some students from

wealthy urban families are doing this when their parents are asleep since these activities take place after midnight (Linh Tam–VNN 2010, Oct. 16).

Adolescents and Increasing Premarital Sex

Today, young people are increasingly accepting of premarital sex, most likely because they are delaying marriage as a consequence of the country's industrialization, modernization, and increased opportunities for education and work. During the young people's grandparents' time, people usually married as teenagers, but according to the 2009 National Census, the mean age at first marriage for men is now 26.2 years old and 22.8 years for women (General Statistics Office of Vietnam 2009).

The two SAVY surveys found that, over time, an increasing number of young people accepted premarital sex. As seen in Fig. 4, the percentages of young people accepting premarital sex for various reasons increased significantly in the intervening five-year period.

This change in young people's opinions is also reflected in their sexual behavior. The SAVY surveys found that, in 2003, 7.7 % of respondents (including single and ever-married adolescents) reported having premarital sex, while by 2009, this had increased to 9.5 %— although, young men tend to report premarital sex more often than young women. In SAVY 2, 13.6 % of male respondents said they had premarital sex compared with 5.2 % among the female group (the corresponding rates in SAVY 1 were 11.1 % for men and 4 % for women). It is interesting to see that the reported ages for becoming sexually active decreased with time according to the SAVY surveys: In 2003, the reported mean age for first sex was 19.6 years old (20 for males and 19.4 for females), while in 2009, this fell to 18.1 years (18.2 for males and 18 for females) (General Statistics Office of Vietnam 2005, 2010). These rates may be underestimated for the overall youth population since only adolescents who lived with their families participated in both SAVY 1 and SAVY 2.

Young Women's Reasons for Having Premarital Sex

Although young people have become more open to premarital sex, they are nevertheless still influenced by traditional culture. The idea of having sex is still linked with the idea of getting married. In both SAVY surveys, almost all married young people who had had premarital sex had done so with the person who later became their spouse.

Qualitative research by Gammeltoft and Thang (1999) gave us insights into young women's motivations for having premarital sex.

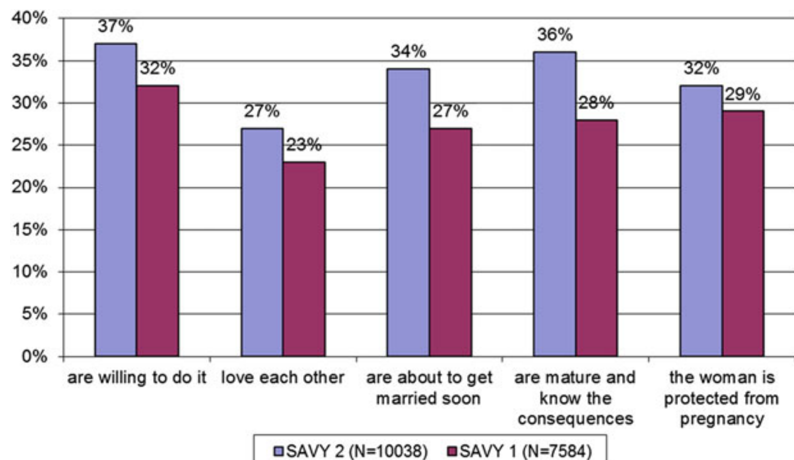


Fig. 4 Percentages of respondents agreeing that "premarital sex is acceptable if the two persons…"

They found that young girls who had unwanted pregnancies believed that they would marry the man involved, which is why they agreed to sex with their male partners. One young woman said, “We did not love each other for fun, you see, we were going to get married. He wanted us to trust each other, so he asked me to sleep with him. I thought: It is about time, we love each other, he suggests this and I trust him, so I will accept. If I had not fully trusted him I would never have done it.” Another young woman, who had a pregnancy and went to the hospital for an abortion, said, “I belong to him now so I am not going to marry anyone else.”

Having premarital sex is also a way that young women attempt to maintain a relationship with their partners. A respondent in the aforementioned study said, “Since we started having sex we have come to trust each other more, we love each other more, and we feel closer.” Another unmarried young woman said, “In my opinion, whether it happens sooner or later does not matter. The most important is that you give everything to the person you love. Whether you have sex before marriage or not is not very important.”

Not agreeing to sex is interpreted as a reason for relationships rupturing; for example, one young woman said: “My former boyfriend did all he could to persuade me, saying I was feudal and that I did not have anything (i.e., virginity), since I did not want to sleep with him. But I instead, I refused him, and then he left me, now he is with another girl who agreed to sleep with him.” Because of this experience, the young woman had sex with her new boyfriend, had an unwanted pregnancy and then went to the hospital for an abortion (Gammeltoft and Thang 1999).

Some young girls are not ready to have sex but do so to show their boyfriends that they love them. At Tu Du Hospital in Ho Chi Minh City in 2004, one of the authors counseled an unmarried young woman who had unwanted pregnancy and wanted an abortion. After being counseled about abortion and contraceptives, she said: “I feel nothing when I have sex with my boyfriend and I am really concerned about my family’s happiness in the future!” Some screening questions were raised to understand her situation. Her answers indicated that she had grown up in a traditional family. She thought that a girl should be virgin until she gets married but, despite her disapproval of premarital sex, she wanted to satisfy her boyfriend. In this specific case, the disharmony between the young woman’s beliefs and practice led to sexual intercourse without any pleasure for her.

Reasons for Adolescent Premarital Sex

Many young people also think that sexual compatibility is critically important for their married life. They therefore have premarital sex to be sure about this before getting married. A young woman in the study by Gammeltoft and Thang (1999), said, “Today it is very common for young people to have sex before marriage, because they want to see if they are compatible or not in order to avoid cases as in the past when people did not suit each other but still had to live with each other.”

Many young people still do not accept the idea of a couple remaining childless, so some young couples want to ensure that they will be able to have children when married. An unmarried young man, who was the partner of a young woman who sought an abortion at a hospital, explained: “I love her and I have decided that I will marry her, so I was curious to know if we were able to become parents or not. I was curious to see if she could have children or not, and if I could become a father” (Gammeltoft and Thang 1999).

Another young man said: “Girls nowadays love [having sex] and having an abortion is popular. I am not concerned about whether a girl is a virgin or not, but she must guarantee she can have children. That is why I would have to try ‘the goods’ before getting married. If she got pregnant, I would marry her. If not, I would say goodbye, even if I love her…” (Baomoi.com 2011).

Concerns for producing the next generation not only arise for young couples but also for their parents. One parent was quoted in an article as saying, “You can love who ever you want, but we will allow you to marry her only if she gets

pregnant. Infertility is a very common problem nowadays. Do that to be sure (you will have children)" (Baomoi.com 2011, Mar. 22).

Such parental opinions are like a green light for young people to have premarital sex even though this goes against traditional norms. In the past, couples never lived together before getting married but today song *thu* (living together without marriage) has become quite popular in Vietnam. As more adolescents leave their families for education and work and live independently with little parental control, young couples feel freer to live together. According to a study conducted by students at the Hanoi Pedagogical University in 2009, about 30 % of respondents from colleges and universities in Hanoi are involved in song *thu*. These young people fall in love but may not yet have enough resources for married life. This residential accommodation allows them to save living costs, while satisfying their sexual needs. In some cases, unwanted pregnancies are a consequence of this modern lifestyle (Thuy 2011).

Nevertheless, despite being more open to premarital sex, young women still want to be considered virgins, even if they already have had sex. This explains why hymen reconstruction, a simple surgical procedure done by trained obstetricians–gynecologists and taking only 15–45 min, is a service chosen by many young girls, especially in big cities such as Ha Noi and Ho Chi Minh City: (Hong Ha Polyclinic "virgin forming" surgery).

Adolescent's Knowledge About Pregnancy and Contraceptive Methods

The SAVY 2 study found that almost all Vietnamese youth (93 %) had heard about pregnancy and contraception from a variety of sources, such as television, newspapers/magazines, radio, commune/ward loudspeakers, friends, spouses, family members, relatives, teachers, health/population workers, the Internet, counseling centers, and clubs (Fig. 5). The majority of young people received information related to contraceptive methods from television (65 %) and newspapers/magazines (47 %). However, the information given via these mass media channels are often not detailed enough, especially on television. Only a small proportion of young people in the study learned about pregnancy and contraceptive methods from family members, counseling centers, clubs, and the Internet sources that might provide more appropriate and detailed information.

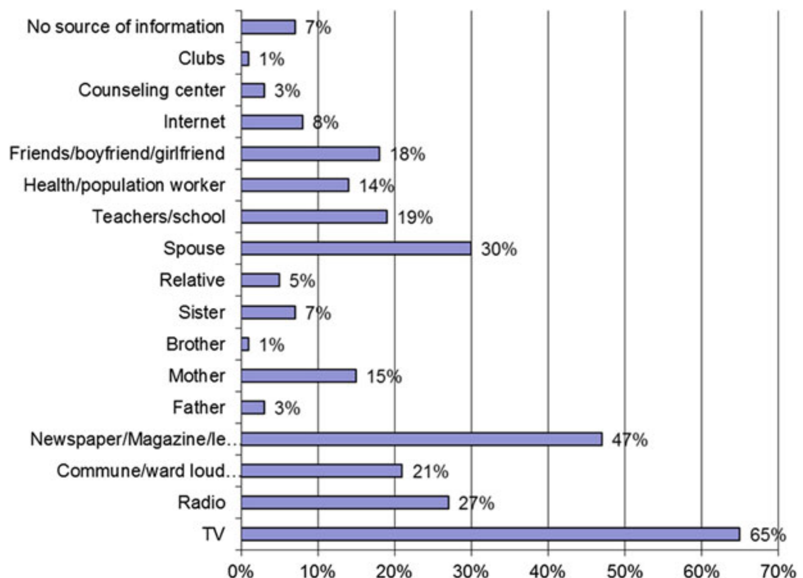


Fig. 5 Percentages of SAVY 2 respondents receiving information about pregnancy and family planning from different sources. For siblings as a source of information, the percentages for "brother" and "sister" were calculated only for those adolescents who had such siblings. The same holds true for the source of information "spouse."

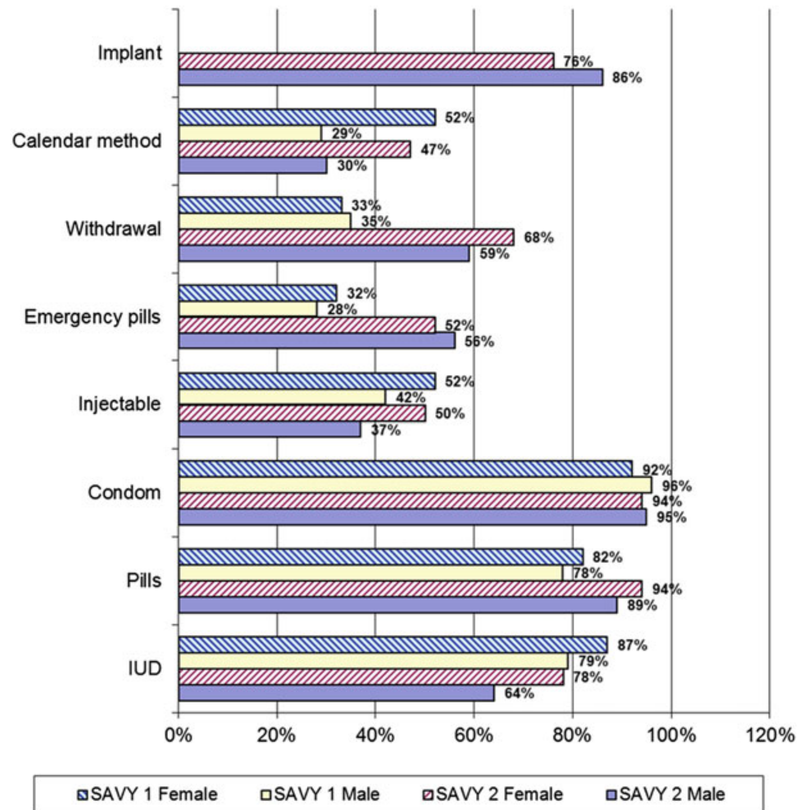


Fig. 6 SAVY respondents' knowledge of contraceptive methods

Although there are large gaps in the sexual and reproductive health knowledge of adolescents, sexual and reproductive health education is not part of the official program in Vietnamese schools. This important topic is now beginning to be introduced in schools but only to a limited extent as part of biology studies. There are some specific sexual education programs but these are only found at schools in project areas (Que 2009) (Fig. 6).

Compared to SAVY 1, young people involved in SAVY 2 had better knowledge about contraceptive methods, except the IUD. Female adolescents seemed to have better knowledge about contraceptive methods but, interestingly, males knew more about implants than females.

The two contraceptive methods best known among adolescents were condoms (95 %) and contraceptive pills (92 %). Other methods known by some adolescents were withdrawal, the calendar method, emergency contraceptive pills, injectables, and the IUD (General Statistics Office of Vietnam 2005, 2010).

The main sources of young people's information about pregnancy and contraception may explain why knowledge in this field is inadequate for a sizeable percentage. In SAVY 2, only 71 % of the respondents answered, "yes" (67 % men and 74 % women) to the basic question: "Can a young girl become pregnant the first time she has sex?" In response to the question, "If you wish to avoid pregnancy, what should you do?" only 82 % of the respondents (83 % men and 81 % women) selected the option "use contraceptive methods." In SAVY 1, only 30 % of respondents gave the correct answer for the question about which time in the menstrual cycle has the highest likelihood of resulting in pregnancy and the percentage was even lower in SAVY 2, 13 % (7 % men and 18 % women). In general, the young people living in urban areas, who had a higher education level and who were older had better knowledge about pregnancy and contraception than those in rural areas, with lower education levels and younger age. In SAVY 2,

Table 1 Knowledge and attitudes concerning condom use as percentages of respondents

	SAVY 2 (%)		SAVY 1 (%)	
	Male	Female	Male	Female
Condoms reduce sexual satisfaction	45	31	76	64
It is costly to use condoms regularly	18	24	26	33
Condom use helps to avoid pregnancy	95	95	99	98
Condom use helps to avoid STIs	95	93	98	97
Condom use helps to avoid HIV	95	92	98	96
Women carrying condoms are morally problematic	34	25	61	47
Men carrying condoms are morally problematic	30	28	55	51
Condoms are only for sex workers or unfaithful persons	17	15	34	26
Number of respondents	5115	4928	3475	3471

female adolescents tended to give more correct answers than males (General Statistics Office of Vietnam 2010).

Adolescent's Attitudes Regarding Contraceptive Methods

Although young people today are more accepting of premarital sex than previous generations, pregnancy and contraception remain topics that they are not willing to openly discuss. Less than half of the SAVY 2 respondents (47 % women and 37 % men) had ever talked to someone about these topics. Those who lived in urban areas had higher educational levels and older age was more apt to have done so (General Statistics Office of Vietnam 2010).

Contraceptive method use, especially condom use, appears to be strongly influenced by young people's beliefs. There is a belief, for example, that condoms are not only a barrier between two bodies; but also a barrier between two souls. As sexual intercourse is considered the highest expression of love, many young people are not willing to use condoms. As one young woman said: "If you love each other and have sex using a condom, you do not get anything from each other, do you? It is as if you are just a machine for him to use. You don't feel that you belong to each other anymore; you just feel like a human machine. He wants to have sex, pleasure, and just wants to be relieved, so he takes you. When he is finished, he does not think about you anymore. With the condom, he does not feel anything anymore… I think condoms are only for those who are having sex for pleasure" (Gammeltoft and Thang 1999). However, the SAVY surveys did find that over time young people's ideas and attitudes related toward condom use became more positive, except regarding condom use for pregnancy and HIV/STI prevention (Table 1) (General Statistics Office of Vietnam 2010).

Another belief that is strongly linked with the use of contraceptive methods is the idea that a woman who uses a daily contraceptive method is preparing for sex, meaning she is not pure. As a consequence, some young people do not use contraceptive methods despite their contraceptive knowledge. A young man said, "I have never thought about contraceptive methods. They are not for me, because I don't plan to have sexual relations before marriage… It just happens because I cannot control myself, I cannot think… When I come to her house to visit her, I don't plan to have sex, I don't think about this beforehand. I only come to see her and talk, or perhaps we go out somewhere, but I don't come to her to have sex" (Gammeltoft and Thang 1999).

Another belief preventing contraceptive use among adolescents is that by doing so means that the young person does not trust his or her partner and that there is no true love between them. As one young person explained: "When you love each other, you rarely use contraception. If men plan beforehand to have sex, they may take precautionary measures. But we didn't, we love

each other; we were going to marry. I think that if you love each other, you shouldn't try to avoid the results of love, so I never thought of contraception. We both felt that if you think of using contraception, it is proof that you do not fully love each other" (Gammeltoft and Thang). Such beliefs even prevent young people from practicing withdrawal as a prevention method: "At that moment, if you tell him to put it outside, it is as if there are no feelings, as if you are just doing it for fun. If you want to, you can say it beforehand, but while you are having sex you don't want to say anything… If you are having sex and then say, `put it outside,' it will spoil the pleasure. It will be awkward and it will feel as if you don't truly love each other" (Gammeltoft and Thang).

The high value placed on virginity for girls also means that there is a belief that men can demand sex while women must be passive; a girl who takes an active role, e.g., suggesting what to do, would be considered impure. A young man said, "Girls are rarely active in sex… For me, it is a question of gender equality. I think it is ok if the girl is active, depending on her needs. But most men don't like it; they are afraid that if she is active, she will be active in relationships with other men as well." Passivity in sex also means that girls should not prepare for sex, e.g., using contraceptive methods. Another young man said, "If you are together with a girl for the first time and she asks you, 'do you know of a way to prevent pregnancy?' Then she is a girl who knows how to think and has good morality. But if she gives you a method of contraception, such as a condom, then of course her morality is not good; only dancing hall girls do that" (Gammeltoft and Thang).

In addition, despite a willingness to engage in premarital sex, young people still are influenced by the belief that sexual intercourse is an activity for married couples: "We did not use condoms because we are not married, so we did not prepare for that. It would be very irrational to arrange for it, because we are not married, so we cannot have sex regularly," a young person said (Gammeltoft and Thang).

Adolescent Access to Reproductive Health Counseling and Contraceptive Methods

According to the SAVY 2 survey, about two-thirds of young people have good access to reproductive health counseling and care, while about 33 % face access barriers to these important services. Although the majority of adolescents can easily access reproductive health services, however, many health care providers are influenced by traditional beliefs and do not have positive attitudes toward adolescents who seek such care. Young people who participated in a Youth-Friendly Services (YFS) Project by acting as mystery clients reported that they were treated in an unfriendly manner and were not provided with sufficient information or good quality care (de Bruyn 2003).

According to the SAVY 2 survey, 95 % of respondents knew where to get condoms, with this knowledge again being higher among females, as well as urban, more educated and older adolescents. This high rate of knowledge is undoubtedly due to the fact that in Vietnam, condoms, and contraceptive pills can be bought easily at pharmacies without a prescription. There is also a network of community-based family planning volunteers, "population motivators," who provide condoms and contraceptive pills freely to people in their villages. However, they only provide these supplies to married couples and not to unmarried adolescents. People can also get contraceptive methods such as IUDs, condoms, contraceptive pills, and injectables at Reproductive Health Centers at the provincial and district levels and at Community Health Centers at the commune level, although there is a prohibition on providing unmarried women with IUDs (Vietnam Ministry of Health 2009). Concerned about side effects, health care providers tend to provide only two kinds of contraceptive methods to unmarried people, condoms and contraceptive pills, so that contraceptive choice is limited for many adolescents (Gallo and Yee 2006).

Maternity and Newborn Care for Adolescent Mothers

Vietnam has strong safe motherhood and newborn care programs. Health care providers are trained in prenatal care, birth attendance skills, postnatal care, newborn care, and vaccinations. Vietnam also has a strong public health network at the community, district, provincial, and central levels. During the period 2000–2010, maternal mortality was reduced significantly from 100 per 100,000 live births in 2000 to 68 per 100,000 live births in 2010, with 92 % of pregnant women having at least three prenatal exams and 94 % having deliveries attended by trained health workers. The infant mortality rate also decreased from 36.7 % in 1999 to 15.8 % in 2010, with 89 % of newborns receiving health care at home (Vietnam Ministry of Health 2011). Nevertheless, there are no specific programs that support teenage mothers and children born to this adolescent group.

Abortion and Unwanted Babies Among Adolescent Girls

In general, it is not difficult for Vietnamese women to access safe abortion services since by law abortion is available upon request until 22 weeks' gestation. Women can go to different public health facilities for abortion services: ob-gyn hospitals, ob-gyn departments of general hospitals, reproductive health centers, and in some communes, health centers for early pregnancies up to 6 weeks' gestation. For gestations up to 12 weeks, abortions can be done using manual vacuum aspiration (MVA), which is quite popular in Vietnam. For gestation up to 9 weeks, women have another choice as well: medical abortion using the combination of mifepristone and misoprostol. For gestations from 12 to 22 weeks, two safe abortion methods can be applied: dilatation and evacuation (D&E) and medical abortion using a combination of mifepristone and misoprostol or misoprostol alone (Cu Le et al. 2004; Vietnam Ministry of Health 2009). Several studies have found that young unmarried women prefer medical abortion since it is more private, does not involve exposure of the body on the surgical table, does not involve abortion instruments, and is similar in nature to a miscarriage (Ganatra et al. 2004).

Abortion Among Adolescents and Unmarried Young Women

Each year, Vietnam reports about 500,000 abortion cases taking place in the public sector (Vietnam Ministry of Health 2012), however, the number of abortions is higher as some pregnancies are terminated in the private sector. This reported number of abortions is about 2.5 times lower than the number reported in 1992 when Vietnam had its highest number of abortion cases (Khe 2006). A study in 2004 reported that 40 of every 100 pregnancies ended in abortion (Gammeltoft and Thang 1999), compared with 22 in 100 pregnancies as reported in the 2002 demographic and health survey (Committee for Population, Family and Children [Vietnam], and ORC Macro 2003).

Of these abortion cases, about 15–33 % occur among adolescents and unmarried young women. According to studies in 2003 and 2006, abortions among adolescents and unmarried young women accounted for 20–30 % of total abortions, while a UNFPA study in 2007 stated that this percentage was 15 % (UNFPA 2007). An evaluation workshop for the Reproductive Health Program in 2008 reported that more than 116,087 abortions were performed in the public sector in Ho Chi Minh City, with 25 % of cases involving unmarried young women and 20 % adolescents. These rates had increased by 5 % compared to 2007 (Research Center for Gender, Family and Environment in Development 2009).

Why do Adolescents Decide to have an Abortion?

As Vietnamese culture still does not generally approve of premarital sex, her family, relatives, or community will not accept a young unmarried

girl who gets pregnant. When a couple cannot marry without parental approval, an abortion becomes the only means of avoiding a child outside marriage. A young female farmer in a study by Gallo and Nghia (2007) explained: "I do not know why my parent has insisted prohibiting me from marriage with him. My parent took the reason that he has no land, no house for me to live." Another young woman who came to hospital for an abortion said, "Vietnamese society is still very feudal. If an unmarried woman has a child it is very shameful for her family. People will say her parents could not bring her up properly, it is something very serious" (Gammeltoft and Thang 1999).

In other cases, young women decide to end pregnancies for educational or employment reasons. With better education, young people are now aware that they can only raise a child well if they have achieved a certain level of prosperity. Therefore, if they do not yet have those conditions, they may decide to end a pregnancy, as shown by the following statements:

> We have not finished our studying yet and it will be long before we can support ourselves. In general, in order to take care of a child you have to have very good conditions so that you do not have to worry about anything, and you have to have the finances to give it what it needs. We had not prepared anything, neither mentally nor materially so we were forced to… We would feel it very regrettable if we could not bring it up to be healthy and to be like other children (Gammeltoft and Thang 1999).

> If I gave birth, I would have to quit my studying. I could not do both, having a child and studying, at the same time (Gallo and Nghia 2007).

> My boyfriend wanted to keep it, but I prefer to get rid of it, because I need to study more, and I need a stable life. I think everyone have a thought like mine. I do not think I have good condition to raise a child (Gallo and Nghia).

> I did not decide to get aborted. I wanted to keep and get married at the moment. However, only some days later, I knew that I could be eligible for work in abroad. Abortion is compulsory. I will say goodbye to my boyfriend and he agrees that (Gallo and Nghia).

Some young women decide to have abortion because they do not love the men with whom who they had sex or their relationship has broken down. A young unmarried girl in one study said she was seeking an abortion because she felt hopeless about her relationship with her boyfriend: "He is a businessman, unmarried, Vietnamese American. He gets back to Vietnam only once or twice a year. We had chatting or telephone before. Now I cannot contact him, could not reach him by phone" (Gallo and Nghia).

Why are Adolescent Girls More Likely to have a Late or Unsafe Abortion?

Vietnamese women generally have abortions early in pregnancy: about 70 % of abortions are at a gestation of 8 weeks or less (Vietnam Ministry of Health 2012). Nevertheless, unmarried young women more often access abortion services later in pregnancy. Gallo and Nghia (2007) found that 53 % of women who had second-trimester abortions were unmarried.

The reasons why unmarried young women have late abortions are varied. First, they do not believe that they can get pregnant because they have sexual intercourse rarely or irregularly. In addition, many of them have irregular menstrual periods, so they do not become aware of the pregnancy until later in gestation (Gallo and Nghia 2007). As shown in the SAVY surveys, many young girls do not know the signs of early pregnancy and they do not talk about this sensitive topic with anyone (General Statistics Office of Vietnam 2010). For example, a 14-year-old girl from a poor family in Dak Lak, a mountainous province in the South, was raped and became pregnant but was not aware of it. As the pregnancy advanced, her family members did not recognize it either until it was too late for an abortion. On her due date, she was accompanied to the district hospital to give birth but she was too young and small for a normal delivery. She was therefore referred to Tu Du Hospital in Ha Noi where she gave birth via a cesarean section to a baby weighing only 2 kg. Her grandmother,

who had accompanied her, asked the hospital to keep the baby since her family could not raise him (Duc 2007).

Second, as young women have little or no experience regarding reproduction and do not talk about this with others, it is difficult for them to take decisions about keeping or ending a pregnancy. Their hesitancy in making the decision means that they delay accessing abortion services if they decide not to carry the pregnancy to term. Furthermore, many unmarried girls hope for marriage but do not receive approval for this from one or both families involved. In some cases, the young men change their minds and do not want to get married anymore (Gallo and Nghia 2007).

Third, is a lack of financial means to pay for an abortion. By the time they have collected enough money, their pregnancies are already advanced.

A fourth reason for late abortions is that young women often try to hide their unwanted pregnancies, which makes it difficult for them to get permission to leave school or work in order to go the abortion facility (Gallo and Nghia 2007).

Unsafe abortions are related to the unfriendly attitudes of abortion providers who disapprove of premarital sex, which causes young women to seek out clandestine untrained providers. During a visit to a hospital in Thai Nguyen, a province in valley area in the north of Vietnam, one of the authors met a young unmarried woman who had an unsafe abortion. She had two earlier pregnancies while waiting to be married and terminated these at a hospital. When she became pregnant a third time, her boyfriend's family did not support the marriage and he abandoned her. Since her pregnancy was advanced, she felt ashamed and was afraid to go to a public hospital where abortion services are not private and providers are not nice to unmarried women. She therefore went to a quack, who inserted a wooden stick into her cervix, with about 5–6 cm sticking outside the vagina. When the abortion had not happened by the third day, she returned to the quack, who replaced the wooden stick with a new one. After returning home, she developed a fever, which increased in gravity until a family member noticed and took her to the hospital. She was treated with a high-dose antibiotic infusion and the abortion was completed, saving her life but leaving her future reproductive capacity in question.

No official research has been done regarding the complications and consequences of unsafe abortions, such as heavy bleeding, STIs, and infertility, but a study in 2002 found that unsafe abortions contributed to 11.5 % of Viet Nam's maternal mortality (UNFPA 2007).

Unwanted Babies Born to Unmarried Young Women

While most unmarried pregnant women in urban areas can access abortion services as needed, those in rural areas have more difficulties, especially when they are young and poor. When unmarried young women cannot access abortion services, they give birth to children who are often unwanted. Given the stigma attached to extramarital pregnancy, these young women do not receive financial or psychological support from their families, communities, schools, and places of work.

In these circumstances, some girls try to hide their unwanted pregnancies and give birth in unclean areas and abandon newborn babies there. Some of the infants die; others suffer from serious diseases and injuries. In other cases, women abandon their newborn babies at hospitals and pagoda gates or in streets or toilets.

According to Dr. Cam Ngoc Phuong of Nhi Dong 1 hospital, the number of abandoned infants has been increasing with time: "Most of mothers who have abandoned their children are at school age; some of them are just 13–14 years of age. At Hung Vuong hospital, 60–70 infants are abandoned every year. At Nhi Dong 1 and Nhi Dong 2 hospitals, about 80 infants are abandoned a year (Research Center for Gender, Family and Environment in Development 2009). At Tu Du hospital—the largest ob-gyn hospital in the south of Vietnam—308 infants were abandoned there in 2005. Nothing is known about the mothers who abandoned their babies because they gave false addresses for registration and left the hospital suddenly. Almost all of the

abandoned babies are first raised at the hospitals or pagodas. Then, they are given up for adoption or transferred to orphanages when they are strong enough (VietBao.vn 2006, Jan. 16).

In July 2006, the case of one abandoned baby generated a great deal of discussion among the mass media and Vietnamese general public. He was born in the mountainous district of Quang Nam, a province in the south of Vietnam. The three-day-old infant was found with serious injuries in a garden, where he had been attacked by an animal and lost his right leg and sex organ. Emergency care and surgery at Quang Nam provincial hospital saved his life. The police found the baby's mother, with newspapers reporting that she was young and poor. After leaving the hospital, the baby was cared for by his grandparents in poor conditions. Finally, at the age of six months, he was adopted by a generous family in Ha Noi and received a lot of national and international humanitarian aid (TienPhong.vn 2011, April 3).

Vietnamese Policies on Adolescent and Youth Reproductive Health

Given the importance of adolescents and youth for national development, Vietnam has adopted various policies designed to protect these age groups, including policies on adolescent reproductive/sexual health.

Based on the results of the SAVY studies, the government developed the *National Strategy on Youth Development* for 2011–2020, which includes in its general objective the development of ethics, a healthy lifestyle and living skills, and good physical and mental health (Vietnam Ministry of Home Affairs 2012). The Vietnamese Ministry of Health had earlier formulated a *National master plan on the protection, care, and promotion of adolescent and youth health for the period 2006–2010 and strategic orientation until 2020*. Adolescent reproductive health is a focal point in the master plan objectives: "To maintain and promote the physical and mental health of young people. Specifically, to improve and increase access to quality health care services, especially for sexual and reproductive health and prevention of STDs and HIV/AIDS, to reduce unwanted abortion, to prevent accidents and injuries, to decrease the prevalence of substance abuse, and to reduce mental health problems." The targets for 2010 included a "reduction in the number of unwanted pregnancies among adolescents and youth by 30 %" and a "reduction in the number of new HIV infections among adolescent and youth by 30 %" (Vietnam Ministry of Health 2006).

In the *Strategy on Population—Reproductive Health in Vietnam for the period 2011–2020,* adolescent reproductive health is one of ten objectives: "To improve the reproductive health of adolescents and youths in order to reduce by 50 % both the pregnancy rate and abortion rate in this group; ensure at least 75 % of RHC service providing facilities offer adolescent- and youth-friendly services by 2020" (Vietnam Ministry of Health 2011).

In 2007, Vietnam's Ministry of Health, with support from the World Health Organization, Save Children Fund US and other UN and NGO agencies, had developed *Guidelines for Providing Adolescent and Youth Friendly Reproductive Health Care*. The guidelines give detailed instructions on how to establish a YFS center, including kinds of services, types of information, and indicators to measure the quality of services (Vietnam Ministry of Health 2007).

In the National Guidelines for Reproductive Health Care Services (2009), adolescent reproductive health is one of the eight covered service areas. These detailed guidelines include the following: general guidance, anatomic and physio-psychological characteristics during adolescence, life skills related to reproductive and sexual health of adolescents and youth, safe and healthy sexuality, counseling on reproductive health for youth/adolescents, menstruation and ejaculation in adolescents, reproductive health examinations for adolescents and young adults, and contraceptive methods for adolescents and young adults (Vietnam Ministry of Health 2009). Vietnamese law considers children born to single mothers to be equal to children born to married couples (News 24/7, 2009, Dec. 10). However, there is no specific policy or program supporting single mothers and their children.

Best Practices in Vietnam on Adolescent Reproductive Health

Intergrating Youth Friendly Services in Reproductive Health Projects - PathfinderInternational, EngenderHealth, Ipas and Vietnam Ministry of Health 2004-2011

The Reproductive Health Projects (RHPs) was implemented in Vietnam from 1994 to 2011 in 16 provinces. Originally, RHPs worked mainly with health care providers in the reproductive health network to improve the quality of care. From 2004 on, young people integrated YFS into the original projects at 28 sites in order to provide services for young people through public reproductive health care settings and increase the utilization of YFS. The YFS were piloted at six sites in one big city, and one province to gain experience; lessons learned were then scaled up to the other 22 sites in 14 cities/provinces. The original health facilities were renovated with separate spaces for adolescent clients—"Green Question" areas—using local funds.

Strategies included improving staff attitudes toward adolescent, enhancing the client perspective in relation to young people, creating separate spaces for adolescent clients, improving client flow to ensure privacy and confidentiality, emphasizing counseling and IEC to promote safe behaviors, establishing service hours convenient for adolescents, and involving the adolescent in determining the services. YFS services were promoted to target populations through social marketing, community outreach, and non-health facilities to create networking. At the same time, other activities were conducted at schools and in communities, such as student/teacher training, peer education, provision of simple services through community centers, bookstores, pharmacies and hotline counseling.

Large numbers of adolescents were reached with promotional messages through the mass media and schools. Adolescent participated in designing and implementing activities and evaluating YFS, which increased friendliness of services and ensured integration of the adolescent's perspectives into YFS (Pathfinder, EngenderHealth 2011).

Chat Project-Online Counseling on Sexuality, HIV/AIDS, and Reproductive Health for Adolescents-CCIHP/CIHP

This Internet project has been conducted since May 2003 using the following approaches: addressing sexuality from a healthy sexuality perspective; promoting sexual and reproductive rights of young people; promoting gender equity; involving adolescents in designing, implementing and evaluating services; and providing counseling with quality, privacy, anonymity, and low cost.

This Web site was designed specifically for adolescents and young people to include a Web site introduction, news, reproductive health, sexual health, HIV/AIDS, seeking friends, self-discovery, forums, online counseling, e-mail counseling, questions–answers, feedback, and Web site evaluation. Web site members can share their thoughts at "Visitor writes," a part of the main page. Young people further actively participate in this project through writing for the Web site, moderated forums, and off-line meetings organized by themselves and by the project.

The project is also connected to other programs such as: a gender-based violence project in Cua Lo town, Nghe An province; hosting psychology students' practice; co-organizing a "Careers Forum" for psychology students at the Institute of Psychology; organizing counseling programs for young workers in industrial zones, students, pupils in Ha Noi, Ho Chi Minh City, Da Nang, Thai Nguyen, Yen Bai; and training peer educators in Ho Chi Minh City for the Youth Union.

As seen in Fig. 7, the number of registered users has increased significantly each year. During the Web site's first month, there were only 70 hits per day; this number reached 100 per day during the third month. Now, the Web site receives 30,000 hits per day.

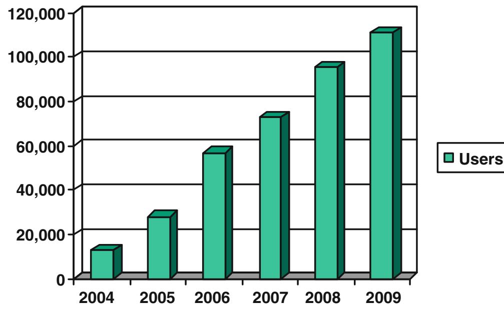


Fig. 7 Number of registered users for the Chat Project Web site

Both male and female adolescents are very interested in this Web site, but the number of male users is almost double than that of females (66 % male compared with 34 % female). The age group of, 16–24-year-olds comprises 57.5 %, followed by the group older than 24 years (38.2 %). Teenagers younger than 16 years of age accounted for 4.3 % of the registered users.

Online counseling is provided 21 h per week, while e-mail counseling is available 24 h per day. As seen in Fig. 8, young people have shown most interest in reproductive health and psychological issues (CCIHP 2008).

Migrant Worker Health: Marie Stopes International in Vietnam (MSI)

The 2009 census reported that Vietnam has 6.6 million internal migrants. The majority of them are young, increasingly single females. The aim of the Migrant Worker Health project is to address the sexual and reproductive health care needs of young migrant workers by providing high quality, accessible, sensitive, and friendly reproductive health services. Since 2005, MSI Vietnam has worked with manufacturers, including Adidas, Pou Yuen, Abercrombie and Fitch, to provide services in both factory and community settings.

The MSI model is client-focused with services provided through different channels including: clinic networks serving migrant worker communities, a network of franchised “Blue Star” private clinics, and mobile clinic services at factories. MSI motivates migrant workers to access services using mechanisms such as pay-per- result voucher schemes and discounted prices. In addition, MSI has trained peer educators who provide sexual and reproductive health information in a sensitive, culturally appropriate, and confidential manner (Marie Stopes International 2010).

Adolescent Friendly Services: Ipas, Youth House, Vietnam Feature Film Studio and students from eight universities and colleges in Hanoi, 2003

This project comprised three parts. In the first part, a group of 21 young students were selected from eight universities and colleges in Ha Noi to receive seven educational sessions related to gender and gender equality, safer sex, pregnancy prevention, unwanted pregnancy, safe abortion, HIV/AIDS and STIs, client rights, and living

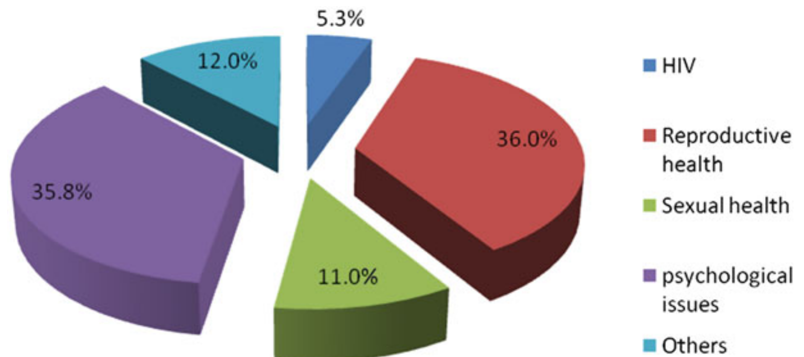


Fig. 8 Topics addressed in counseling through the Chat Project

skills. In the second part, this group of students visited five public clinics and hospitals as mystery clients to learn the real situation about reproductive health services provided to adolescents. At the same time, they received instruction in basic drama skills.

In the third part, based on their own experiences, the students developed scripts that deal with unwanted pregnancy, problems that adolescents often face when assessing reproductive health services and their expectations. The students selected one script and produced it as a drama, ultimately presenting the play to a group of health care providers, policymakers, and representatives of NGOs and UN organizations. An open discussion followed the performance. A video recording done during this stage was used in YFS training courses to sensitize health care providers and to motivate attitudinal change toward adolescents and unmarried young people in order to improve the quality of their reproductive health services for adolescents (de Bruyn 2003).

Conclusions and Recommendations

As shown above, Vietnamese adolescents are now influenced both by modern life and by traditional culture. They are better educated, more technologically savvy, and an increasing number are living independently from their families for some time. In comparison to the pre-Doi Moi era, young people are becoming sexually active at an earlier age (including outside marriage) but they do not yet have sufficient knowledge in relation to safe sex and contraception, which leads to a high number of pregnancies.

Despite their increased independence and acceptance of premarital sex, adolescents are still close to their families and usually accede to parental influence regarding pregnancy and marriage. Premarital pregnancies are not approved; so unwanted pregnancies often end in abortion. Because of various barriers, unmarried young women tend to access abortion services late in pregnancy may seek clandestine (and unsafe) abortion care, or give birth, and then abandon the newborn babies.

Comprehensive Sexuality Education

In order to reduce unwanted pregnancies among unmarried young women, greater efforts must be made to educate adolescents regarding healthy sexuality, gender equality, reproductive rights, safer sex, and pregnancy prevention. Key messages would include the following:

- The importance of gender equality and women's right to participate actively in sexual relationships and decision making,
- The need to use modern contraceptive methods to prevent unintended pregnancies and use of barrier methods to avoid HIV/STI transmission,
- Use of emergency contraception to prevent unwanted pregnancies,
- Recognition of signs of early pregnancy and the need to seek safe abortion services as early as possible.

Adequate knowledge, positive attitudes, and appropriate skills for ensuring safer sex can be provided to adolescents and young people through varying communication channels: schools, peer education, family communication (implying a need for parental education as well), the mass media, and counseling by qualified health and other staff.

Since most Vietnamese children and adolescents attend primary and secondary school integrating reproductive health education into school as well as college curricula would be an important step in improving young people's reproductive health knowledge and practices. Supplementing life skills education in the educational sector with activities in other settings, including media used by adolescents such as the Internet, would require cooperation and collaboration among schools, families, communities and social agencies such as the Youth Union, Women's Union, and Farmers' Union.

Youth-Friendly Services

The influence of traditional culture in preventing the implementation of YFS has presented an obstacle to young people's access to contraceptive and safe abortion services. There is a

continuing need to train health care providers and coach them in changing their attitudes and behaviors toward adolescents and unmarried adolescents as part of the national strategy to provide YFS. Since young people only go to the health sector when they already have a problem, such as unwanted pregnancies or STIs, both male and female adolescents should be encouraged to attend counseling and services. A major aim of counseling should be to help young people choose appropriate methods to prevent STI/HIV and unwanted pregnancies and know how to use them correctly.

Since young people often shy, they may prefer to go to more private clinics for reproductive health services, including contraception and abortion. While the government is committed to the public health sector, little attention is given to the private sector. To ensure that young people can receive high-quality reproductive health services at any clinic they access, health care providers in the private sector must be trained on provision of YFS. A monitoring system to manage the quality of reproductive health care in both sectors should be established and maintained at different levels of the health system.

Social Marketing as an Educational Tool

Although agreement could be reached in Vietnam on the need for comprehensive sexuality education and youth-friendly services, implementation of these programs faces challenges in reality. First, as mentioned above, apart from the sexual education programs that received aid from international organizations and which were limited to certain schools, sexuality education has suffered from a shortage of trainers nationwide. As sexuality is a very sensitive topic, it must be appropriately addressed in programs by experienced educators, but the number of qualified trainers in this area is currently low.

Second, the provision of youth-friendly services is still more theory-rather than practice-oriented. Many reproductive health-care facilities in the public sector have offered Youth-Friendly Service Corners, but most of them do not attract adolescent clients. Factors contributing to this include barriers formed by health-care providers' negative attitudes and behaviors, a shortage of human and infrastructural resources, and a failure to connect or link up these public reproductive health-care facilities with schools, colleges and universities. Many students do not know such services are offered at the reproductive health-care centers. For those who are aware of them, they may not access the services due to concerns about their privacy and inconvenient hours of operation.

Given these circumstances, other means should be identified/to facilitate good communication channels with adolescents. Social marketing is a public-health tool used to help improve people's knowledge, attitudes, beliefs and practices through the use of marketing principles and practices (Schiffman et al. 2001). For example, to address adolescent abortion rates, a social change campaign could be initiated to change adolescents' erroneous beliefs about unprotected sex. Lessons can be learned from good examples in other countries. Such as a campaign in South Africa that helped promote condom use among college students in Durban (Purdy 2006). Another example comes from DKT Indonesia, a social marketing enterprise that successfully increased overall condom sales by 22% after 3 years (2003–2006) by creating a condom brand for youth with the slogan, Fruity, Fun and Safe (Maharaj and Cleland 2006).

Availability of Contraceptive Methods

Currently, only two contraceptive methods are provided to unmarried adolescents, condoms and contraceptive pills. National policies should be updated, based on recent international evidence, so that health care providers are trained to also provide injections, implants, hormonal pads, hormonal rings, and the IUD to young women. In addition, since emergency contraceptive methods can help reduce unwanted pregnancies, counseling should be given on this contraceptive method along with prescriptions so that young people who are sexually active have a backup pregnancy prevention method.

Improvements in Abortion Care

As mentioned above, some adolescents and unmarried young women prefer medical abortion methods, as they are more private and similar to a natural miscarriage. This safe abortion technique should be provided widely as a choice for women who have unwanted pregnancies, including adolescents and young women.

Although medical abortion is now included in national standards and guidelines for reproductive health and medical training, more training courses are needed as well as the establishment of a coaching and monitoring mechanism to ensure good quality of care.

While most reproductive health centers link abortion and contraceptive services, abortion care at the majority of hospitals is still isolated from other reproductive health services. Abortion care providers should be able to refer women to services related to domestic and sexual violence, HIV/STI testing and support, and reproductive tract infection diagnosis and treatment (e.g., Pap smears).

Education on sexual orientation and gender identity

Finally, one area that has been largely neglected thus far in relation to adolescent sexual life is education and counseling on sexual orientation. Education on sexuality must address sexual orientation other than heterosexuality from a human rights perspective and the needs of lesbian, gay, and transgender young people must be addressed in policies and programs.

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Postscript 7–5–13

In the chapters of this volume, there are lessons we can learn and possible solutions we can test. These chapters offer examples of different philosophical, political, and programming efforts, and the impact they have on adolescent sexual and reproductive behavior. It can also be observed in these chapters that *claim–makers*, which too often shape the public perception and response to adolescent pregnancy, are powerful influences that have to be considered.

Adolescent pregnancy is often characterized by claim–makers, as a careless, problematic behavior among individual adolescent girls that threaten the social and economic order. The public, for the most part, views adolescent girls who become pregnant as breaking with the "natural cycle of life," which dictates that pregnancy and motherhood or fatherhood is an experience restricted exclusively to adult life. Despite this type of philosophy, the reality is that children and adolescents need accurate sexual education to be able to protect themselves from sexual missteps and exploitation both within and from outside of the family unit.

An observation that seems counter intuitive to many is the paradox that teaching sexuality can reduce the rate of STIs, unintended pregnancies, and can reduce the rate of abortions among adolescents. Accurate knowledge about female sexuality and available contraception can reduce an adolescent girl's risk of an unintended pregnancy and of being infected with an STI. Moreover, sexual education is a necessity if girls and young women are to take control of their reproductive lives. In modern society, girls and women must have control of the timing and number of children they give birth to. Ignorance is not bliss, when adolescent girls are deprived of sexuality education. Ignorance puts these adolescent mothers and their offspring at high risk of serious physical and emotional harm.

If we assume that a child has rights and that these are inalienable rights, one right is access to sexual and reproductive health information and services. A foundation on which to build a rational response to adolescent sexual experimentation and behavior, at this point, seems to be a rights–based construct of sexual and reproductive health that truly enshrines a female's right to prevent an unwanted pregnancy, to plan a pregnancy with her partner should they wish, to make a decision concerning the outcome of a pregnancy, to terminate that pregnancy safely should she wish, and to access nondiscriminatory prenatal and postnatal care should she take the pregnancy to term. A rights–based approach to sexual and reproductive health also means that girls and young women should not be penalized in their vocational, economic, and social roles because of their reproductive status. While there are still many obstacles and challenges associated with "adolescent pregnancy," rights–based legislation offer a rational platform on which to develop policy and programming.

There is much work to be done. We must normalize sexual experimentation and sexual expression among adolescent girls while

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providing educational, economic, and occupational opportunities for girls who wish to delay childbearing. Likewise, modern society must reinvent motherhood as an institution that does not totally depend on marriage or females establishing a union with a male who accepts financial responsibility for the mother and child. Governments must provide support for adolescent girls and young women who wish to have a child or children as single mom. To normalize adolescent parenthood, government must provide financial support for the mother and child, educational support, childcare, and education on child development and child rearing.

While some countries unmistakably do a better job–providing sexual and reproductive health services to their adolescent citizens than others, what is clear from these chapters is that the worldwide decline in adolescent pregnancy did not result from a public policy or programming options. The rapid decline in adolescent pregnancy worldwide was driven by the accelerated increase in mass communication and the realization among adolescent girls worldwide that social changes have increased their career opportunities, and thus their life choices. Given these realities, the next logical step is to design public policy and programs that support the aspirations of adolescent girls as they go through sexual and reproductive development, on their journey to adulthood.

Finally, we wish to express our thanks to the professionals who try to separate fact from fantasy in their efforts to provide best practice sexual and reproductive health services in a nurturing and adolescent friendly manner. Most of all, we wish to express our gratitude to the adolescent girls who have taught us once again that there is much we can learn from each other.

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