GIRLS NOT BRIDES | The Global Partnership to End Child Marriage

Thematic brief | December 2021

SUPPORTING MARRIED GIRLS, ADOLESCENT MOTHERS AND GIRLS WHO ARE PREGNANT

With 90% of adolescent births taking place within the context of marriage[1], adolescent pregnancy[a] and child marriage[b] are closely linked.

PICTURED: A group of friends after participating in life skills classes facilitated by Janaki Women Awareness Society, Terai Region, Nepal. Building life skills, networks and agency is key to girls' wellbeing, particularly if they are pregnant or young mothers. Photo: *Girls Not Brides*/Thom Pierce

Married adolescent girls and girls who are already pregnant or mothers have unique needs which health care, education and social services systems are often not set up well to meet. Responses to adolescent pregnancy to date have been heavily focused on prevention and maternal health, ignoring broader sexual and reproductive health and rights (SRHR), and the psychological and socio-economic consequences of adolescent pregnancy. Prevention efforts therefore need to be implemented alongside initiatives that address the wider needs and rights of girls who are already pregnant or mothers.

This brief explores these needs, shares examples of successful approaches from around the world, and calls for holistic responses to support married girls, pregnant adolescents and adolescent mothers to be integrated into existing strategies to address education, child marriage, adolescent pregnancy and adolescent health more broadly.

1. Why it is important to think about child marriage and adolescent pregnancy together

Every year 12 million girls marry before the age of 18.[2] Child marriage has many overlapping causes but is primarily driven by unequal gender norms which deprive girls and young women of their sexual and reproductive rights, and limit their life choices.[3] Every year 12 million girls aged 15 to 19 – and 770, 000 girls under 15 – give birth in low- and middle-income countries.[4]

In many contexts, **child marriage drives adolescent pregnancy** because married girls are under intense social pressure to prove their ability to have children.[5] On the other hand, **adolescent pregnancy can act as a catalyst for child marriage**, because unintended pregnancy can create pressure for girls to enter into unions with the father of the child, leading girls to marry earlier than they otherwise would have.[6]

In **South Asia the majority of adolescent pregnancy takes place following marriage.**[7] In sub-Saharan Africa[c] and Latin America and the Caribbean, **pregnancy happens both within and outside formal marriages and unions**, and is therefore both a cause and consequence of child marriage.[8]

Globally, adolescent birth rates have decreased by about a third since the 1990s.[9] Adolescent birth rates today are highest in West and Central Africa, Southern Africa and LAC, at 108, 95 and 61 births per 1,000 girls aged 15-19 respectively. The global average is 41 births per 1,000 girls.[10]

Pregnancy among girls aged 10-14 is much less common than pregnancy among older adolescents, and occurs most frequently in sub-Saharan Africa.[11] **Very early pregnancy is often the result of sexual violence,**[12] **and is strongly associated with child marriage and poverty.**[13]

The disruption to sexual and reproductive health (SRH) care caused by the COVID-19 pandemic is already estimated to have led to an additional **1.4 million unintended pregnancies** among women of all ages.[14] The impact on child marriage is likely to be greater: **10 million additional girls are expected marry** by 2030 due to the pandemic.[15]

Key messages:

- The majority of adolescent mothers globally are married girls.
- Adolescent pregnancy may occur *before* or *after* a girl enters a marriage or union.
- In **South Asia**, almost all adolescent mothers are married girls.
- In **Latin America and the Caribbean** (LAC) and **sub-Saharan Africa**[c], adolescent pregnancy takes place both within and outside of marriage and unions.

2. The specific social, developmental and health needs of adolescent mothers and girls who are pregnant

Adolescent pregnancy is rightly recognised as a major public health issue. Pregnancy and childbirth are both significantly riskier for girls under the age of 20, and pregnancy- and childbirth-related complications are consistently among **the leading causes of death for adolescent girls globally.** While girls under the age of 15 face the greatest increased risks, pregnancy in this age group remains relatively rare, and up to **99% of maternal deaths among women aged 15 to 49 occur among adolescent girls aged 15 to 19.**[16] The children born to adolescent mothers are also more likely to have health issues, including low birth weight, poor nutritional status and an elevated risk of under-five mortality.[17]

Adolescent mothers – particularly those who are married – are also likely to experience **rapid, repeat pregnancies** which further endanger their health and that of their babies, as limited space between pregnancies increases the risk of complications.[18]

Much of the focus on adolescent pregnancy to date has therefore been on prevention strategies, and to a lesser extent on adolescent girls' lack of access to appropriate maternal health care. However, **there is increasing recognition that the focus on maternal and child health has neglected the other needs and rights of married girls and adolescent mothers.**[19]

This section explores common experiences of adolescent mothers which require policy and programmatic responses.

[a]Adolescent pregnancy is pregnancy to a girl aged 10-19.

[b]In this brief, we use the term "child marriage" to refer to all forms of child, early and forced marriage and unions where either party is under the age of 18.

[c]*Girls Not Brides* generally avoids the use of the term "sub-Saharan Africa" due to its racial and colonial connotations, and lack of specificity. However, we use it in this brief to reflect the available data and evidence, which refers to sub-Saharan Africa as a geographical region.

PICTURED: Girls at primary school in Samburu, Kenya. Kenya has taken steps over recent years to repeal policies that ban pregnant girls from the classroom. Photo: *Girls Not Brides*/Thom Pierce

Disruption to education

Adolescent pregnancy often means the end of a girls' education; **up to 4 million girls drop out of school every year due to pregnancy in sub-Saharan Africa alone.**[20] Girls may get pregnant or married and then choose to drop out, or they may be pushed out by policies that explicitly or implicitly ban them from the classroom.[21] As adolescent pregnancy is often highly stigmatised, it is often considered inappropriate to have a pregnant girl in the classroom, as she is perceived as setting a bad example to other students.[22]

Other common obstacles adolescent mothers face after childbirth include lack of awareness of school re-entry policies, lack of school flexibility, financial difficulties, lack of parental support, lack of affordable childcare and prevailing discriminatory attitudes on the part of teachers, administrators and fellow students.[23] For example, in the Dominican Republic, which has one of the highest rates of adolescent pregnancy in Latin America, girls find it almost impossible to continue with their studies due to inadequate support and judgemental attitudes on the part of teachers and other school staff.[24]

In South Asia, social norms, low quality education and limited female labour force participation contribute to the **perception of marriage and motherhood being the only viable option for girls and women**, and girls typically drop out of school to get married and then become pregnant, with marriage and education viewed as incompatible.[25]

Impact on future life prospects

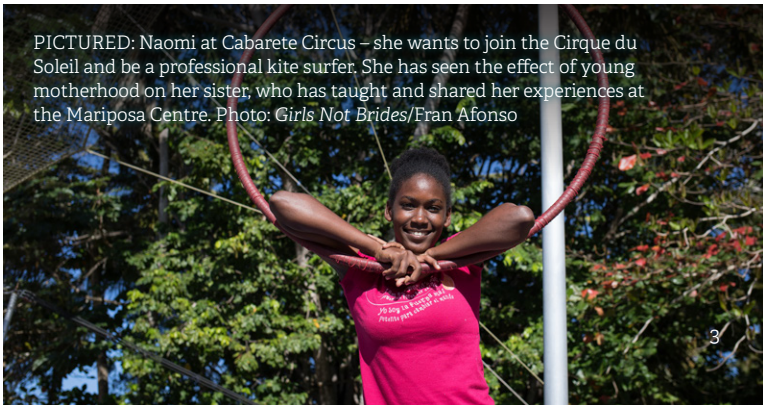
In middle- and lower-income countries young women are less likely to be in paid employment than their male counterparts, and more likely to work in insecure, informal jobs.[26] Adolescent pregnancy compounds that disadvantage. Evidence from 22 countries in Asia, Africa and LAC suggests that adolescent mothers are more likely to be in employment with **limited cash-earning potential throughout their working lives.**[27]

The daughters of adolescent mothers are more likely to become adolescent mothers themselves, **pushing adolescent mothers and their children into a cycle of poverty.**[28] Adolescent mothers who have experienced rapid repeat pregnancies face additional challenges returning to school or work as they have more caring responsibilities than girls and (young) women who only have one child.

Due to social norms related to premarital sex and children being born outside of marriage, unmarried girls who are pregnant or mothers often experience a high level of stigma from parents, teachers, families, religious leaders and the wider community.[29] Pregnant girls may be forced out of the parental home,[30] or pressured by parents to get married to avoid the dishonour of a pre-marital pregnancy.[31]

In LAC and sub-Saharan Africa, adolescent mothers are often **abandoned by the fathers of their children**, who may deny paternity or simply be unwilling to take on the responsibility of fatherhood, which can lead girls to seek further informal unions or engage in transactional sex.[32]

In South Asia, adolescent pregnancy usually takes place after entering into a child marriage and rather than carrying stigma, in fact is often seen as the **most appropriate life path for a respectable adolescent girl.**[33] However, adolescent pregnancy and child marriage may still lead to social exclusion in these contexts, as girls are often withdrawn from school and their peers, and made to stay at home under the influence of their partner's family, with restricted **freedom and mobility.**[34]



PICTURED: Naomi at Cabarete Circus – she wants to join the Cirque du Soleil and be a professional kite surfer. She has seen the effect of young motherhood on her sister, who has taught and shared her experiences at the Mariposa Centre. Photo: *Girls Not Brides*/Fran Afonso

Gender-based violence

Adolescent pregnancy is frequently the result of **rape, sexual coercion or sexual abuse of a minor,**[35] particularly when the girl is under the age of 15. Despite their vulnerability and age of consent laws which criminalise sex with minors, adolescent mothers who have experienced sexual violence are often not provided with adequate psychological support, referrals to social support services or access to justice.[36]

Women who gave birth as adolescents are also more likely to **experience intimate partner violence** throughout their lives.[37] In South Africa, adolescents who have been pregnant are more likely to report physical partner violence (47.2%) than those who have not (16.8%).[38]

Reproductive coercion and the violation of sexual and reproductive rights

Many adolescent mothers **report that the decision to have a child was not made by them**, in violation of their reproductive rights.[39] Reproductive coercion can take the form of pressure from a partner or a partner's family for a married girl to have a child, the hiding of contraception or refusal to allow a girl or woman to use birth control.[40] Sexual health care providers **may also refuse to provide contraception to married girls** who have not yet had children, due to myths about its impact on fertility. Similarly, unmarried girls may be denied access to contraception due to provider attitudes about pre-marital sex.[41]

Pregnancy as a result of rape leads to **forced motherhood** in contexts where access to safe abortion is restricted,[42] a clear violation of a woman's right to decide if and when to have children.

Impact on mental health

Adolescent pregnancy is associated with increased risk of mental health issues, including depression, anxiety and suicidal thoughts.[43] Stigma, the experience of rape or incest, economic hardship, abandonment by partners and the experience of forced marriage are all thought to contribute to mental health issues among adolescent mothers.[44]

Forced motherhood due to reproductive coercion and lack of access to safe abortion is a source of distress for women of all ages. In El Salvador and Guatemala there is evidence that unwanted pregnancy is driving pregnant adolescent girls to take their own lives.[45]

In the case of very young adolescents, particularly where the pregnancy is the result of rape, the girl may not understand that she is pregnant until the pregnancy is advanced, leading to a significant level of trauma.[46]

Despite this, adolescent mothers – including those who have experienced sexual violence – are often not offered the psychosocial support they need.[47]

Adolescent pregnancy and HIV

In East and Southern Africa, where rates of infection are high among adolescent girls, **HIV overlaps strongly with adolescent motherhood.**[48] The double impact of adolescent pregnancy and an HIV diagnosis can be particularly overwhelming as girls have to simultaneously navigate the challenges associated with new motherhood and initiation onto lifetime HIV treatment, and potentially the stigma associated with both adolescent pregnancy and HIV.[49]

Poor maternal, reproductive and neonatal health outcomes

Despite pregnancy being significantly riskier for girls under the age of 20, **adolescent mothers are less likely to access maternal health services than older women.** Unwanted adolescent pregnancy creates the need for safe abortion services, and restrictive abortion laws mean that pregnant adolescent girls frequently turn to **clandestine, unqualified abortion providers** who put their health and even lives at risk. To learn more about the barriers adolescent girls face accessing youth friendly maternal health care and safe abortion, see *Girls Not Brides*' Child marriage and maternal health brief.

PICTURED: Pamela – surf instructor at the Mariposa DR Foundation – watches the girls surfing in Cabarete, Dominican Republic. The Foundation has a health and wellness centre and access to a psychologist. Adolescent pregnancy is associated with increased risk of mental health issues.
Photo: *Girls Not Brides*/Fran Afonso

3. Towards a holistic approach to reaching and supporting adolescent mothers and girls who are pregnant, and supporting them to build their own agency

As shown above, adolescent mothers and girls who are pregnant have complex needs that go beyond maternal and neonatal health. They need support to return to school, access economic opportunities, navigate their new role as mothers, access SRH care, and access justice and support services where their pregnancy is related to sexual violence.

The ultimate responsibility to uphold adolescent girls' rights lies with national governments. To meet the needs of adolescent mothers and those of their children, policies to support them should be integrated into existing national strategies for education, child marriage, adolescent pregnancy and adolescent health more broadly.

Multi-sectoral recommendations

Both Jamaica and Guyana have detailed multi-sectoral policies to support the reintegration of adolescent mothers into the school system,[50] which include the creation of mechanisms to identify adolescent mothers and girls who are pregnant and to refer them to other services, including counselling and maternal health services. While neither have been thoroughly evaluated, these policies are examples of promising practice that can be replicated elsewhere. We call for the implementation of the following multi sectoral policies and programmes to be implemented:

- **Create referral and tracking mechanisms** between the health, education and child protection systems to identify pregnant adolescents in school and refer them to appropriate maternal health, support and child protection services.
- **Create safeguarding policies in schools** to refer girls to appropriate child protection and psychosocial support services where the pregnancy is the result of rape or the father is an adult.
- **Track adolescent girls who have left school due to pregnancy** and actively reach out to girls after birth to facilitate reintegration into school.
- **Combine access to education, health and child protection services with community-based programmes** to lessen the stigma associated with adolescent pregnancy and motherhood and build girls' agency.

Case study: *Reencontrandome* programme in Mexico

Reecontrandome ("Finding myself again"), was a Mexican programme that aimed to address the multiple needs of adolescent mothers and to build their agency to make plans for the future.[51] The programme used a multipronged approach:

- it built support networks for adolescent mothers;
- ran workshops to build their skills and agency to support return to school, gain employment, and learn about SRHR;
- trained SRH care providers on adolescent SRHR, and monitored the availability contraception.
- identified cases of sexual violence and referred girls to appropriate services.

By the end of the programme:

- The proportion of girls using contraception increased by over 30%.
- The proportion of girls who reported communicating assertively with their partner increased by 33%.
- The proportion of girls either attending school or in paid work increased by 40%.
- The proportion of girls who reported having a support network they could rely on increased by nearly 70%.

Education sector recommendations

Many countries – including Jamaica and Guyana and 26 countries in Africa – have adopted re-entry policies to ensure that pregnant adolescents and adolescent mothers can remain in the school system.[52] While few of these policies have been evaluated, many respond to known barriers faced by pregnant adolescents and adolescent mothers and aspects of these policies should be replicated elsewhere. We call for the implementation of the following policies and programmes:

- **Remove all policies that explicitly or implicitly ban pregnant girls and adolescent mothers from the classroom** and offer girls the flexibility to pick up school where they left off.
- **Support girls to balance their caring responsibilities with education**, for example by establishing childcare facilities near to schools and offering adolescent mothers flexible school hours.
- **Provide in-school psychological support** to adolescent girls in the form of counselling.
- **Provide financial support** to adolescent mothers to attend school. For example, Mexico, Dominican Republic, and Costa Rica offer scholarships to support adolescent mothers to return to school.

- **Conduct sensitisation and values clarification** with teachers and other school staff on the rights of adolescent girls to complete their education free from stigma.
- **Provide referrals to sexual and reproductive health care**, including youth-friendly contraception and safe abortion.
- **Provide comprehensive sexuality education** to all high school students.
- **Ensure adequate funding, implementation and evaluation of existing return-to-school policies** to strengthen the evidence base for what works.

Social support sector and community-level recommendations

As well as access to education and health care, pregnant adolescents and mothers need support navigating the challenges of becoming a first-time parent, and to build their agency and life skills. We call for the implementation of the following policies and programmes:

- **Deliver comprehensive community-based programmes** that build adolescent girls' agency, life skills and knowledge of maternal and reproductive health.
- **Build support networks and safe spaces** so that adolescent mothers and pregnant girls can share their experiences and help each other to cope with stigma and isolation.
- **Engage husbands and partners** in parallel programming to promote couple communication, use of contraception, responsible fatherhood and to reduce domestic violence.
- **Engage the wider community** including adolescent girls' parents, in-laws, teachers, and community and religious leaders, on the needs of adolescent mothers and on young people's sexuality, to reduce stigma and change social norms.
- **Target adolescent mothers in programmes to support the transition from school to work,** and offer social protection in the form of cash transfers for adolescent mothers who are looking for work.

Case study:

USAID's First Time Parents project provided a holistic package of interventions for first time mothers and fathers in Nigeria, Burkina Faso and Tanzania. It combined learning about maternal and child health, contraception, and gender equitable relationships with building support networks for first time mothers, and engagement with the wider community. Both first time mothers and fathers under the age of 25 participated, and by the end of the project improvements in couple communication, use of contraception, birth spacing, and division of house-hold and parenting tasks were observed.[53]

Health sector recommendations

Ministries of health should prioritise improving health outcomes for pregnant adolescents and adolescent mothers by increasing the budgetary allocation for adolescent sexual and reproductive health care – and for adolescent health more broadly – and by working with the education and social sectors to implement the following changes to policy and health care delivery:

- **Remove any legal barriers** preventing pregnant adolescents from accessing maternal health care, HIV services, contraception, and safe abortion.
- **Provide both married and unmarried adolescent girls with post-partum contraception** so they can delay and space future pregnancies.
- **Urgently conduct sensitisation and values clarification exercises with sexual and reproductive health care providers** to change attitudes towards adolescent mothers and inform them about their sexual and reproductive rights.
- **Create reporting mechanisms for cases of pregnancy resulting from rape.** Offer victims of rape appropriate medical care, including the morning after pill and Prep where appropriate.
- **Consider implementing special maternal health centres for high-risk pregnancies** in rural areas where rates of adolescent pregnancy and sexual violence are high. In Nicaragua, "maternal houses" provide access to maternal health care and a safe for space for girls and women with high-risk pregnancies in rural areas where access to maternal health services is otherwise challenging.[54]
- **Implement community outreach services to reach the most marginalised girls** through home visits and telephone consultations. Telemedicine is particularly important in the context of the COVID-19 pandemic which has created additional barriers to accessing health care.
- **Combine the delivery of health care with community engagement** on comprehensive sexuality education and sexual and reproductive health and rights, focusing on adolescent mothers, their parents and husbands/partners, and the wider community.

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NINETY PERCENT OF ADOLESCENT BIRTHS TAKE PLACE WITHIN THE CONTEXT OF MARRIAGE

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