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Review Article

Teenage Pregnancy: A Latin-American Concern

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Abstract

Teenage pregnancy, in the context of social healthcare and gender equity, exemplifies the multiple vulnerabilities and deficiencies in children and teenagers' rights. Accordingly, this phenomenon may be qualified as one of the most complex and dramatic problems in Latin-America's present healthcare.

In 2013, the teenage fertility rates in Latin-America was 73.2 per thousand, which compared with a 48.9 at a worldwide level, and the 52.7 in developing countries reflects a series of ethical, educational, socio-economic and territorial inequities within these territories. Unfortunately, this situation is related to an early sexual initiation, teenagers' behavior, a lack of information and comprehensive sexual education, alcohol and drug use at early ages and to the lack of preventive measures for single and repetitive teenage pregnancies and associated risk behaviors by most of the Latin American healthcare system.

Keywords: Teenage pregnancy; Inequity; Adolescent behavior; Drug consumption; Contraception; Abortion

1. Introduction

Adolescence is a transitional period characterized by accelerated body changes that are often not correlated to psychosocial maturation. This circumstance depending on the environment leads to the maintenance or even the increment of teenage pregnancy rates in many Latin-American countries during the last 15 years. It is important to note that this condition does not exclusively depend on the chronic deficit in socio-sanitary and educational policies in those countries.

Teenage pregnancy (TP) may occasionally be the secret aspiration to constitute the own family, but in other cases, the exposure of a hidden abuse sustained over time. The feelings of impotence and invulnerability, added to the hegemonic masculinity installed within Latin-American societies, lead teenagers to expose themselves to circumstances that may endanger their integrity (drugs, tobacco, alcohol, early and/or non-consensual sexual relations) with no use of contraceptive methods [1]. Adolescents exhibit different bio-psycho-social changes that are independent of his /her affective-emotional growth; however, this does not indicate that they are prepared to take on parenting responsibilities. The increase in sexual activity in teenagers and the reduction in the sexual initiation age have been recognized at worldwide level, which, inevitably leads to a growth in pregnancy rates among youngers [2]. Departing from these concepts, TP has been defined as the one that takes place within the transitional teenage stage, which represents multiple vulnerabilities and deficiencies in the rights of children and adolescents including a series of bio-psycho-social risks and additionally, a lack of effectiveness in the health and gender equality policies [5].

The teenage fertility rates (TFR) (15-19 years old) in South-America, with a ratio of 73.2 per thousand, stands out for being the highest, compared with a 48.9 at a worldwide level, and the 52.7 in developing countries. This figure practically duplicates the numbers worldwide, being only overtaken by Africa [6]. These differences remained practically unchanged in the last dacades [19]. In the Southern Cone countries, the TFR remains stable, except for Brazil and Uruguay, with a rate of 64.8 and 52.8 per thousand respectively, which reduced their numbers in the last years [6,19]. On the other hand, Argentina has shown sustained TFR (69.6, 65.6, 64.9 in 2011, 2012 and 2013 respectively), being the highest rates at present time in the Southern Cone. This figure represents 117386 teenage mother deliveries (114125 born from mothers aged between 15 and 19 and 3261 under 15) [6,11]. It is noteworthy that these indices of motherhood under 15 have no improved in the last 20 years. These data are relevant taking into consideration the increment of maternal and fetal complications and that some of these pregnancies are the result of child sexual abuse, forced relations or sexual exploitation of minors [16,22].

This situation is favored by the adverse life conditions, the limited access to health services, late or inadequate pre-birth control, malnutrition or drinking alcohol, exclusion of the educational system, deficient family backing and accompaniment, among others [22]. Consequently, TP reveals unprotected sex, unwanted pregnancy and unsafe abortion [22] being one of the most complex and dramatic problems in public health in developing countries. The aim of this review is to detect the most important facts that avoid lowering TP rates in Latin-American countries during the last decades.

1.1 Teenage pregnancy as a reflexion of inequity

Teenage pregnancy contributes to hallmark the extreme social inequities (gender, sanitary, cultural, educational and economical) that characterize each region [27].

1.1.1 Ethnic and cultural inequity: Cultural traits, social and economic origins, conditions of living and reproductive behaviors are some of the major determinants in the maintenance of the rates in TP among indigenous adolescents [6]. The rates of Indigenous adolescent mothers, between 15-19 years old in Latin-American varies from country to country.

Compared with Caucasian adolescents, Paraguay shows the highest rates of indigenous adolescent mothers with a 97.9%, followed by Brazil with a 59.1% and Argentina with a 37.7% [6]. Otherwise, indigenous adolescents from Bolivia, Guatemala, Ecuador and Nicaragua had a deeper unsatisfied need of family planning than non-indigenous. These indigenous had less probabilities of receiving sexual education due to the low school assistance, which leads situations of discrimination and stigmatization [27].

1.1.2 Socio-economic inequity: In Latin-American countries, critical differences are registered in the rate of teenage pregnancy according to the socio-economical strata they belong to. It is noteworthy that in Paraguay, the number of mothers that belong to low economical strata doubles the number of mothers that belong to a medium economic class and triples the number that belongs to high strata. In Brazil, the fertility rate in low strata is higher than 126 per thousand women, 31 in medium strata women and just 8 per thousand in the high ones [6]. According to the Argentinian Magazine of Sociology, up to 49% of the teenage mothers live in substandard housing, 53% do not have social security, in relation to a 27% that do have [18].

The concept of "reproductive dynamics of poverty" [18] identifies the significant psycho-social and economic behavioral differences in male and female teenagers that lead them to an early sexual initiation, that feeds back the same pattern that deteriorates the social groups of lower socio-economical levels. This also represents an asymmetric exercise of human rights and basic reproductive rights, which ends up reflecting an unwanted maternity experience, which is more frequent among teenage women belonging to the poorer levels [18].

The socio-economical level and the social security system coverage are directly proportionally. According to Argentina's Health Ministry, in 2012, 63% of the teenage mothers in Argentina did not have social security [18].

1.1.3 Territorial inequity: There is a significant regional disparity among the different Southern Cone countries. Analyzing rural or urban housing, the TP rates and deliveries are much lower in urban areas. In 2014, according to the Argentinian Ministry of Health, the highest indices have been described in the North regions ranging from 2.5 to 5.1 [7].

Expressed in actual numbers, in Tucumán (North-West Argentina) where the largest number of babies born alive in 2016 were registered, 20% of those babies were born from mothers under 19 representing a total of 5451 births [21].

1.1.4 Educational inequity: Most of the adolescents becoming pregnant in the Southern American countries were out of the educational system when they got pregnant (75%, 40%, 55%, and 71% in Paraguay, Brazil, Argentina, and Uruguay respectively). According to Georgina Binstock and Mónica Gogna, 36% of the pregnant mothers just studied, 19% just worked and 9% worked and studied when getting pregnant. Nevertheless, more than half of them (55%) were out of the educational system during the first trimester of pregnancy and, the ones that did not attend to school had not completed secondary school.

In one Argentinean survey about the living conditions during childhood and adolescence (2011-2012) the jurisdictions with the higher rates of fertility showed as well the higher percentage of adolescent mothers with an educational level below the expected [11]. Accordingly, the Argentinian Ministry of Health, in 2012 informed that in the year 2010, the 19% of the mothers, aged 14 to 17, had no instruction or had the primary level and, 33% had completed primary level as a maximum not completed at the moment of their first pregnancy [19]. And in the National Youth Survey, 2014, 30% of the youngsters between 15 and 29 years old who abandoned their studies, did it because of the pregnancy and, 56% of the mothers with secondary school incomplete, do not have a job and are no longer looking for one [30].

2. Adolescent behaviour and risk factors

2.1 Psychoactive substances usage and TP: The World Health Organization recommends total abstinence of alcohol in adolescent dependence group to under 18 years old, for the later they start using them, the smaller is the risk of addiction during adulthood. Despite this fact, it is still widely consumed by male and female adolescents as a proactive substance with effects in the central nervous system, with the capacity of altering perception, state of mind and behavior, determines negative socio-sanitary effects. 46% of secondary school teenagers consume alcohol during weekends.

According to the Secretary of drug addiction prevention and struggle against drug trafficking, in 2014 in Argentina 70% of young people consume alcohol, 65% energy drinks, 35% tobacco, 15.9% marijuana, 3.8% cocaine and 3.5% solvents [9-11]. The related facts identified were: multigenerational households, an under-25-year-old household head, non-stable unions, parents with incomplete secondary studies, having an accident within the last year and the association to misuse of other substances [10].

Different studies in Latin-American countries reveal similar data. In Peru in 2015, it was informed that from the 204 secondary students between 13 and 15 years old, 87% consumed alcohol and 83.8% had sexual intercourse, showing a significant statistical association [14]. Similarly, in Colombia, 83% of the women from a 500 students survey had had sexual relations [15]. In Mexico, the association between alcohol use and more frequent sexual relations, lower rate in preservative use and higher number of sexual partners was established among 1000 adolescents between 14 and 20 years old that participated in a survey [17].

2.2 Sexual initiation and contraceptive methods: The knowledge, access and consistent and efficient use of contraception is essential to avoid TP. There are three concepts to analyze: first, if the sexual relations initiation age is more advanced and the teenager does not want a pregnancy, should correctly use an efficient contraceptive method. Second, the decision of continuing or ending pregnancy, and finally, third, to assure a safe post-delivery or post-abortion contraceptive method to avoid a second non-planned pregnancy. It is clear that in most Latin American countries these decisions are not consensual based on knowledge and data but based on the influence of a set of individual, social, family and cultural factors [18].

In 2013, 52% of Argentinean adolescents initiated their sexual relations between the ages of 15-19, mostly with their

boyfriends. 16% of these relationships lasted a month, 21% 2-3 months and 20% between 4-6 months [6]. Among those who referred having used protection the most widely used method was the condom. In a survey done at Rivadavia Hospital (Tucuman, Argentina), 92.1% had already had sexual intercourse at time of the interview [2]. These data are similar to those found in the ECOVNA survey on living conditions during childhood and adolescence [11].

The main information sources on contraception in adolescence are the school, family and peers, pharmacists and media-press (representing 41%, 31.5%, 46% and 34% respectively), reflecting the coverage deficit in sexual health in the public sanitary systems [11].

The decision of having sex among adolescent females was in 82.7% of cases referred to a mutual decision, while the other 17% indicated that were forced by their partners were not convinced but weren't able to say no, while none of the male adolescents referred to this situation [2]. Data from the Perinatal Information System in Argentina shows that 67.5% of the adolescents that gave birth during 2014 were not looking for a pregnancy, while 79.9% were not using any contraceptive method [33]. Similar results were found in a recent survey on 1571 adolescent mothers by Gogna and Bistock showing that 60% of adolescent mothers referred not planning pregnancy, and additionally, in the time they got pregnant only 18% always used protection and 36% rarely used. Even though a 71% mentioned using a condom, and a 13% oral contraceptives, evidence suggests that compliance was inadequate [19].

In situations of poverty, sometimes maternity represents the passage to adulthood with a position of higher respect, an attempt to escape from conflictive family situations, a wish to raise their own children or a mechanism to obtain protection or economical support from a male, decisions that do not solve their socio-economical, sanitary and emotional pre-existent situation [29].

3. The interruption of the adolescent pregnancy in a general context of abortion

The WHO defines risky or unsafe abortion as that practiced under inadequate and unsafe sanitary and security conditions performed through the use of dangerous techniques in places lacking proper hygiene and, in most occasions, performed by unqualified medical personnel with severe socio-sanitary consequences. The illegality of this practice in the counties from Latin-America and the Caribbean (LAC) propitiates this underground practice and the corresponding sub-register [22].

A recent publication on the illegal abortion practice in LAC suggest that 97% of the women in reproductive age live in countries with restrictive laws. Six of these countries have a total restriction, 9 permit it only to save the mother's life and only a 2 permit it in limited situations such as rape or serious fetal malformations. Less than 3% of the women in reproductive age, including the adolescents, live in countries where the abortion is legal in broad terms [23].

In the period 2010-2014 in LAC, only 1 every 4 abortions took place under safe conditions. Annually, near 760,000 women receive attention in the region for unsafe abortions and, at least 10% of the maternal deaths where as a consequence of illegal abortions. It is estimated that in South America, these procedures reached up to 48 per thousand women in 2014

[23].

Hospitalization for abortion has increased in Argentina in a 57% from 1995 to 2000 and it is worth noting that 40% of them is under-20-year-old [24]. Accordingly, up to 20% of adolescent women in their first pregnancy and 15% in their second have considered abortion in this country [19]. Moreover, the Argentinian Ministry of Health reported that in 2011 a total of 47879 hospital discharges were registered due to abortions and that 36 adolescents under 20 died for causes related to pregnancy or delivery, which represents a 12% of the maternal mortality [29].

4. Recurrence in adolescent pregnancy

Teenage prenatal control, delivery, post-delivery and post-abortion attention as well as the care and control of the child in the sanitary system are privileged opportunities for counseling and supplying a contraceptive method [13].

An evaluation in 2017 in three maternities in Argentina showed that 52% of the adolescent mothers had no schooling, 21% had a previous child and 15% three or more previous children. 93% of them, before being discharged, referred wanting a method of contraception (CM), however, only 64% post-delivery patients and 30% of the post-abortion patients received counseling. As CM 73% received pill containing only progestin and 27% received condoms. 54% of those who not received CM, reported no having been referred to get it [13]. Although the sample has not enough numbers, it reveals that the coverage of contraception in post-abortion in adolescents is deficient and inefficient. The suggested methods are still the same previous to the pregnancy. Therefore, the risk of a second pregnancy remains underlying. The methods independent from the adolescent user that allow a safe and long lasting contraception are still not being considered [13].

The fact of not being able to accomplish a systematic behavior in the correct usage of the short term of the CM among adolescent patients with a first pregnancy is a key issue for the public policies to consider as a priority to retrain their professionals in matters such as counseling and availability of reversible contraceptive methods of long action as first line in this patients [19].

5. Conclusion

It is un-doubtful that Latin America is a region in which TP is a true social, health, educational and economic problem. It is also patent that some countries have improved their indicators in the last years in accordance their actual situation. However, Argentina is maintaining its indicators intact through the last 15 years and is the country with the highest teenage fertility rate in Latin America at present.

In spite of all actions implemented to reduce TP incidence including new legislative frameworks that favors and guaranties the rights of girls, boys and adolescents, non-punishable abortions in situations of child abuse and the current pragmatic context on Adolescent Sexual and Reproductive Health and sexual education, the rights in Adolescent Sexual and Reproductive Health are not fully ensured [29].

Therefore, there is a need for attending adolescent sexual and reproductive health, based on an integral sexual education. Ultimately, the measures should be directed to avoiding school desertion (ranging from 25 to 30% between 14-17years old) [6] because more than half of the TP occurred out of the educational system at the moment of pregnancy and furthermore, all actions focused on adolescent sexual health should be extended to all places that the adolescents attend.

Primary and secondary school teachers' training is one of the main goals in an integral sexual education strategy and one of the keystones for the application of the integral sexual educational program in LAC that has not shown progress in the last 5 years.

Finally, the abortion de-penalization laws approved in different LAC, are not the solution to improve the rates of TP but to act against the discrimination and violation of women's rights diminishing the rate of adolescent mortality and morbidity for problems related to pregnancy and unsafe abortion and reducing costs in health due to pregnancy and abortion complications.

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