GIRLS NOT BRIDES | The Global Partnership to End Child Marriage

SUPPORTING MARRIED GIRLS, ADOLESCENT MOTHERS AND GIRLS WHO ARE PREGNANT

Thematic report

October 2021

With 90% of adolescent births taking place within the context of marriage,[1] adolescent pregnancy and child marriage[a] are closely linked. This thematic report explores the rights and complex needs of married girls, pregnant adolescents and adolescent mothers, sharing successful approaches and recommendations from around the world.

Married adolescent girls and girls who are already mothers have unique needs, which health care, education and social services systems are often not set up well to meet. Responses to adolescent pregnancy[b] to date have been heavily focused on prevention and maternal health, ignoring broader sexual and reproductive rights, the psychological and socio-economic consequences of adolescent pregnancy, and the complex needs of married girls, pregnant adolescents and adolescent mothers.

Despite prevention efforts, adolescent pregnancy remains high: **an estimated 12 million girls aged 15 to 19 – and 770, 000 girls under 15 – give birth every year** in low- and middle-income countries.[2] Prevention efforts therefore need to be implemented alongside initiatives to address the needs and rights of girls who are already pregnant or mothers.

This thematic report explores these needs, shares examples of successful approaches from around the world, and calls for holistic responses to deliver on the rights and needs of 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.

Specifically, we call for:

- Implementation of **clear referral and tracking mechanisms between the health and education** systems to identify pregnant adolescents in school, support them to access appropriate maternal health and support services, and return to school after birth.
- **Establishment of mechanisms for identifying cases of pregnancy arising from sexual violence or coercion** and referral to child protection services and legal authorities where appropriate.
- Implementation of **flexible return-to-school policies** that accommodate the specific needs and rights of adolescent mothers, including the provision of affordable or free childcare.
- **Financial support; provision of scholarships or cash transfers for adolescent mothers** to support their return to school and/or support them to enter the workforce or generate income.
- Implementation of **social support programmes** to help adolescent mothers overcome stigma and

PICTURED ON COVER: 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

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

navigate becoming a mother for the first time, including building support networks, agency, and life skills, and engagement with the wider community.

- **Training of sexual and reproductive health care staff** on the rights of adolescent mothers to access health services – regardless of age or marital status – and on the risks faced by pregnant adolescents.
- **Access to contraception** for married girls and adolescent mothers who wish to delay or space their pregnancies.
- **Access to safe abortion and post-abortion care** for adolescents who do not wish to continue with their pregnancies.

1. WHY IT IS IMPORTANT TO THINK ABOUT CHILD MARRIAGE AND ADOLESCENT PREGNANCY TOGETHER

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, while in **Latin America and the Caribbean** (LAC) and **sub-Saharan Africa**, adolescent pregnancy takes place both within and outside of marriage and unions.
- Adolescent mothers and pregnant girls under the age of 15 are in the most vulnerable position, as their pregnancies are often the result of sexual violence, and they are least likely to be equipped for the transition to motherhood.

In many contexts, **child marriage drives adolescent pregnancy** because married girls are under intense social pressure to prove their ability to have children, are more frequently exposed to unprotected sex, and are less likely to use contraception than their unmarried counterparts.[3]

Adolescent pregnancy can also act as a catalyst for child marriage. Unintended pregnancy – particularly in contexts where girls' premarital sexuality is taboo – creates pressure for girls to enter into unions with the father of the child, and ultimately leads girls to marry earlier than they otherwise would have.[4]

In South Asia the majority of adolescent pregnancy is thought to take place following marriage, although social norms mean it is hard for researchers to collect evidence of extra-marital pregnancy.[5] **In sub-Saharan Africa and LAC, pregnancy happens both within and outside formal marriages and unions**, and is therefore both a cause and consequence of child marriage.[6]

PICTURED: Erika – a community advisor for the Women's Justice Initiative – facilitates a workshop on delaying child marriage with primary school-age Kakchiquel Mayan girls in Chimaltenango, Guatemala. In many contexts, child marriage drives adolescent pregnancy, and vice versa. Photo: *Girls Not Brides*/James Rodríguez/Arete

Importantly, **girls may *choose* to enter into an early marriage or union or become pregnant**. Both are more common among girls from poorer backgrounds with limited opportunities,[7] and particularly where motherhood is highly valued and secures certain rights and privileges; becoming a mother may be the best of the limited options available for girls and women.

Globally, adolescent birth rates have decreased by about a third since the 1990s. The biggest reductions have been in South and Central Asia, where adolescent childbearing is now only 25% of the level it was in the 1990s.[8] Adolescent birth rates today are highest in West and Central Africa, East and Southern Africa and LAC, at 108, 95 and 61 births per 1,000 girls aged 15-19, respectively.

Unequal outcomes between higher- and lower-income countries are clear: only 12 girls per 1,000 give birth in the world's richest countries, compared with 91 in the lowest-income countries. The global average is 41 births per 1,000.[9]

Less is known about pregnancy among younger adolescents (those aged 10-14) as they are often excluded from surveys and data collection systems due to sensitivities around the topic and the assumption that pregnancy among girls of this age is rare. From the limited data available, pregnancy among girls aged 10-14 is indeed much less common than pregnancy among girls aged 15-19, occurring most frequently in LAC and sub-Saharan Africa. Only a small number of countries have more than 10 births per 1,000 adolescents aged 10-19: Angola, Mozambique, Nigeria and Bangladesh. **Very early pregnancy is often the result of sexual violence,[10] and is strongly associated with poverty and child marriage**.[11]

While adolescent pregnancy has declined over the last thirty years, the disruption to sexual and reproductive health 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.[12] The impact on child marriage is likely to be greater: **10 million additional girls are expected marry** by 2030 due to the pandemic.[13]

2. THE ISSUE: 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 15-49 occur among adolescent girls aged 15-19.**[14]

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.[15] Not only are adolescent girls physically predisposed to complications during pregnancy, evidence from around the world shows that they are also less likely to use appropriate maternal health care, including antenatal screening, childbirth assisted by a skilled birth attendant and postnatal care.[16] Adolescent mothers – particularly those who are married – are also likely to experience **rapid, repeated pregnancies,** which further endanger their health and that of their babies as limited space between pregnancies increases the risk of complications.[17]

Much of the focus on adolescent pregnancy to date has therefore been on prevention strategies and, to a lesser extent, on adolescents' lack of access to appropriate maternal health care. Both are vital to improving maternal and child health outcomes. 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**.[18]

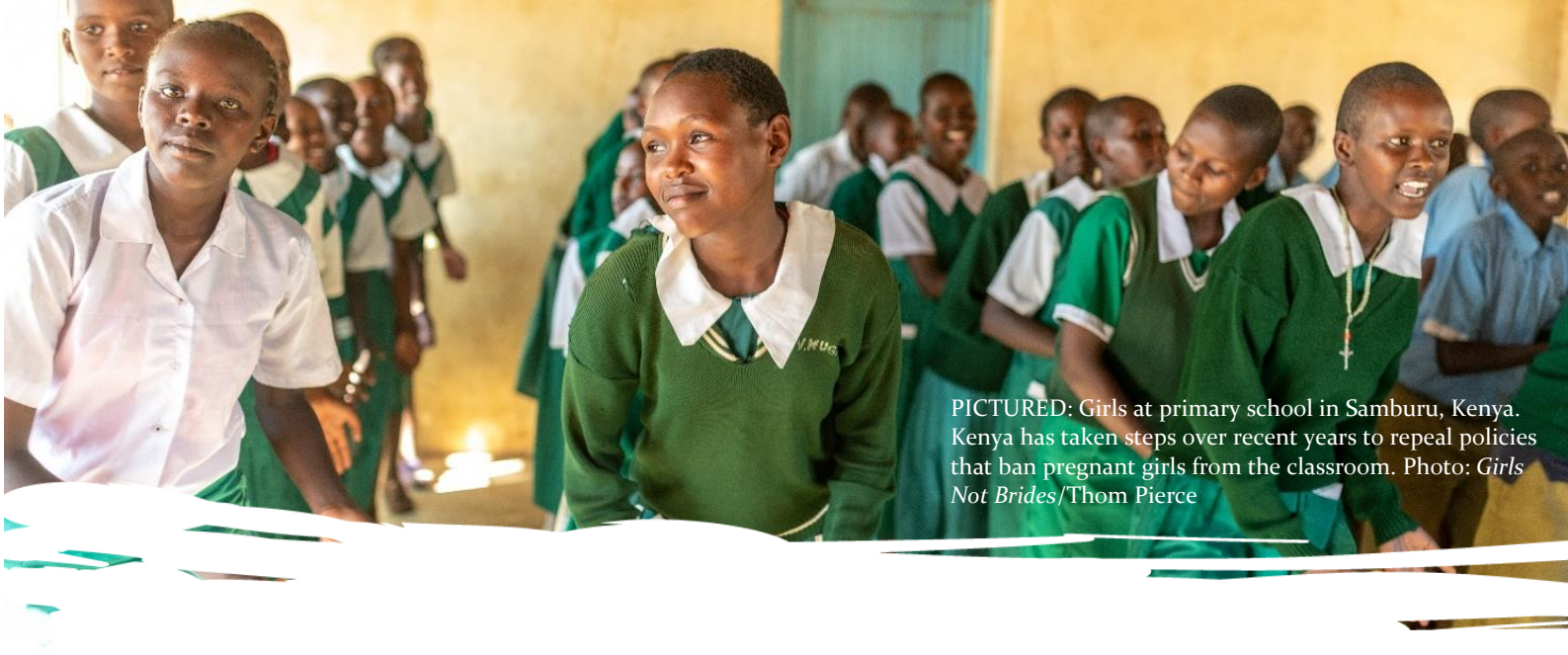
When an adolescent girl gets pregnant and/or becomes a mother, her sexual and reproductive rights and her rights to education are affected, but she is also likely to experience other long-term impacts on her relationships, future prospects and other dimensions of her wellbeing including her mental health. This section explores the other common experiences of adolescent mothers that require policy and programmatic responses.

Disruption to education

Adolescent pregnancy often means the end of a girl's education. It is estimated that **up to 4 million girls drop out of school every year due to pregnancy in sub-Saharan Africa alone;** comparable data for other regions is not available.[19] In both LAC and sub-Saharan Africa, girls may get pregnant or married and then choose to drop out of school, or they may be pushed out by policies that explicitly or implicitly ban them from the classroom.[20]

As adolescent pregnancy – particularly outside of marriage – is often highly stigmatised by families, communities and teachers, it is often considered to be inappropriate to have a pregnant girl in the classroom, as she is perceived as having poor morals and setting a bad example to other students.

Policies related to adolescent pregnancy often then take a "**punitive approach**", where education is seen as a privilege that can be withdrawn as a punishment for getting pregnant.[21] In some countries – such as Morocco and Sudan – unmarried pregnant girls may be



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

prosecuted for having engaged in premarital sex.[22] Such policies are a violation of girls' right to education and contribute to the social exclusion of adolescent mothers and pregnant girls.

Over 20 African countries – including Kenya, Sierra Leone and Malawi – have taken steps in recent years to repeal policies that ban pregnant girls from the classroom or have adopted continuation or re-entry policies to ensure that pregnant girls can continue their education after childbirth. However, despite these positive steps in the right direction, **adolescent mothers often face additional obstacles to returning to the classroom**, such as lack of awareness of re-entry policies, lack of flexibility to pick up where they left off, financial difficulties, lack of parental support, lack of affordable childcare support, paperwork requirements, policies that require a prolonged gap between giving birth and resuming education, and prevailing discriminatory attitudes towards adolescent pregnancy on the part of teachers, administrators and fellow students.[23]

In LAC, while most countries have laws that guarantee girls' rights to education and there are fewer or no laws banning pregnant girls from school, in practice it is also common for girls to drop out of school after becoming pregnant in order to not be seen as setting a "**shameful example**".[24] 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 a combination of inadequate child care and support services, social stigma, and judgemental and marginalising attitudes on the part of teachers and other school staff.[25]

In South Asia, low-quality education and limited female labour force participation both 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.[26] Perhaps for this reason, there is a lack of data on the impact of adolescent pregnancy as a cause of school dropout, with most of the literature focused on the impact of child marriage on girls' education.

Impact on future life prospects

Adolescent pregnancy and the disruption to education that it often entails holds girls and women back economically for the rest of their lives. Young women are already at a disadvantage when it comes to labour force participation: across middle- and lower-income countries, gender norms act as barriers to paid work for young women, who are the least likely to be in paid employment, particularly those with no education or who have

disabilities. Where they are in paid employment, young women are more likely to work in insecure, informal jobs than their male counterparts.[27]

Adolescent pregnancy compounds that disadvantage. Across 22 countries in Asia, Africa and LAC, women in their early twenties who had a child before age 18 are more likely to be in work. However, women of all ages who had a child as an adolescent are less likely be in paid work than women who had children later or not at all. They are instead more likely to be in unpaid work or work that only provides in-kind payments. This suggests that adolescent mothers are not only **pushed into unpaid jobs,** but that they remain in employment with **limited cash-earning potential throughout their working lives**.[28] In six countries in Latin America, women who were young adolescent mothers were found to be **three times less likely to get a university degree** as adults than women who had their first pregnancy later.[29]

There is also evidence that the daughters of adolescent mothers are more likely to become adolescent mothers themselves, **pushing adolescent mothers and their children into a cycle of poverty**.[30] Adolescent mothers who have experienced rapid repeat pregnancies will face additional challenges returning to school or work as they have more caring responsibilities than girls and (young) women who only have one child.

PICTURED: Mwajuma took a hairdressing workshop with SOFRES and can now earn an income for herself and her son. Adolescent pregnancy can often hold girls and women back economically for the rest of their lives. Photo: *Girls Not Brides*: Thom Pierce

Social exclusion and changing relationship dynamics

Both adolescent pregnancy and child marriage are more common among girls who come from marginalised and poor communities,[31] and the experience of adolescent pregnancy **adds to that marginalisation**. Around the world, **adolescent pregnancy can lead to a high level of social exclusion** as not only does it lead to school dropout, but unmarried girls who are pregnant or mothers often experience a high level of stigma by parents, teachers, families, religious leaders, and the wider community.[32] The parents of pregnant adolescents may react angrily to their pregnancies, straining relationships and in the worst cases leading to girls being forced out of the parental home, causing financial insecurity and girls entering into child marriages with the fathers of their children.[33] Parents may themselves pressure their

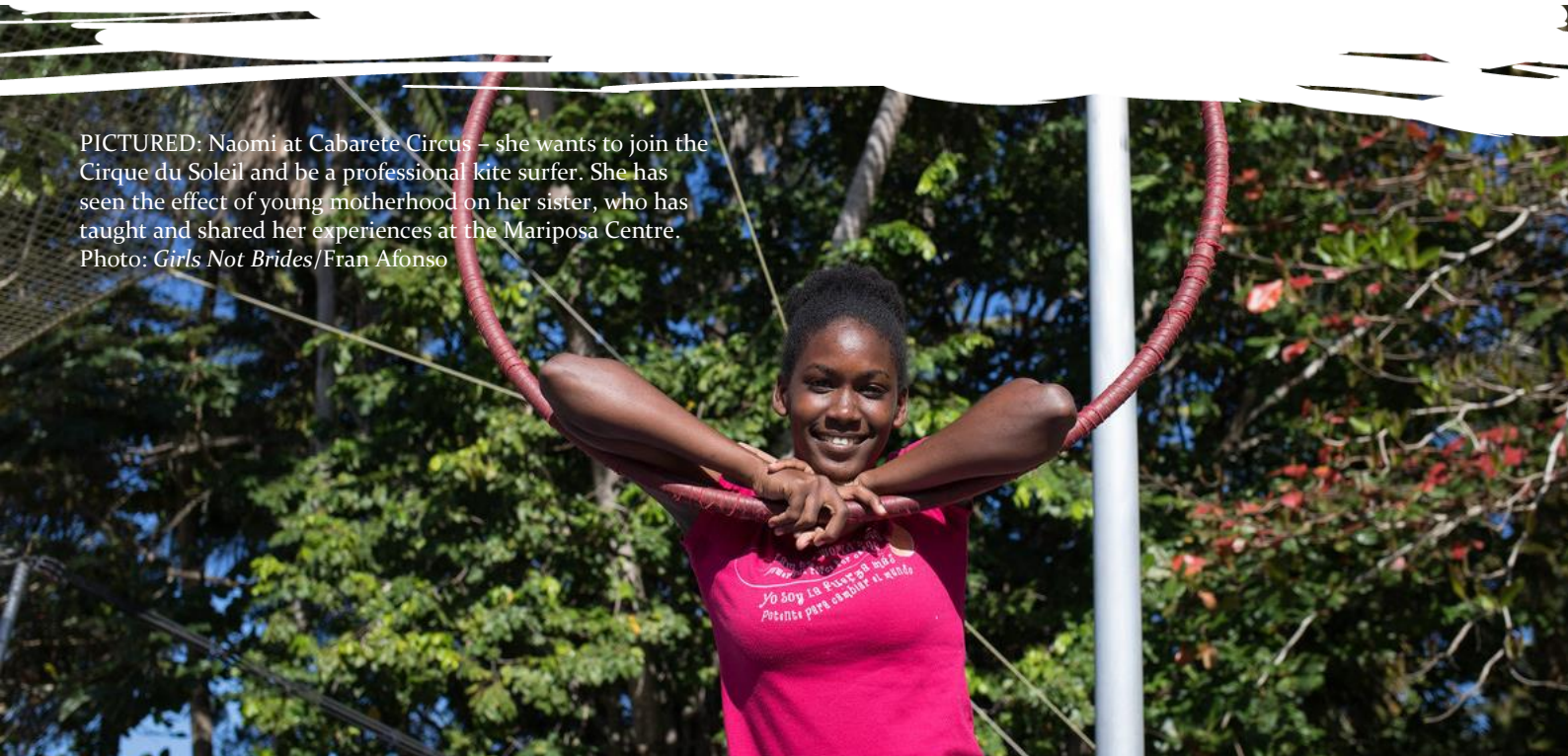
daughter to enter into a child marriage to avoid the dishonour of a pregnancy outside of marriage.[34]

Adolescent mothers also report changes to their friendships after becoming a mother, as their single, child-free counterparts struggle to relate to their experiences, contributing further to social isolation and loneliness.[35] In LAC and sub-Saharan Africa, adolescent mothers report often being **abandoned by the fathers of their children**, who may deny paternity or simply be unwilling to take on the responsibility of fatherhood. This can lead them to seek further informal unions or engage in transactional sex, pushing them into a cycle of poverty and insecurity.[36]

In South Asia, adolescent pregnancy is less likely to be unintended and more likely to take place after entering into a child marriage. In these contexts, adolescent pregnancy does not carry stigma and in fact is often seen as the **most appropriate life path for a respectable adolescent girl**, according to social norms that primarily value girls and women for their role as wives and mothers.[37] Despite this, adolescent pregnancy and child marriage may still lead to social exclusion in these contexts, as girls are withdrawn from school and their peers, and instead made to stay at home under the influence of their partner's family, with restricted **freedom and mobility**.[38]

Adolescent mothers also often have to navigate the impact of their pregnancy on the dynamics withing their relationship or household. First time parenting programmes in Mexico, Burkina Faso, Nigeria and Tanzania have found that the relationship status of adolescent mothers can be quite fluid, with girls both forming and exiting relationships with the father of their child in the first few years after their pregnancy.[39] If they remain unmarried and living with their parents, the pregnancy may put strain on their family relationships.

Lack of social support and the high levels of social stigma and marginalisation faced by adolescent mothers and girls who are pregnant in turn contributes to a greater risk of **depression, anxiety and suicidality** – that is, risk of suicide, usually indicated by suicidal thoughts or intent – among adolescent mothers and girls who are pregnant. This is compounded by the multiple other challenges they face (see below). Despite this, adolescent mothers – including those who have experienced sexual violence – are often not offered the psychosocial support they need.[40]



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

It is important to understand that globally, adolescent pregnancy is frequently the result of **rape, sexual coercion or sexual abuse of a minor**.[41] This is particularly likely to be the case where the girl is under the age of 15. There is a lack of reliable data on the direct links between sexual violence and adolescent pregnancy, but in Mexico it is estimated that 16,521 girls aged 10-14 were raped in 2015. The following year, Mexico registered 11,808 births to girls in the same age range.[42]

Despite the increased vulnerability of their position – 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 or referrals to social support services or access to justice.[43]

Women who gave birth as adolescents are also more likely to **experience intimate partner violence** throughout their lives.[44] 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%).[45]

Reproductive coercion and the violation of sexual and reproductive rights

Adolescent mothers often become mothers not out of choice but because they lacked the agency to make their own reproductive choices.[46] **Many adolescent mothers report that the decision to have a child was not made by them, in violation of their reproductive rights**.

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. **Pressure to produce a son** is a particular driver of reproductive coercion among married adolescent girls in South Asia, who may be pressured into having repeat pregnancies until one results in the birth of a male child.[47]

Sexual health care providers **may refuse to provide effective methods of contraception to married girls** who haven't yet had children, or even to provide any contraception at all, due to myths about its impact on fertility. Similarly, unmarried girls may be denied access to contraception due to provider attitudes about premarital sex.[48]

Pregnancy as a result of rape leads to **forced motherhood** in contexts where access to safe abortion is restricted. Forcing adolescent girls – particularly those who have been sexually abused or raped – to continue with an unwanted pregnancy through the denial of emergency contraception or safe abortion is a clear violation of their sexual and reproductive rights.[49] Where religion has considerable influence on sexual and reproductive health policy, abortion is often criminalised, to the extent that women can be jailed for abortion. In El Salvador, women and girls **who suffer miscarriage through no fault of their own** are accused of inducing abortion, charged with homicide and can be jailed for up to 30 years.[50]

Impact on mental health

Research is limited, but **adolescent pregnancy is associated with increased risk of mental health issues**, including depression, anxiety and suicidal thoughts.[51] The experiences discussed above – including stigma, the experience of rape or incest, economic hardship, abandonment by partners or the experience of forced marriage – are all thought to

PICTURED: Ghazal and Khalid with their children in a refugee settlement in Lebanon. Ghazal was married at 13 and had children soon after. She has participated in International Refugee Committee sessions on gender inequality, decision-making in the home and healthy relationships, and has supported her sister to follow a different path. Photo: *Girls Not Brides*/Thom Pierce

have a negative impact on the mental health of adolescent mothers.[52] In Brazil, a study of suicidality found that **13% of adolescent mothers had exhibited suicidal behaviour** and that those who had limited social support were nearly 70% more likely to exhibit suicidal behaviour than those with high levels of social support.[53] Forced motherhood due to reproductive coercion and lack of access to abortion is a source of distress for women of all ages. In El Salvador and Guatemala there is emerging evidence that this is leading pregnant adolescents to take their own lives.[54]

In the case of very young adolescents, particularly where the pregnancy is the result of rape (see below), the girl may not understand that she is pregnant until the pregnancy is advanced, leading to significant level of trauma.[55]

Poor maternal, sexual and neonatal health outcomes

Despite pregnancy being significantly more physically risky for girls under the age of 20, **adolescent mothers are less likely to access maternal health services than older women**. Barriers to access include lack of awareness of the need for them, lack of knowledge of where to access them, initial denial of the pregnancy, financial and logistical barriers, feelings of shame and fear of stigma, attitudes of service providers towards adolescents, and laws and policies that deny the use of such services on the basis of marital status or age. In many countries in South Asia – including in Nepal, India and Bangladesh – legal and policy frameworks prevent girls under the age of consent from accessing maternal health care even if they are married. Married girls may also need permission from their partner or partner's mother to access health care.

Girls who do receive maternal health care often experience judgemental attitudes from providers and poor quality of care, including **obstetric violence**[c] and lack of information about future methods of contraception. Obstetric violence – unacceptable in all cases – is more commonly experienced by younger, unmarried and uneducated women. It is frequently reported by adolescent mothers in Latin America and can range from judgemental attitudes during labour to reports of systematically enforced insertion of intrauterine devices (IUDs) after labour in Mexico.[56] All of this contributes to poor maternal and neonatal health outcomes.[57]

Adolescent pregnancy is often associated with subsequent rapid, repeat pregnancies that further endanger the mother's health. Adolescent mothers require **postpartum access to contraception** to improve maternal health through pregnancy spacing and prevention.[58]

Unintended and unwanted adolescent pregnancy creates the need for safe abortion services, as not every girl will wish to continue with the pregnancy. Restrictive abortion laws mean that pregnant adolescent girls frequently turn to **clandestine, unqualified abortion providers** who put their health and even lives at risk. While data is unreliable, Guttmacher estimates that between 8 and 11% of all maternal deaths are due to unsafe abortion, and that adolescent girls are more likely than older women to go to unsafe providers.[59]

In East and Southern Africa, where rates of infection are high among adolescent girls, **HIV overlaps strongly with adolescent motherhood.**[60] The double impact of adolescent pregnancy and an HIV diagnosis – especially when the pregnancy is unplanned – can be particularly overwhelming as girls have to deal with the challenges associated with new motherhood and initiation into lifetime HIV treatment and potentially the stigma associated with both pregnancy and HIV. Adolescent mothers in East and Southern Africa have lower rates of retention in HIV care and treatment than older women, and therefore need more support to ensure they receive the care they need.[61]

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 show above, adolescent mothers and girls who are pregnant have complex needs that go beyond maternal and neonatal health. They need support to realise their rights, return to school and access economic opportunities, navigate their new role as mothers, and to access justice and support services where their pregnancy is related to sexual violence. Pregnant girls and adolescent mothers have often been overlooked by the adolescent sexual and reproductive health sector, which historically has been heavily focused on adolescent pregnancy prevention and has tended to regard adolescent mothers as failures.[62] Similarly, married girls have often been overlooked by the end child marriage movement, with the bulk of research and programming focused on the consequences of child marriage and prevention strategies.[63] They are therefore also often **overlooked or inadequately included in**

[c] Obstetric violence is a term coined in Latin America to refer to the abuse and mistreatment directed towards mothers during labour, including verbal and physical abuse, refusal to administer required health care, including pain relief and lifesaving procedures, and the administration of medical procedures without the consent of the mother.

national strategies to prevent child marriage or adolescent pregnancy or to improve adolescent health more broadly.

On the other hand, while many countries have school re-entry policies, these are often not sufficiently linked to health and social services, meaning that many adolescent girls' needs are not met and they are more likely to drop out again. This is not only a violation of girls' rights to education and their sexual and reproductive rights but also an issue that affects long-term development goals.

The ultimate responsibility to uphold adolescent girls' rights lies with national governments. **To meet the needs of adolescent mothers and that of their children, policies to support them should be integrated into existing national strategies to ensure that adolescent mothers are offered a holistic package of support.** The interlinked nature of the needs of adolescent mothers and the challenges they face means that health, education, child protection and social services sectors should work together to identify gaps in the current policies and programmes directed towards adolescent mothers and design and deliver the additional support services that girls need. Referrals for girls who experience sexual violence is a particular gap across virtually all contexts that should be urgently addressed. Policies across different sectors also need to be harmonised.

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

CASE STUDY

Reencontrandome programme in Mexico

Reecontrandome ("Finding myself again") was a Mexican programme that aimed to address the multiple needs of adolescent mothers living in poverty and helped them to build their agency to make plans for the future. [64] The programme had multiple objectives:

- To support adolescent mothers to exercise their sexual and reproductive rights through increased awareness and use of different methods of contraception and increased awareness of the benefits of spacing the birth of their children
- To support adolescent mothers to make decisions about their futures including returning to school or work, and developing life goals
- To improve couple communication and build life skills
- To achieve sustainability by converting graduates of the programme into agents of change in their communities.

The programme identified building support networks as an essential strategy to support adolescent mothers. It worked at multiple different levels. Direct support was offered to adolescent mothers through the building of support networks – where they could meet others in similar situations to themselves – and workshops on returning to school, youth employability and sexual and reproductive health and rights (SRHR). The programme also included sensitisation of sexual and reproductive health care providers – including doctors and nurses – on adolescent SRHR. It also monitored the availability of a range of contraception methods. Cases of sexual violence were identified and referred to appropriate services. By the end of the programme:

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

Multi-sectoral recommendations

Both Jamaica and Guyana have detailed multi-sectoral policies to support the reintegration of adolescent mothers into the school system and – in Jamaica – to support the transition from school to work. Both policies include the creation of intersectoral 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.[65] We call for 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 a **safeguarding policy** to refer girls from schools to appropriate child protection and psychosocial support services where the pregnancy is the result of rape or the father is an adult.
- Develop **harmonised education and health policies for the length of time that a girl is advised to stay at home after the birth of her child**. Track adolescent girls who have left school due to pregnancy and actively reach out to girls after birth – especially those in rural areas – 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. These programmes should include creating support networks for adolescent mothers to meet and share experiences, engaging parents and partners of adolescent mothers and provisions of life skills and information on SRHR.

Education sector recommendations

Many countries – including Jamaica and Guyana and 26 countries in Africa, including Gabon, Kenya and Malawi – have adopted re-entry policies to ensure that pregnant adolescents and adolescent mothers can remain in the school system.[66] 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:

- **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, without the need for a lengthy period of time off school after giving birth.
- Support girls to **balance their caring responsibilities with education**:
  - Establish childcare facilities such as nurseries near to schools, as was done in Jamaica
  - Offer adolescent mothers flexible school hours and accommodate childcare needs such as breast feeding or time off when babies are ill or need check-ups.
- Provide **in-school psychological support** to adolescent girls in the form of counselling.
- Provide **referrals to sexual and reproductive health care**, including youth-friendly contraception and safe abortion.
- Provide **financial support** to adolescent mothers to attend school. In Latin America, support for adolescent mothers to return to education more often take the form of scholarships, as in Mexico, Dominican Republic and Costa Rica.[67]
- 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 **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, building their agency and life skills.

- Deliver **comprehensive community-based programmes** that build adolescent girls' agency, life skills and knowledge of maternal and childcare, contraception and reproductive health. For example, USAID's First Time Parents project provided a holistic package of interventions for first-time mothers and fathers in Nigeria, Burkina Faso and Tanzania. Approaches combined learning about maternal and child health, contraception and reproductive health, and gender equitable relationships, 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 household and parenting tasks were observed.[68]
- Build **support networks** of adolescent mothers to share their learnings and experiences.
- Create a **safe space** for girls to share their experiences can help girls cope with the stigma and isolation often experienced by adolescent mothers and pregnant girls. The Reencontrandome programme in Mexico identified building support networks as an essential strategy to support adolescent mothers.[69]
- Engage **husbands and partners** in parallel programming to promote couple communication, use of contraception, responsible fatherhood and to reduce domestic violence. Population Council Ethiopia's Meseret Hiwat and Addis Hiwan programmes engaged young married girls and their husbands in parallel; the girls' programme focused on communication, self-esteem, reproductive health and gender through girls' groups, while the husbands' programme focused on non-violence, support to families and reproductive health. At the end of the programme, girls reported improvements in spousal support with domestic work and increased use of contraception, with stronger results when the husband had also participated in the programme.[70]
- **Engage the wider community** including adolescent girls' parents, mothers in law, teachers, and community and religious leaders on the needs of adolescent mothers and on young people´s sexuality and choices 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.

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 – and for adolescent health more broadly – 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 utilising sexual health services including maternal health, HIV, contraception and abortion on the basis of their age, marital status, or the number of children they have.
- As part of quality maternal health services, both married and unmarried adolescent girls should be **counselled on contraception** so that 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 educate them on the sexual and reproductive rights of young people. Put in place reporting mechanism for cases of obstetric violence directed towards adolescent mothers.
- **Train staff on the links between adolescent pregnancy and sexual violence** and put in place mechanisms for reporting cases of pregnancy resulting from rape. Offer victims of rape appropriate medical care, including the morning after pill and PrEP – the medicine taken to prevent getting HIV – 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 space for women and girls with high-risk pregnancies in rural areas where access to maternal health services is otherwise challenging.[71]
- Put in place **community outreach services to reach the most marginalised girls** through home visits and telephone consultations that provide counselling on contraception and referrals to maternal health services. Telemedicine is particularly important in the context of the Covid-19 pandemic and has been used by, for example, the Plan International *Arriba* project in Bolivia to identify high-risk pregnancies and refer them immediately to services.[72]
- Work with social services to **pair the delivery of health care with community engagement** on comprehensive sexuality education and SRHR, targeting adolescent mothers, their parents and husbands/partners, and the wider community.

CONCLUSION

Child marriage and adolescent pregnancy often go hand in hand, but it is often not recognised that the majority of adolescent mothers are married girls. Efforts to address either should not be implemented without taking into consideration the links between the two and the unique needs of adolescent mothers, pregnant girls and married girls. While prevention efforts are important to help adolescent girls avoid the negative outcomes associated with child marriage and adolescent pregnancy, girls who are already married, pregnant or mothers must not be overlooked by policies to improve adolescent health, education and wellbeing.

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