ADOLESCENT PREGNANCY IN PERU

A systems analysis of the structural barriers to the reduction of teenage motherhood across Peru

June 15-17, 2020

Annie Kuster & Sara Surani

TABLE OF CONTENTS

MOTIVATION

Adolescent pregnancy not only impacts teenage girls but also influences all aspects of Peruvian society, from education and employment to health, policies, and gender equity.

Over 29 combined months working in the region, Sara and Annie have worked alongside young women—holding dreams, ambitions, and curiosities just like themselves—who became pregnant before the age of 15.

Learning from girls like Joanna, a spunky 16-year-old singing fanatic from the Andes, and Mariella, an 18-year-old aspiring mathematician from the Amazon, Annie and Sara saw systematic barriers leading to high rates of adolescent pregnancy in Peru and perpetuating obstacles to young mothers' success.

METHODOLOGY

Our research is grounded in existing literature and government policies, semi-structured interviews with key stakeholders, and conversations with adolescents.

PRIMARY

84 

Interviews with adolescents (54 girls, 30 boys)

27 

Interviews with key stakeholders in the following sectors:

- Government
- Local NGOs
- International organizations
- Healthcare providers
- Gender experts

27 

Interviews with community health workers

SECONDARY

5 

Quantitative data sources

44 

Reports, including academic papers, international guidelines, and government policies

Limitations in our research include:

- No interviews with parents of youth
- No interviews with social influencers in reproductive health in Latin America (celebrities, actors, etc.)
- Limited sample could reduce generalizability of our findings

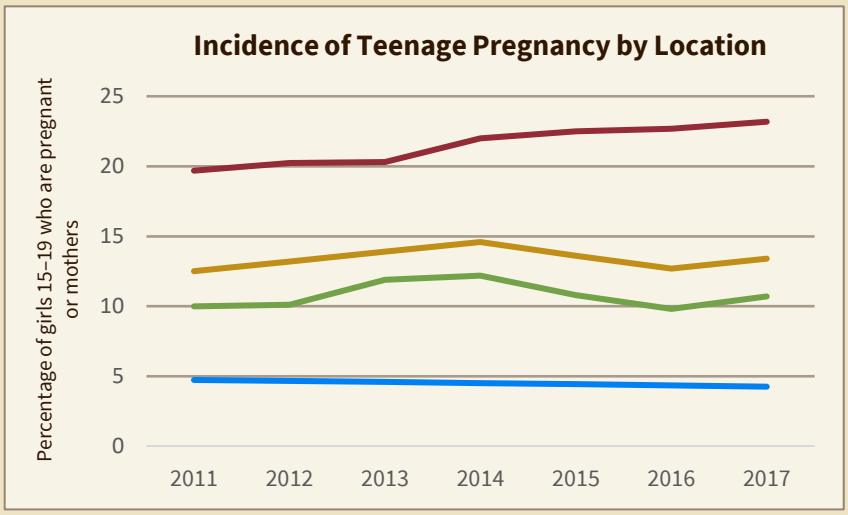
INTRODUCTION

The Peruvian healthcare environment is unfairly gendered. This is most obvious in the high incidence of adolescent pregnancy, which has been a structural problem for decades.

Pregnant adolescents are more likely to suffer:

- Gender-based violence
- Psychological distress
- Complications in pregnancy and delivery
- Challenges staying in school and entering the labor market

These challenges contribute to the increased likelihood that their own children become adolescent parents, thus contributing to cycles of young motherhood (Mollborn & Morningstar, 2009; Rexhepi et al., 2019).

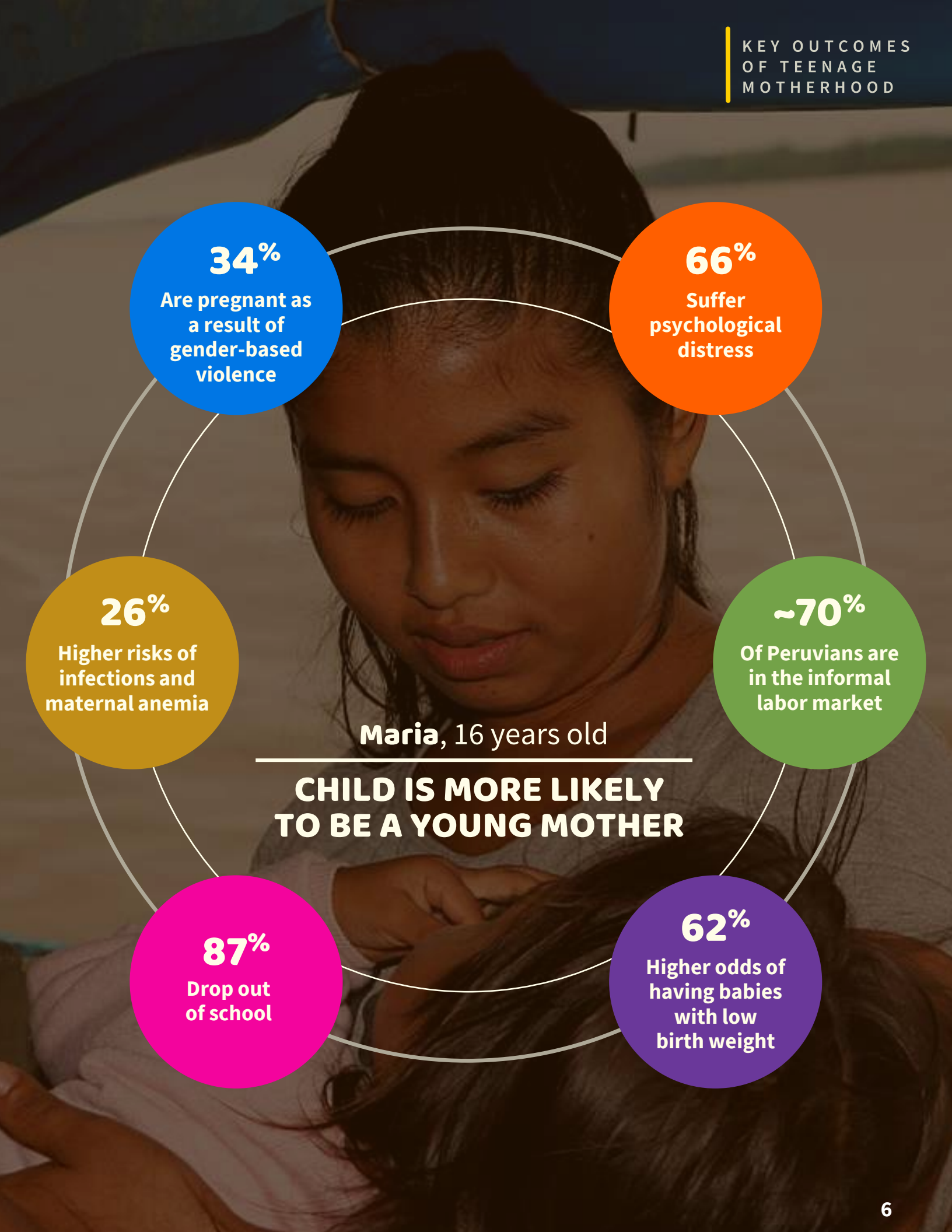


	Compound Annual Growth Rate (2011-2017)
Rural Peru	+2.8%
Overall Peru	+1.2%
Urban Peru	+1.1%
Global	-1.8%

Despite governmental and grassroots efforts to reduce the incidences of teenage pregnancy, rates have increased, and are increasing twice as fast in rural areas. We hypothesize this is attributed to:

- **Limited political accountability**
- **Limited healthcare access** in rural communities
- **Sex education that is not comprehensive or culturally sensitive**
- **Socioeconomic barriers**
- **A pervasive culture of machismo** norms and expectations

Such issues undercut programming and foster myths and misinformation, limited understanding of and access to contraception, and differential power dynamics between boys and girls, which contributes to a high incidence of violence, particularly in rural areas.



34% Are pregnant as a result of gender-based violence

66% Suffer psychological distress

26% Higher risks of infections and maternal anemia

~70% Of Peruvians are in the informal labor market

Maria, 16 years old

CHILD IS MORE LIKELY TO BE A YOUNG MOTHER

87% Drop out of school

62% Higher odds of having babies with low birth weight

National

Community / Regional

Interpersonal

Individual

SOCIOECONOMIC FACTORS

POLITICAL WILL

SEX EDUCATION

CULTURAL NORMS

HEALTHCARE ACCESS

KEY FACTORS EXERT INFLUENCE ACROSS SEVERAL LAYERS OF PROXIMITY TO ADOLESCENT GIRLS

PROBLEM LANDSCAPE

Political Will

Peru's "National Action Plan for Infancy and Adolescence" (PNAIA) prioritizes reducing rates of adolescent pregnancy by increasing public expenditure and programming in sex education. However, political instability and corruption lead to implementation challenges. Further, inefficient collaboration across ministries leads to diluted political accountability (PNAIA, 2012).

Despite the Ministry of Health's unsubstantial investment in adolescent pregnancy prevention in 2019, the Ministry experienced budget surpluses, demonstrating inefficient spending practices.

> The government of Peru spends only four soles a year ($1.50) per person to prevent adolescent pregnancies, which is very limited given its total budget.
>
> *—Founder & Executive Director, PROMSEX, Lima*

Moreover, Peru's Minister of Education has changed three times over the past year, rendering it difficult to incorporate proposed gender-focused approaches to a national comprehensive sex education (CSE) curriculum. This attrition was largely due to pushback from conservative parties, especially "Con Mis Hijos, No Te Metas", which protest inclusion of gender equity in CSE.

> The old Minister of Education tried to integrate CSE into Peruvian schools but was rejected by Con Mis Hijos No Te Metas, so he was forced to leave in 2016. Since him, there hasn't been a been focus on CSE.
>
> *—Researcher, Ministry of Education, Lima*

PROBLEM LANDSCAPE

Healthcare Access

Barriers to accessing adequate healthcare services pose significant challenges for adolescents. In 2018:

- 45.9% of women in the highlands couldn't access healthcare because they **were too far from services**.
- 41% of women didn't want to **go alone**.
- In over 88% of cases, the **medicines they were looking for weren't there** (ENDES, 2018).

> Even though contraception is 'free,' resources are not accessible. In rural areas, homes are very far from health clinics. Adolescents often don't have control over going and don't trust health professionals. There is still a lot of shame in discussing sex, even with the doctor.
>
> *—Midwife, Highland Region*

Geographic barriers, especially in highland and jungle regions, provide significant inconveniences in seeking out health resources, health education, and health care, especially when **30% of young women do not have health insurance** (UNFPA, 2018; Svanemyr, 2015). Even when girls afford care and travel to clinics, and physicians are present, they risk not being seen due to **sociocultural and legal beliefs**.

> In theory, adolescents can request an appointment, but some doctors still think parents legally need to be there. So they'll only be seen if the doctor agrees to see them alone.
>
> *— Surgeon, Amazon Region & Lima*

> "Privacy concerns prevent girls from seeking healthcare. These are small communities, and everyone knows what's going on."
>
> *—Midwife, Amazon Region*

PROBLEM LANDSCAPE

Sex Education

Youth being knowledgeable and empowered about their sexuality, reproduction, and contraceptives is associated with significant decreases in adolescent pregnancy (Pick de Weiss et al., 1991). Unfortunately, only **9% of Peruvian adolescents receive comprehensive sex education** (Motta et al., 2017). Teachers state that they lack the resources, training, and partnerships necessary to effectively implement CSE.

> Teachers aren't training their students on these topics because they don't have training. This is a huge limitation, because there are not specific personnel (like ob-gyns) who go to high schools to educate teachers or students.
>
> *—Community Health Worker, Local NGO, Amazon Region*

When sex education classes are available, they take place infrequently and are only facilitated in communities with access to a nearby health clinic, excluding many rural communities (Interviews with Carmen Luz and Gery Parada).

Therefore, adolescents turn to informal modes of sex education (e.g., pornography, social media, friends), which propagate myths, misinformation, and *machismo*.

> When formal education is limited, community members spread their misinformed knowledge. I heard more than once that a woman can only get pregnant if she enjoys the sex. Or that herbs are just as effective as formal contraception.
>
> *—Women's Health Coordinator, Local NGO, Highland Region*

PROBLEM LANDSCAPE

Socioeconomic Factors

Adolescent pregnancy disproportionately occurs among low-income communities. In 2015, **26.9% of pregnant adolescents in Peru were in the lowest income quintile**. Girls in **rural areas**, who are disproportionately low-income and indigenous, **are 50% more likely to become pregnant** as adolescents than their urban counterparts (ENDES, 2018; Interviews with Rosario Gavarito).

Girls from low-income and marginalized backgrounds are also more likely to drop out of school: **41.7% of women who only have primary school education were mothers or pregnant in Peru in 2018** (UNFPA, 2010; ENDES, 2018). Moreover, after becoming pregnant, **67% of girls drop out of school**, limiting their ability to academically advance find employment in the formal economy (Motta et al., 2017). Additionally, there exists significant labor market discrimination for young mothers.

> Having a kid affects your job opportunities a lot. There are some jobs that ask you if you are single or have kids, and won't accept you if you have children.
>
> *—Founder Millennials Movement, Lima*

PROBLEM LANDSCAPE

Cultural Norms

Experiences of Peruvian adolescents are intrinsically linked with cultural norms and expectations that surround them. Peru struggles with ***machismo***, a "stereotype that emphasizes hypermasculinity associated with Latin American males" that began as a colonial understanding of masculinity as dominating and is today understood as a widespread belief that men control women's bodies (Hardin, 2002).

> Without a gender focus and gender perspective, we will keep having violence against women and *machismo.*
>
> *—Co-Founder, Observatorio de Genero y Equidad, Lima*

74% of Peruvians consider Peru a *machista* (or chauvinistic) country, contributing to Peru's high rates of femicide and gender-based violence rates (Immigration and Refugee Board of Canada, 2018). According to UN Women, 31.2% of Peruvian women have experienced physical or sexual violence, an 18% increase since 2015 (MIMP, 2012). Further, in 2010, **34% of adolescents who suffered sexual violence became pregnant**, 14% of were aged 10-14 (UNFPA, 2018; PNAIA, 2012).

> If a man tells you to stay still, you don't move a muscle. He mandates everything.
>
> *—Young woman, Highland Region*

EXISTING SOLUTION LANDSCAPE

Current solutions focus on improving **healthcare access** and **comprehensive sex education**, with some **socioeconomic initiatives**…

…but ignore considerations of political will and cultural nuance.

While many stakeholders are involved—


International Organizations


National Government


Church


Local Government


Clinics


Advocacy Groups & Think Tanks

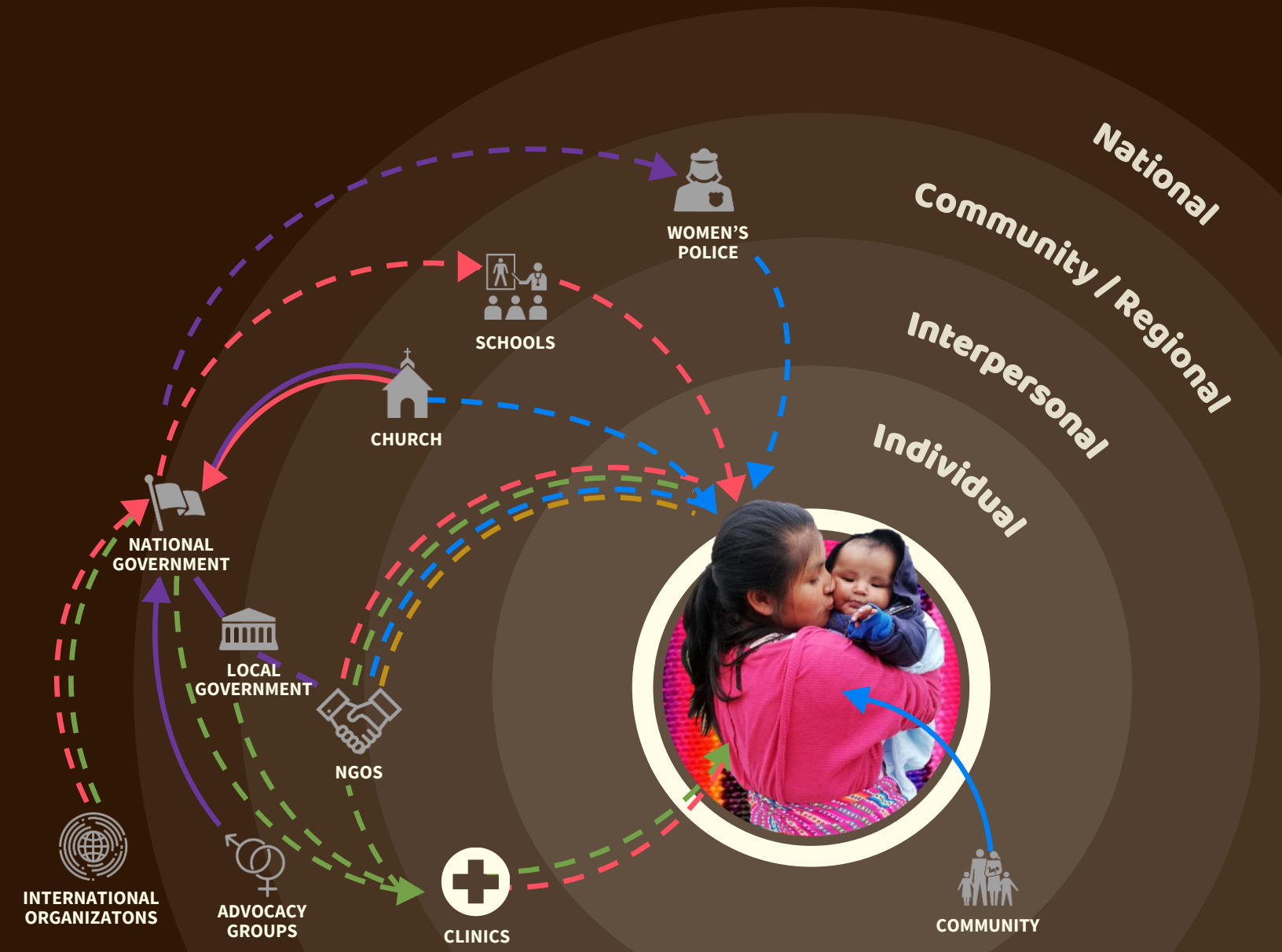

Women's Police


Schools


Local NGOs


Communities

collaboration between stakeholders is inefficient and dilutes responsibility without promoting synergistic capacity building.



MANY PARTIAL SOLUTIONS EXIST, BUT FEW STAKEHOLDERS OFFER COMPLETE SOLUTIONS

KEY

- Sex education
- Health access
- Political will
- Cultural norms
- Socioeconomic initiatives

CURRENT SOLUTIONS LANDSCAPE

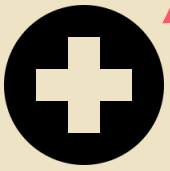
"Comprehensive" Sex Education

The Peruvian government facilitates **joint programming** between the Ministries of Health, Education, Women, and Finance to address sex education. **Comprehensive sex education (CSE)** has been nominally mandated **since 2008**, with the passage of CSE guidelines by the Ministry of Education.

The Ministry of Education is trying very hard to improve CSE, but it's a problem. They want to focus more on gender and gender equity, but there is a lot of political backlash.

—Co-Founder, Observatorio de Genero, Lima

Successes include **midwives in local health clinics teaching reproductive and sexual health education** to youth over 12 years, usually one session every two months. Further, local NGOs and larger international organizations, including PROMSEX, INPPARES, and the Center for Juvenile Development, prioritize sex education programming as a part of their missions.



Clinicians and midwives become responsible for sexual education of youth. Usually, we have sessions once every two months in the high schools starting at age 12. But since there are so many high schools, most children see us far less than that.

—Midwife & Sex Educator, Highland region

CURRENT SOLUTIONS LANDSCAPE

Healthcare Access

Similarly to educational programming, healthcare access is offered nationally and hyper-locally, with limited points of connection.

The Peruvian healthcare system attempts to provide access to all citizens through a nuanced four-tiered system.

	Postas	*Centros*	Regional Hospitals	National Hospitals
Care Capability	1 (very generalized)	2	3	4 (all-encompassing)
Location	Small rural towns	Major rural towns	Regional cities	Lima
Staffed by	Residents completing graduation requirements who may rotate posts / nurse	Residents completing graduation requirement / nurses	Full general medical staff	Full medical staff, including specialized professionals
Gaps	Limited hours; limited treatment capability	Located as far as a full day from rural communities; limited treatment capability	Located as far as several full days from rural communities; expense; limited treatment capability	Located as far as several full days from rural communities; expense

Peru offers a **mixed health system in which public and private sectors coexist** (Huicho et al., 2018). Therefore, in theory, all Peruvian citizens should have access to free contraception at *centros*.

CURRENT SOLUTIONS LANDSCAPE

Socioeconomic Factors

The Peruvian government has experimented with some **conditional cash transfer programs**, including JUNTOS, and has seen positive significant correlation with maternal-neonatal expenditure when implemented with increased education (Guerrero et al., 2020).

Further, the Peruvian government has placed substantial faith in a "trickle-down" theory: **invest in education** (e.g., COAR public magnet schools) and economic improvements will follow.

On the local level, some microfinance organizations successfully exist, but their impact is limited by geographic reach and scalability constraints.

Right now, programming focuses a lot on education, because girls with higher educational attainment are more likely to obtain formal labor outside the home and therefore have her own money, which she is more likely to spend on her own health than her male counterpart.

—Former Director of Program Expansion, Local NGO, Highland Region

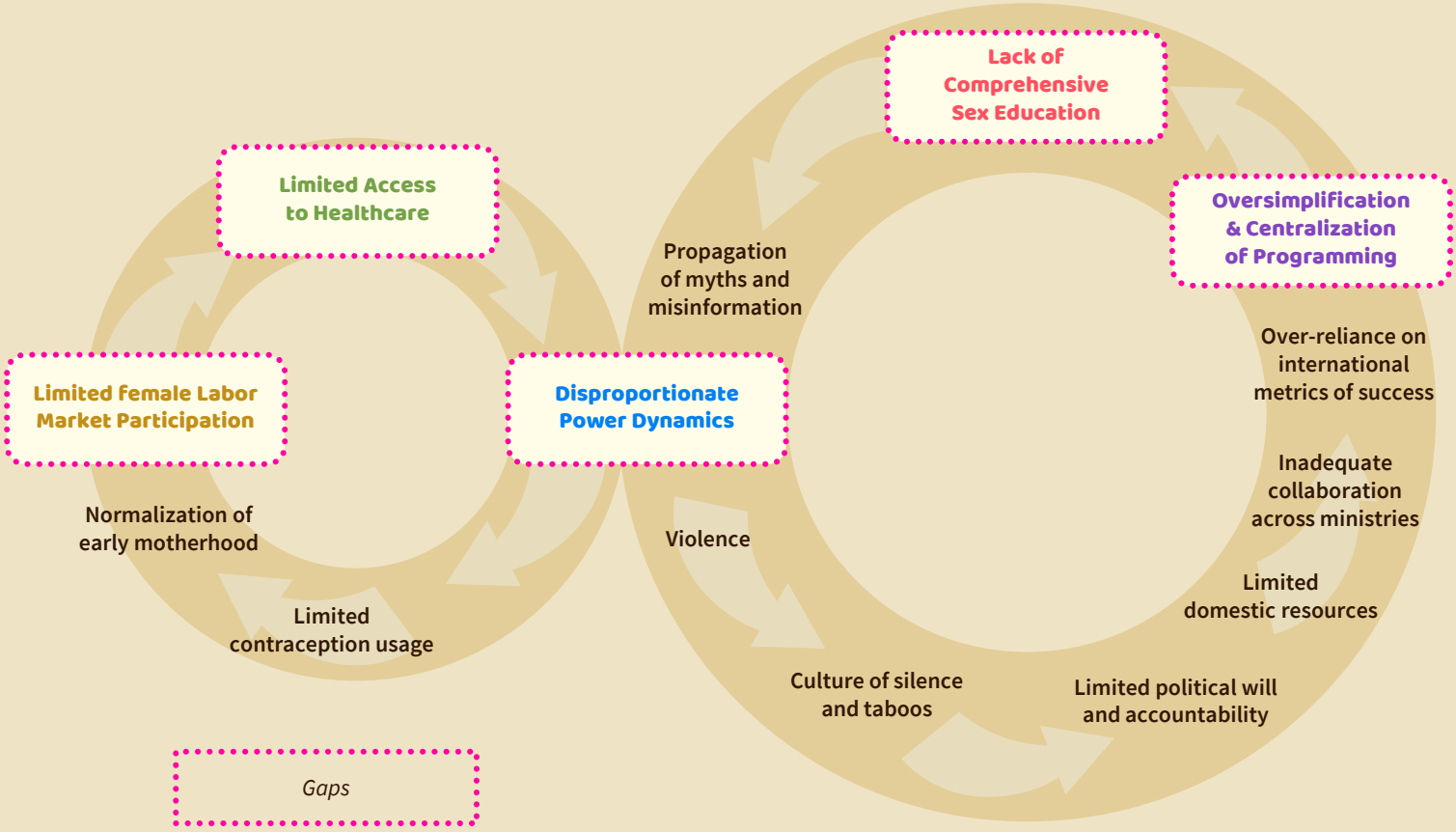
Access to formal work opportunities is so important. Peru's economy is 68-79% informal, and as an informal worker, you don't get access to the same social protections, which an adolescent mother would really need.

—Professor of Gender, Domestic Work, and Health, Universidad del Pacifico, Lima

EXISTING SOLUTIONS	GAPS	LEVERS OF CHANGE
Following international community lead	**Oversimplification & Centralization of Programming**	**Reallocation of resources** to regional governments. Improved **collaboration**
Some NGOs focusing on masculinity.	**Machista Power Dynamics**	**Redefine masculinity** through empowerment methodology.
“Free” healthcare access	**Limited Access to Healthcare**	**Community health workers** **Vending machines**
“Comprehensive” sex education in schools	**Lack of Comprehensive Sex Education**	**Partnerships** **Regional resources & metrics of success**
Cash transfers	**Limited Female Labor Market Participation**	Specific **targeting** of programs Improve **education options**

GAPS AND LEVERS OF CHANGE

Failure to consider cultural, socioeconomic, and political reality creates feedback loops that limit effectiveness of current **education** and **healthcare** programming.

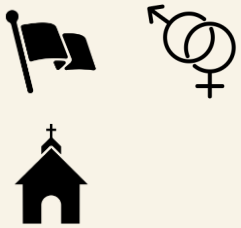


We identified five levers of change that can help alleviate teenage pregnancy and stop the cycle of feedback loops by leveraging several stakeholders.

- **International Organizations**
- **National Government**
- **Church**
- **Local Government**
- **Clinics**
- **Advocacy Groups & Think Tanks**
- **Women's Police**
- **Schools**
- **Local NGOs**
- **Communities**

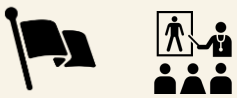
GAPS AND LEVERS OF CHANGE

Over-centralization & Resultant Simplification of Programming

<table>
<tr><th>Levers of Change</th><th>Gaps Addressed</th><th>Stakeholders</th></tr>
<tr><td>Reallocate funding locally to better adapt and address implementation issues</td><td rowspan="2">Increased government expenditure not initially matched by increased successes, making it difficult to justify continued spending on reproductive health</td><td>  </td></tr>
<tr><td>Encourage outsourcing of education to local and international NGOs with existing expertise</td><td>  </td></tr>
<tr><td>Clearly define initiative ownership and national metrics of success</td><td>Limited political accountability due to inefficient ministry collaborations</td><td>  </td></tr>
<tr><td rowspan="2">Public relations campaign clarifying government intent and responsibility</td><td>Con Mis Hijos No Te Metas and other conservative movements exerting pressure on state to limit access to abortion and sex education</td><td rowspan="2">  </td></tr>
<tr><td>Concern surrounding public perception of promotion of reproductive rights due to previous government wrongdoings (e.g., forced sterilization of rural women)</td></tr>
</table>

GAPS AND LEVERS OF CHANGE

Lack of Comprehensive Sex Education

Levers of Change	Gaps Addressed	Stakeholders
Leverage international and local **partnerships** with relevant expertise	Lack of gender sensitivity and empowerment perspectives	
	Limited culturally sensitive or adaptable resources	
Community Health Worker (CHW) methodology, including text message or app-based education materials	Limited CSE in rural areas	
Set **national metrics of success**	Limited CSE in private schools	
Start CSE **earlier**	Education starting after age of first sexual experience	

GAPS AND LEVERS OF CHANGE

Limited Access to Healthcare

Levers of Change	Gaps Addressed	Stakeholders
Scale successful programming	Limited usage of allocated funding	
Support partnerships running successful programming		
Community Health Worker methodology and **alternative access points** (e.g., vending machines, text message services, 24 /7 availability)	Geographic access constraints	
	Language barriers	
	Insurance gaps	
	Privacy issues	
	Timing constraints (e.g., health posts closed on weekends or after school)	
Information campaign focused on realigning doctors' and parents' expectations	Misunderstanding of legal structures	

GAPS AND LEVERS OF CHANGE

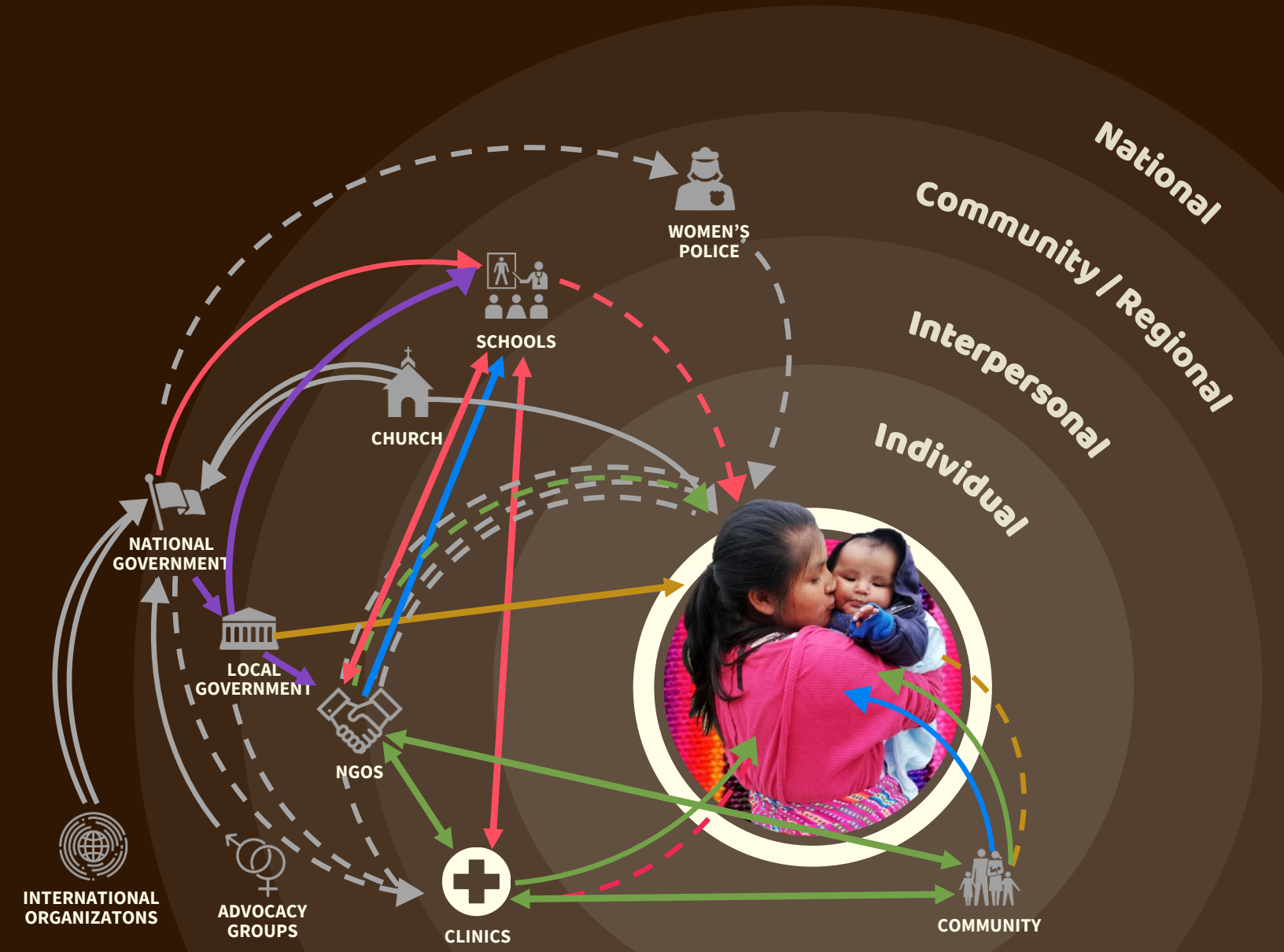
Limited Female Labor Market Participation

Levers of Change	Gaps Addressed	Stakeholders
Implement **nonconditional cash transfer** programs	Conditional cash transfer programs limit agency of low-income communities to spend as they see necessary (e.g., on contraception)	
Implement programming **targeted at young women**	Limited programming aimed at targeted population	
Introduce app-based, **distance learning**, or boarding options	Geographic constraints to general, non-COAR education	
Welcome, expand, and **scale existing MFIs**	Existing *microfinanzas* are limited in scope	
Consider public **childcare options** for adolescent mothers	High dropout rates Labor market discrimination	

GAPS AND LEVERS OF CHANGE

Disproportionate Power Dynamics

<table>
<tr><th>Levers of Change</th><th>Gaps Addressed</th><th>Stakeholders</th></tr>
<tr><td rowspan="3">Fund and scale existing programming focusing on empowerment through storytelling, identity making, and communication</td><td>Discussion of masculinity and male roles in reproductive health</td><td rowspan="3">  </td></tr>
<tr><td>Fostering communication across and between genders</td></tr>
<tr><td>Myths and misinformation</td></tr>
<tr><td>Mentorship program emphasizing women from similar communities who have achieved different definitions of “success”</td><td>Limited belief in life beyond cultural norms</td><td>  </td></tr>
</table>



LEVERS OF CHANGE CAN BE IMPLEMENTED BY IMPROVING COMMUNICATION AND REGIONAL PARTNERSHIPS

KEY

- Sex education
- Health access
- Political will
- Cultural norms
- Socioeconomic initiatives

KEY INSIGHTS AND LESSONS LEARNED

Many complex factors contribute to high incidence of adolescent pregnancy.

While some are addressed through solutions in this report, it is unlikely that Peru will see significant changes in adolescent pregnancy without significant systemic overhaul , starting with strategic partnerships and communication across different sectors.

The Peruvian government has yet to fully identify this issue as a crisis.

Several interviewees remarked that adolescent pregnancy is only nominally a priority of the Peruvian government. In order to create systematic change, members from grassroots to government must identify adolescent pregnancy as a crisis calling for immediate action.

Men and boys should be actively involved in the solution.

When approaching adolescent pregnancy, young women are placed at the epicenter of the solution. We observed how many programs are primarily focused on women and how there is a critical lack of male involvement in the reproductive and sexual education of youth. There will not be change until men and boys are actively participating in reducing high rates of adolescent pregnancy and gender inequity.

Peruvian solutions can be adapted to the global stage.

Although Peru has one of the highest adolescent pregnancy rates in the region, challenges and implications of adolescent pregnancy are not limited to Peru. Frameworks embraced to understand systemic barriers to change can be applied globally.


Flora, 4 years old
ENDING THE CYCLE OF TEEN PREGNANCY
Redefining gender roles through empowerment methodology
Education opportunities & specific transfers
Partnerships & regionalized CSE
Community health workers & vending machines
Reallocation of resources